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## An Exploratory Study of the Intrapersonal, Socio-cultural, and Behavioral Factors that Influence HIV Risk Behaviors Among Ethnic Subgroups of Black Heterosexual Men: The Intersection of the Beliefs and Perceptions of Black Women

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An Exploratory Study of the Intrapersonal, Socio-cultural, and Behavioral Factors  
that Influence HIV Risk Behaviors Among Ethnic Subgroups of Black Heterosexual  
Men: The Intersection of the Beliefs and Perceptions of Black Women

by

Shalewa Noel-Thomas

A dissertation submitted in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy  
Department of Community and Family Health  
College of Public Health  
University of South Florida

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Socio-ecological, Sexual Health, Health Beliefs, Theory of Gender and Power

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Dedication

*To Mavis Lloyd-Johnson*

To all who continue to fight to eradicate HIV and AIDS across the world.

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An Exploratory Study of the Intrapersonal, Socio-Cultural, and Behavioral Factors that Influence HIV Risk Behaviors among Ethnic Subgroups of Black Heterosexual Men: The Intersection of the Beliefs and Perceptions of Black Women

Shalewa Noel-Thomas

ABSTRACT

Twenty five years after AIDS was first scientifically described, the disease continues to take its toll on the human population. HIV/AIDS disproportionately affects marginalized groups such as poor, underserved, minority populations. In the United States, Blacks become infected with and die from HIV/AIDS more than any other ethnic or racial group. Despite a vast body of literature on HIV/AIDS, little research has focused on black heterosexual men and even fewer studies have explored the context of risk among subgroups of black men.

Using qualitative research methods and a socio-ecological framework, this study explored the intrapersonal, socio-cultural, and behavioral factors that influence sexual behaviors in ethnic subgroups of black men who identify as heterosexual. Further, the study examined black women's perceptions of the sexual behaviors of black men. Conducted in a metropolitan area in Southwest Florida , the study consisted of two phases: 1) semi-structured in-depth interviews were conducted among U.S.-born (N=15) and Haitian-born (N=14) heterosexual men who are 18 years and older and have lived in the U.S. for at least 3 years. 2) Using focus group methodology, phase 2 explored black women's (N=23) perceptions of black male sexual behaviors.

Study findings have significant implications for public health education, research and practice. Findings reveal that while Haitian-born and U.S.-born men have high levels of knowledge about HIV, they also ascribe to HIV conspiracy beliefs and practice high risk sexual behaviors such as unprotected sex and partner concurrency. Results show that black men's sexual behaviors are influenced by socio-ecological factors such as family norms, hip-hop culture and religious beliefs. Female study participants perceived factors such as masculine ideologies, socialization, and the male-to-female ratio imbalance as critical influences on male sexual behaviors. While intrapersonal approaches are important to address HIV risk behaviors, ecological frameworks are necessary to inform the development of HIV prevention programs that address the socio-ecological factors that create an environment of risk. This inquiry underscores cultural and gender differences in the conceptualization of HIV/AIDS. Findings have implications for HIV prevention and demonstrate the need for gender-specific and culturally relevant HIV prevention approaches for U.S.-born and Haitian-born blacks.

*It is people joining forces in a time of great need. It is hope, it is sharing the burden. It is people caring for their own and finding love, and surviving, and believing in the future even when we are hurting more than we have ever hurt before .It is AIDS.  
(Chris Brownlie – 1951-1989)*

## CHAPTER ONE: INTRODUCTION

### *Statement of the Problem*

Racial and ethnic disparities in the incidence and prevalence of HIV and AIDS continue to exist globally and in the United States. Blacks comprise 13% of the U.S. population, but account for almost half (49%) of the more than 1 million people living in the United States with HIV/AIDS (CDC, 2008a). Critical to fighting this racial divide in the AIDS epidemic, is an understanding of health disparities and the devastating impact these inequities have on minority communities. The National Institutes of Health defines health disparities as “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States” (NCI, 2007). According to the National Minority AIDS Council (NMAC), a more systematic approach that addresses public policy is urgently needed to address the root causes of the health inequalities that devastate black communities (NMAC, 2006). Therefore, efforts must be made to address the need for new, innovative, multi-layered, mixed-methodological approaches to understanding appropriate and effective interventions.

The Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS), was first identified in the United States in June

1981. Since then, this disease has caused significant morbidity and mortality both in the United States and globally. According to the World Health Organization (WHO), as of December 2008, there were approximately 33.4 million people living with HIV/AIDS globally. In 2008, including 2.7 million people were newly infected with HIV. In this same year, 2 million died from the disease. Of the 6,800 people who were infected each day in 2007, 96% lived in low and middle income countries, 50% of the infections were among women and 40% among young people between the ages of 15 and 24 years (WHO, 2009).

#### *Burden of HIV/AIDS in the U.S.*

Likewise, the epidemic in the United States is far from over. Latest Center for Disease Control and Prevention (CDC) estimates show that over 56,000 new infections occur every year – one person every 9.5 minutes (Hall, Song & Rhodes et al., 2008). The CDC estimates that at the end of 2003 there were 1,039,000 to 1,185,000 persons in the United States living with HIV. In 2007, the estimated number of deaths of persons with AIDS in the United States and dependent areas was **14,561**. In the 50 states and the District of Columbia, this included **14,105** adults and adolescents, and **5** children under age 13 years. The cumulative estimated number of deaths of persons with AIDS in the United States and dependent areas, through 2007, was **583,298**. In the 50 states and the District of Columbia, this included **557,902** adults and adolescents, and **4,891** children under age 13 years (CDC, 2009a). While HIV prevention and education efforts have been in existence for over 25 years; the United States continues to face the heavy burden of HIV and AIDS. HIV/AIDS continues to be a devastating disease which ravages the lives of individuals and communities.



### *Burden of HIV/AIDS in the U.S. Black Population*

The black population is disproportionately infected and affected by HIV. African American males continue to bear the greatest burden of HIV infection. In 2006, the HIV diagnosis rate for all black males in 33 states was the highest of any group— more than 7 times that for white males, more than twice the rate for Hispanic males, and more than twice the rate for black females. African American females are also disproportionately affected by HIV infection. In 2006, the HIV diagnosis rate for black females was more than 19 times the rate for white females (CDC, 2008a).

In addition, the rate of AIDS diagnoses for black adults and adolescents is 10 times that for whites and 3 times the rate for Hispanics. In 2007, African Americans accounted for 51% of the estimated **42,495** new HIV/AIDS diagnoses in the United States (see Appendix A, Figure 1), (CDC, 2009b). Blacks also experience disparities in HIV-related deaths and survival outcomes. Since the beginning of the epidemic, 38.6% of AIDS deaths have been among blacks and this proportion is increasing. According to the Health Resources and Services Administration (HRSA), critical issues related to the disproportionate rates of HIV in the black population include: blacks are more likely to be uninsured than whites; blacks are three times more likely to live in poverty than whites; and blacks have poorer quality and worse access to health care than whites (HRSA, 2008).

The effect of AIDS in the black community has become more devastating over time. The AIDS case diagnosis in blacks rose from 25% of total cases diagnosed in 1985 to 49% in 2006. In recent years, this percentage has remained relatively stable (Henry J. Kaiser Family Foundation, 2008a). At the national level, data are not collected for black

sub-populations. Rather, infection rates in sub-populations are reported as African American data. Risk factors for HIV transmission within the black population are complex and require multiple approaches to address them. This study will increase our understanding of the intrapersonal, socio-cultural, and behavioral factors that may increase the risk of heterosexual transmission among two ethnic subgroups of U.S. black heterosexual men: U.S.-born and Haitian-born men living in the U.S. for at least three years.

### *Rationale for the Inquiry*

In the United States, HIV/AIDS disproportionately affects minority populations with blacks accounting for half of the new infections each year. HIV/AIDS is one of the major health disparities between whites and blacks in the United States. Because of the complex factors that influence acquisition of the virus, the black population remains vulnerable to HIV infection. These factors include poverty, stigma, lack of access to health care, discrimination, incarceration, homophobia, substance abuse and mental health problems (CDC, 2007a). Moreover, African American women continue to experience high rates of infection via heterosexual transmission. Yet, little is known about the risk behaviors of black men who identify as heterosexual and who may be the transmitters of the disease to black heterosexual women. Further, even less is known about the subgroup differences in HIV risk behaviors among black men. An exploration of the behaviors of black men is warranted to better understand the factors that increase the risk of heterosexual transmission. This study explored the knowledge, attitudes and beliefs about HIV and sexual behaviors among black men, and the influence of intrapersonal, socio-cultural, and behavioral factors on HIV risk behaviors. The findings

of this study have significant implications for prevention of heterosexual HIV transmission among blacks.

Much of the research on the heterosexual AIDS epidemic in the U.S. has focused on women (Campbell, 1995). Likewise, research efforts regarding HIV transmission and prevention among the U.S. black population have largely focused on women and gay populations. Heterosexual men have been the “forgotten group” in this area of inquiry (Exner, Gardos, Seal & Ehrhardt, 1999, p. 347). According to Dworkin, Fullilove & Peacock, (2009), it is time to shift the HIV/AIDS discourse and prevention practice focused on heterosexually active men from gender-neutral to gender-specific and gender-transformative. Moreover, there is a paucity of research addressing the, socio-cultural, intrapersonal, and behavioral factors that influence HIV-risk behaviors in black heterosexual men.

Even fewer studies have addressed the influence of these factors on sexual behaviors within ethnic subgroups of the heterosexual black male population. The rising proportion of U.S. blacks who are foreign-born is expected to affect the health profile of the black population in the U.S. (Read & Emerson, 2005; Read, Emerson & Tarlov, 2005). The HIV pandemic has reached all regions of the world, but Sub-Saharan Africa has been the hardest hit, followed by the Caribbean. In Latin America and the Caribbean, an estimated 2 million people are living with HIV/AIDS. Of these, 160,000 were newly infected in 2007 (Henry J. Kaiser Family Foundation, 2008b). As of the end of 2007, an estimated 230,000 people were living with HIV/AIDS in the Caribbean, with 75% of those infected living in Haiti and the Dominican Republic. AIDS is one of the leading causes of death in the Caribbean among those aged 25-44 (Henry J. Kaiser Family

Foundation, 2008c). Based on these data, immigration patterns may influence the HIV prevalence in the United States and ultimately affect the health profile of the U.S. black population.

The literature reveals a critical gap in research that acknowledges the diversity of the black population (Beatty, Wheeler & Gaiter, 2004). Little is known about the socio-cultural beliefs, knowledge, and attitudes related to HIV transmission and risk behaviors among ethnic subgroups of U.S. blacks. Much of the current literature assumes homogeneity among U.S. blacks and does not account for distinct ethnicity. While there are different and similar socio-cultural experiences across population sub-groups, the differences need to be identified and specific interventions and prevention initiatives developed accordingly. There is a need to adopt approaches to fight HIV/AIDS in the black community that consider the social, structural, and contextual environments (McCree, 2009).

This study furthers the body of knowledge as it allows for an in-depth exploration of the socio-cultural, intrapersonal, and behavioral factors that influence the HIV-risk behaviors of U.S.-born and Haitian-born black heterosexual men. The study also allows for comparison of the perspectives of black men with that of black women from similar ethnic subgroups. The results of this study may be used to design quantitative instruments for future studies and broader application. Study results also provide insights for HIV education and behavioral interventions to reduce HIV/AIDS health disparities within ethnically diverse black populations. Based on the identified gaps in the literature, the following research questions were explored in this inquiry.

## *Research Questions*

Research questions were guided by research objectives which included the following:

*Objective 1:* To understand the intrapersonal factors (knowledge, attitudes and beliefs) that influence HIV-risk behaviors in subgroups of black men (Native born African Americans and Haitian-born immigrants) who identify as heterosexual.

*Research Question:*

1. What are black men's knowledge, attitudes, and beliefs about HIV/AIDS transmission?

*Objective 2:* To understand the socio-cultural and behavioral factors that influence HIV risk behaviors in subgroups of black men (Native born African Americans and Haitian-born immigrants) who identify as heterosexual.

2. What cultural norms influence sexual behavior among black men who identify as heterosexual?
3. What are the HIV-risk behaviors practiced by black men who identify as heterosexual and what factors are associated with these behaviors?
4. How do gender norms influence sexual behavior among black men who identify as heterosexual?

*Objective 3:* To discover how black *women* conceptualize and perceive the socio-cultural and behavioral factors that influence black men's HIV-risk behaviors.

5. What are black women's perceptions of the risk behaviors practiced by black men who identify as heterosexual?

6. What are black women's perceptions of the gender and cultural norms that influence sexual behavior among black men who identify as heterosexual?
7. What are black women's perceptions of the ways in which black men's sexual behaviors affect black women's health?

#### *Delimitations*

1. This study was delimited to Haitian and African American heterosexual men who reside in Hillsborough County, Florida.
2. This study was delimited to Haitian and African American men 18 years of age and older residing in Hillsborough County, Florida.
3. For purposes of this study, male participants included men who self identify as heterosexual.
4. This study included Haitian and African American women 18 years and older residing on Hillsborough County, Florida.
5. Only U.S.-born and Haitian-born black men and women who volunteer to participate in the study were included.

#### *Limitations*

Limitations refer to limiting conditions or restrictive weaknesses inherent in the study (Locke, Wyrick Spirduso & Silverman, 2000). The following are limitations of this study:

1. Researcher subjectivity refers to the researcher's own perspective (Grbich, 1999). As is characteristic of qualitative inquiry, the views and perspectives of the researcher may have some influence over the study. My professional and personal background, attitudes, beliefs and worldviews may have influenced interpretation of the data.

2. The study findings were based on self-reported data from study participants.
3. Individuals who volunteered to participate in this inquiry may be different from those who did not agree to participate.
4. The results of this study are based on the participants' perceptions, recall and interpretation of their lived experiences.
5. Convenience sampling methods were used to recruit study participants.

#### *Definition of Relevant Terms*

1. *Acquired Immunodeficiency Syndrome (AIDS)*: AIDS is the final stage of HIV infection. Having AIDS means that the immune system has been weakened and the body has a difficult time fighting infections. To be diagnosed with AIDS, an individual must have a CD4 count less than 200 and/or have an AIDS defining opportunistic infection (U.S. Department of Health and Human Services [DHHS], 2010).
2. *African American*: An American of black African descent. Persons who self-identify with African American ancestors who were involuntary immigrants to the United States (Ogbu as cited in Lewis & Kertzner, 2003).
3. *Behavioral Health*: Behavioral health was first coined in the 1980's to describe the combination of the fields of mental health and substance abuse. It focuses on the study of behavioral health problems such as depression, eating disorders, substance abuse, domestic violence, and anxiety disorders.
4. *Blacks*: Individuals of African descent. For the purposes of this study, "black" is used as the catchall term to describe all persons of African descent.

5. *Culture*: A set of rules, standards, or beliefs shared by the members of a group that when acted upon by those members, produces behaviors that fall within a range considered acceptable and proper by those members (Matthews, 2004).
6. *Haitian-born immigrant*: A native of Haiti who migrated to the United States. For the purpose of this study, Haitian immigrants must have lived in the U.S. for at least three years.
7. *Heterosexual*: A person sexually attracted to persons of the opposite sex or a person who has sexual relations with the opposite sex (Medicine Net, 2008).
8. *Human Immunodeficiency Virus (HIV)*: This is the virus that causes AIDS. HIV finds and destroys the immune system by attacking white blood cells (T cells or CD4 cells) that enable the body to fight disease (CDC, 2010).
9. *Social ecology*: The social ecology perspective involves examining the behaviors of individuals within the context of their social and physical environment (DiClemente, Salazar, Crosby & Rosenthal, 2005).
10. *Substance Abuse*: For the purposes of this study, substance abuse refers to illegal drugs (e.g. cocaine, methamphetamines, marijuana etc.) as well as alcohol.
11. *U.S. blacks*: Individuals of African descent living in the United States. For the purposes of this study, U.S. blacks refer to U.S.-born blacks and Haitian-born blacks living in the United States for at least three years.



## CHAPTER TWO: LITERATURE REVIEW

This chapter provides a review of the current literature on HIV/AIDS risk behaviors, knowledge, attitudes and beliefs about HIV risk, and the socio-cultural, and behavioral factors that influence sexual behaviors. This literature review will explore black population data including epidemiological data on HIV/AIDS in the United States. Critical to this inquiry, is an analysis of the theoretical perspectives that will inform the study. This chapter will present a modified socio-ecological perspective as the overarching framework as well as the health belief model and the theory of gender and power which will be used to inform specific aspects of the study.

### *Overview of HIV/AIDS Research on Risk Behaviors*

Historically, HIV/AIDS social science research has focused primarily on individual risk behaviors, personal agency and individual volition. Little attention has been devoted to the context within which sexual behaviors occur. (Adimora et al., 2001; Farmer, Connors & Simmons, 1996; Parker, 2001; Wight, 1999; Raiford, DiClemente & Wingood, 2009). The concepts of individual responsibility and behavioral individualism have dominated the sexual behavior research literature while social and environmental factors have seldom been considered. These approaches are based on the idea that individuals have total personal control over their health behaviors which leads to the failure to conceptualize sexual behavior within a social and cultural context.

Clearly, the focus on individual psychology and subjectivity has done little to reduce or explain the increasing HIV infection rates in minority populations. Evidenced by the CDC's launch of *A Heightened National Response to the HIV/AIDS Crisis among African Americans* (CDC, 2007a), the epidemic continues to be a significant problem in the black community. It has become clear that a complex set of social, cultural, economic and structural factors interplay to affect the dynamics of risk and individual level factors cannot fully explain sexual behaviors (Parker, 2001). The combined effect of social factors such as poverty, substance abuse, oppression, racism and oppression increases vulnerability to HIV infection (Farmer et al., 1996; Parker, 2001; Romero-Daza, Weeks, & Singer, 1998). Recognizing these influences is important in shaping the research agenda to better address these social and cultural factors that increase risk behaviors and susceptibility to HIV infection.

Additionally, the HIV/AIDS literature has largely failed to address the risk behaviors of heterosexual black men. While many studies have focused on the risk behaviors and HIV interventions among women and gay identified men, much less attention has been devoted to heterosexual men. Ironically, in black communities, men are the main source of HIV transmission, yet little research has focused on their risk behaviors (Exner, Gardos, Seal, & Ehrhardt, 1999; Miller, Serner & Wagner, 2005; O'Sullivan, Hoffman, Harrison & Dolezal 2006). It is therefore imperative that research not only explore social and cultural determinants of sexual behavior but also that heterosexual men are included as the focal participants of future research studies.

### *U.S. Black Immigrant Population*

As immigrants from Africa, the Caribbean, Europe, and Latin America continue to migrate to the United States, the U.S. population has undergone a racial and ethnic transformation (Kent, 2007). In 2000, 36.2 million or 12.9% of the U.S. population reported that they were black (U.S. Census, 2000). The number of foreign-born blacks more than tripled between 1980 and 2005 (Kent, 2007). Approximately 10% of the black population is foreign-born. In 2000, 84% of the foreign-born blacks were from the Caribbean (60%) or Africa (24%) (U.S. Census Bureau, 2000). Black Caribbean immigrants primarily emerge from three countries: Jamaica, Haiti, and Trinidad. Guyana also contributes significantly to the U.S. black foreign-born population (see Appendix B, Table 1).

Since the founding of the United States, African Americans have comprised a significant proportion of the population. In 1790, they accounted for one-fifth of the 3.9 million Americans counted in the census. During this time, African Americans were involuntarily brought to the United States, a reality of the African slave trade. After the slave trade ended, black immigration to the United States was restricted while there was an increase in whites migrating from Europe to the United States. By the 1900s, blacks who migrated to the U.S. emerged primarily from the Caribbean and settled mostly in New York. Since the 1970s, there has been resurgence in the rates of black migration to the U.S. As noted, many of these immigrants hail from Africa, the Caribbean and Latin America. In recent decades, immigrants from these areas have settled in major cities such as New York, Miami, and Washington, DC. (Kent, 2007).

Florida has an increasingly ethnically diverse black population with about 16% of the black population being foreign-born. In Hillsborough County, the majority of foreign-born black individuals are from Jamaica, Haiti and Trinidad & Tobago (U.S. Census Bureau, 2000). (see Appendix B, Table 2). In the past several years, the Haitian population in Hillsborough County has more than doubled. Between 1994 and 2005, the Haitian population has increased from 8,000 to approximately 20,000 (Lush, 2002).

The influx of black immigrants has implications for the HIV/AIDS disparities that persist in the United States. The impact of heterogeneity and diversity within the U.S. black population is largely unaccounted for in HIV/AIDS research and national imperatives to reduce HIV/AIDS health disparities. To reduce these disparities, research must focus on the subgroup differences within the black population that may account for differential risk taking behaviors.

#### *Burden of HIV/AIDS among Black Men in the U.S.*

Black men in the United States are heavily affected by HIV/AIDS. In 2005, black men accounted for 41% of men living with HIV/AIDS in the United States and made up 65% of HIV/AIDS cases among blacks (CDC, 2009b; CDC, 2007b). Among black men living with HIV/AIDS, 48% of cases are related to homosexual contact, 23% are related to injection drug use and 22% are related to heterosexual contact (CDC, 2007a). During 2001-2005, black males accounted for more new HIV/AIDS diagnoses than males from any other race/ethnicity in the Southern and Northeastern regions of the United States (CDC, 2007c). In 2005, the rate of AIDS diagnoses for black men was 8 times the rate for white men (CDC 2009b).

### *Burden of HIV/AIDS among Black Women in the U.S.*

According to the CDC, the HIV epidemic presents a serious health threat to women in the United States, particularly women of color. Today, women account for over 25% of all new HIV diagnoses. In 2004, HIV infection was the leading cause of death for black women aged 25-34 years, the third leading cause of death for black women aged 35-44 years and the fourth leading cause of death for black women aged 45-54 years. In 2005, the rate of AIDS diagnosis for African American women was approximately 23 times the rate for white women and 4 times the rate for Hispanic women (2008b). Between 2001 and 2005, among females, blacks accounted for the majority of HIV/AIDS diagnoses in the Southern, Northeastern and Midwestern regions of the United States (CDC, 2007c). The primary exposure category for HIV/AIDS among black women is heterosexual contact followed by injection drug use (CDC, 2008b). The data show the devastating impact of HIV/AIDS among black women who are at increased risk for infection. The dramatic and sustained increase in the rates of infection in black women is alarming and should be cause for concern among the black community, the public health community, and the nation as a whole.

### *Burden of HIV/AIDS among Blacks in Florida*

In Florida, the effect of the AIDS epidemic has been no less devastating within the black community. Similar to the national rates, blacks comprise 15% of Florida's adult population but account for 54% of AIDS cases and 45% of HIV cases reported in 2007 (see Appendix A, Figure 2). Among black males, the AIDS case rate for 2007 was 6 times higher than among white males. Among black females in 2007, the AIDS case rate was 20 times higher than among white females (Florida Department of Health, 2007a).

According to the Florida Department of Health's "Silence is Death" Report, more blacks are living with HIV/AIDS or have died from the disease in Florida than any other racial or ethnic group (Florida Department of Health, 2006a). In fact, 1 in 209 white men compared to 1 in 44 black men are living with HIV/AIDS in Florida (Florida Department of Health, 2010). Through 2006, 1 in 68 black women were living with HIV/AIDS compared to 1 in 1281 white women and 472 Hispanic women. Further, in Florida, HIV is the leading cause of death for black men and women ages 25-44 years (Florida Department of Health, 2008). These data show the severe HIV/AIDS disparities that exist in the black community in Florida. HIV/AIDS infections in the black community have reached critical proportions, as the disease continues to affect people of color.

#### *Burden of HIV/AIDS among Blacks in Hillsborough County, Florida*

Hillsborough County ranks among the top 5 counties in Florida for persons living with HIV/AIDS and is one of the Emerging Metropolitan Areas for HIV/AIDS in the State (Florida Department of Health, 2006a). In Hillsborough County, 48% of the adult HIV cases and 69% of the pediatric cases are among blacks (Hillsborough County Health Department, 2006) (see Appendix A, Table 1). The Florida Department of Health (2006a) reports that 1 in 85 blacks are living with HIV/AIDS in Hillsborough County compared to 1 in 375 whites and 1 in 309 Hispanics. Among men in Hillsborough County, 1 in 55 blacks are living with HIV/AIDS versus 1 in 157 whites and 1 in 177 Hispanics (Florida Department of Health, 2010). Among women in Hillsborough County, 1 in 92 women are living with HIV/AIDS compared to 1 in 1007 whites and 1 in 403 Hispanics. These rates closely mirrors the state and national rates.

Although the CDC has reported decreases in the infection rates among black women on the national level, the impact of this devastating disease in the black community at all levels of society is undeniably critical. As a result, the CDC (2007a) has issued a report called *A Heightened National Response to the HIV/AIDS Crisis among African Americans* with the realization that the burden of HIV/AIDS in the black community continues to be monumental. In addition, as part of the CDC's *Act Against AIDS Campaign*, the CDC has launched a \$10 million dollar, five year partnership with key African American organizations to develop and implement strategies to continue the fight against HIV and AIDS in the black community. These initiatives along with a united community response will be necessary to win the fight against HIV especially in communities of color.

#### *Burden of HIV/AIDS among Immigrants in Florida*

As Florida's population continues to grow and diversify, it becomes even more critical to collect and analyze data for immigrant populations as well as tailor specific interventions that are culturally relevant and appropriate. In recent years, the Florida Department of Health has implemented HIV/AIDS case reporting for Caribbean-born immigrants. Florida surveillance data from 2008 show that a total of 24,069 HIV/AIDS cases among Caribbean-born individuals were reported through 2008 (see Appendix A, Table 2), 46% of which were reported among Haitian-born immigrants. Surveillance data also show that Caribbean-born blacks comprise the majority of HIV/AIDS cases reported among Caribbean-born individuals. Through December 2008, among Caribbean-born men with HIV/AIDS, 53% were black and 45% were Hispanic. Among Caribbean-born

women with HIV/AIDS, 77% were black, 21% were Hispanic, and 1% were white (Florida Department of Health, 2008b).

#### *Burden of HIV/AIDS among Haitians in Florida*

The Florida Department of Health also reports HIV infection rates for the sub-population of Haitians who make up 1.05% of Florida's population. Of the black adults living with HIV/AIDS in the state of Florida through 2008 (N=42,973), Haitians account for 15% (N=6,647). Males comprised approximately 56% of the adult AIDS cases in this Haitian sub-population (Florida Department of Health, 2008c).

#### *Rationale for Focus on Haitian-born Blacks*

Epidemiological data also show that there are also high infection rates in the Haitian population in Florida. Even though they comprise 1.1% of Florida's population, they account for approximately 7.3% of HIV cases in the state (Florida Department of Health, 2008c). In addition, the influx of Afro-Caribbean individuals into Florida and Hillsborough County warrants an investigation of the cultural and social implications for HIV transmission and prevention. Most notably, the Haitian population in Hillsborough County has more than doubled in the past several years (Lush, 2002). Finally, there are distinct cultural differences between the African American and Haitian cultures that may manifest in significantly different beliefs and practices around sexual behavior. For example, unlike African American culture, Haitian culture incorporates the concept of *voodoo*, a form of magic that often dictates beliefs around illness and health behavior.

#### *Risk Factors for HIV Transmission in the Black Population*

The widespread transmission of HIV/AIDS within the black population can be attributed to a complex set of intrapersonal, socio-cultural, and behavioral factors.



Embedded within these factors are issues of racism, discrimination, poverty, unemployment, denial, stigma, homophobia, limited access to healthcare, delayed prevention messages, HIV/AIDS conspiracy beliefs, incarceration, unstable housing, injection drug use, lack of awareness of HIV serostatus, high rates of sexually transmitted diseases, and risky sexual behavior among HIV-positive individuals (CDC 2007a; CDC 2008a; Florida Department of Health, 2006; National Minority AIDS Council, 2006; Plowden, Fletcher and Miller, 2005).

### *Intrapersonal Factors*

Since the beginning of the HIV epidemic, much of the social science literature and theoretical frameworks have focused on the intrapersonal behavioral correlates of HIV infection. Largely, the focus of this body of knowledge has been on the extent to which the individual's knowledge and perceptions influence risk behaviors (Parker, 2001; Rhodes, 1997). Social psychological theories have been postulated to conceptualize the internal factors that explain HIV-risk behaviors. Among these are the theories of *reasoned action*, *social cognitive theory*, *information-motivation-behavioral skills theory*, *the health belief model*, *stages of change* and the *AIDS risk reduction model*. Based on these psychological models, key factors posited to be associated with HIV risk include, knowledge, attitudes, beliefs, perceptions, self-efficacy, subjective norms, behavioral skills, and motivation (Bandura, 1994; Catania, Kegeles & Coates, 1990; Fisher & Fisher, 2002; Montano & Kasprk, 2002;. Prochaska, Redding & Evers, 2002; Rosenstock, 1974a).

The health belief model conceptualizes six key dimensions of health behavior change: *perceived susceptibility*, *perceived severity*, *perceived benefits*, *perceived*

*barriers, cues to action, and self-efficacy* (Basen-Enquist, 1992; Janz, Champion & Strecher, 2002). These individual level concepts are hypothesized to be associated with sexual behaviors and intentions. Even though the health belief model incorporates environmental influences, the cognitive dimensions are the central tenets of the theory. Likewise, Bandura (1977) posits that cognitive processes mediate change and self-efficacy is central to effecting behavior change. *Self-efficacy* is defined as “the conviction that one can successfully execute the behavior required to produce outcomes” (Bandura, 1977 p. 193). Bandura (1994) argues that self-regulative skills and personal volition over sexual behavior and drug activities are required to translate health knowledge and information into effective self-protection against HIV infection. Therefore, with regard to HIV-risk behaviors; these critical cognitive processes must occur for an individual to take the recommended action to reduce HIV risk.

The AIDS risk reduction model is comprised of three stages that emphasize efficacy, emotional influences and interpersonal activities. Central to this model, are individual level influences on sexual risk behavior such as, knowledge of risky sexual activities, belief in personal susceptibility to HIV, and belief that AIDS is undesirable (Catania et al., 1990). Likewise, the information-motivation-behavioral skills model (IMB) conceptualizes the psychological determinants of HIV preventive behavior. The fundamental assumptions of the IMB are that HIV prevention information, motivation and behavioral skills are the basic determinants of HIV preventive behavior. Therefore, if individuals are adequately informed, are fully motivated, and possess the necessary skills, they are likely to practice HIV preventive behaviors (Fisher & Fisher, 1992; Fisher & Fisher, 2002).

These theoretical frameworks have provided the foundation for many studies on HIV-risk behaviors in different populations. The hypothesized constructs have for decades dictated the way researchers conceptualize HIV-risk behaviors but, used independently, provide limited perspectives on the factors that influence risk behaviors. According to Wight (1999), these models have been widely criticized for their focus on individual attitudes and beliefs while ignoring social, cultural, and other factors that influence behavior. While intrapersonal factors are important to understanding HIV-risk, social, cultural and contextual factors must also be explored to derive a holistic view of the epidemic. Through a holistic lens, beneficial interventions can be developed to more adequately address the multiple factors that influence HIV risk behaviors and HIV transmission.

#### *Social Factors.*

*Among the most pernicious of the social barriers [to HIV prevention] are poverty, racism, gender inequality, AIDS-related stigma, and society's reluctance to openly address sexuality.*

*(Institute of Medicine, 2001)*

The social factors that influence HIV vulnerability and transmission are interconnected and play a key role in determining the spread of the HIV epidemic. Social factors include economic deprivation and poverty, gender inequality, discrimination and racism, social attitudes, and AIDS-related stigma (Adimora et al., 2001; Farmer, 1996; Parker, 2001). These factors contribute to behaviors that lead to the transmission of sexually transmitted diseases and HIV and continue to impede HIV prevention efforts.

#### *Economic Deprivation.*

Poverty and economic deprivation have helped to fuel the HIV epidemic among poor populations. According to Farmer (1996), in the United States, urban poverty has

provided the perfect machinery for the spread of HIV. Blacks are concentrated in these poor urban areas which present a socially disadvantaged environment characterized by substance abuse, joblessness, welfare dependency, vigorous drug trade, high rates of incarceration, opportunities for unprotected sex, single parenthood, and lack of access to preventive care (Farmer, 1996; Massey, 2004; National Alliance of State and Territorial AIDS Directors [NASTAD], 2005). These social and environmental characteristics translate into high disease rates among blacks. For example, injection drug use is the second leading cause of HIV infection for African American men and women (CDC, 2007a; Center for AIDS Prevention Studies (CAPS), 2001; National Minority AIDS Council (NMAC), 2006).

A complex nexus of social factors influence high-risk sexual behavior. Sumartojo (2000) points out that cost may be a barrier to the acquisition and use of condoms. Peterson et al. (as cited in Mays, Cochran & Zamudio, 2004), found in their study of 250 African American men who have sex with men (MSM) that poor men were more likely to engage in high risk behaviors such as exchanging sex for money. Similarly, Wheeler (2006) discovered in his study of non-gay identified black men that economics and drugs were the root factors for engagement in high risk sexual behaviors. Unemployed men in his study population exchanged sex for money, drugs and other resources. Plowden and colleagues (2005) found in their study of urban African Americans that condom distribution and needle exchange programs were less effective because individuals were selling needles and condoms for money to obtain drugs. Low socioeconomic status may also affect the masculine sense of self. In the United States, a man who has weak economic capacity may compensate for his low status by controlling or conquering

females (Whitehead, 1997). This behavior in turn puts them and their partners at greater risk for HIV transmission.

Economic deprivation and the drug culture have resulted in high rates of incarceration among black men. By June 30, 2006, an estimated 4.8% of black men were in prison or jail, compared to 1.9% of Hispanic men and 0.7% of white men. More than 11% of black males ages 25 to 34 were incarcerated (U.S. Department of Justice, 2007). The CDC (2007a) reports that the incarceration of African American men presents significant risk for HIV transmission. The incarceration epidemic is so extensive that it has become a reality of the dating and mate selection patterns in black communities. Whitehead (1997) found that black women in urban communities primarily consider incarceration history when selecting sexual partners. Women are cognizant of the fact that incarceration is often linked to high risk behaviors such as drugs and anal sex which may lead to HIV infection. Therefore, when considering a mate, black women may take into account a man's prison history. Within the prison population, situational sex is a common occurrence. Prison inmates often exchange sex for tangible goods and other services. In other cases, inmates are raped and sodomized further increasing the risk of HIV transmission. Injecting drugs and tattooing are also risk factors for HIV transmission within the prison environment. According to the U.S. Department of Justice (2004), AIDS is three times more prevalent in prison populations than in the general population.

In addition, the confinement of black men has created a sex ratio imbalance within the black population. A low male-to-female sex ratio has been hypothesized to be associated with multiple sex partners, concurrent sexual relationships, and other high risk behaviors among men. The sex ratio imbalance presents a context in which black men

may devalue women, seek multiple sex partners, demonstrate less tolerance for disagreements in relationships, and refuse to negotiate condom use with black women (Ferguson, Quinn & Sandelowski, 2006; Lane et al., 2004; Logan, Cole & Leukefeld, 2002; Thomas & Thomas, 1999). In their study of the social context of sexual relationships among rural African Americans, Adimora et al. (2001) found that the relative scarcity of black men and the socioeconomic dependence of black women worked synergistically to influence partner selection and women's sexual availability. "Women put up with the men they have because there aren't that many" (p. 73). Clearly, the sex ratio imbalance creates a power disparity that adversely affects men's sexual behavior making women more vulnerable to contracting HIV. As Wingood & DiClemente (2000) posit, the more power men have over women in heterosexual relationships, the more likely women will experience negative health outcomes.

Among black women, economic dependence and the "sugar daddy" concept is one factor that contributes to transmission of the virus to women. Women who are economically dependent on their male sexual partners have less sexual power and control and are reluctant to negotiate condom use with their partners for fear of dismissal and abandonment (Turmen, 2003). Relationship power plays an important role in safe sex decision-making and HIV risk. Women with low levels of economic power in a relationship are less likely to report consistent condom use (Pulerwitz, Amaro, De Jong, Gortmaker & Rudd, 2002). Further, women who live in poverty may have multiple concurrent sexual relationships for economic reasons. Bedimo, Bennett, Kissinger and Clark (1998) found that it was not uncommon for some African American women in their study to have "sidekicks" (p. 52), men who gave them clothes or money in exchange for

sex. Gadon, Chierici & Rios (2001) found that even though Haitian women may suspect their partners of infidelity, they accepted unprotected sex in order to keep a man's financial support. Haitian women also referred to "chache lavi" or prostitution for economic survival. Therefore, being economically disadvantaged defines the sexual relationship as being male dominated and dependent and limits a woman's ability to negotiate safe sexual practices. In addition, women may engage in risky behaviors for economic gain. Clearly, women's HIV risk must be framed in the context of their relationships with male partners.

Women who live in poverty are less likely to practice safe sex because they are more concerned with basic survival rather than HIV-protective behaviors (Logan et al., 2002). Poor women, especially poor women of color, are at greater risk for poor health outcomes because of their low socioeconomic status. These women have less than adequate health care and are at greater risk for multiple diseases such as cancer, obesity, respiratory problems, diabetes, cardiovascular disease, and AIDS (Reid, 2000). According to Amaro, Raj and Reed (2001), women's sexual health is affected by their low social status. They argue that relegation to the lower segments of society has led to women's lack of sexual autonomy and limited access to health care and medical treatment. Women with lower income are also more likely to have higher levels of stress and riskier sexual partners indicating that social class is an important predictor of individual risk (Ickovics et al., 2002). Clearly, these social factors; poverty, income disparity, and lack of social capital all affect behaviors that facilitate HIV transmission.

### *Gender Disparities.*

Gender disparities are manifested by the feminization of HIV/AIDS. Gender inequalities impact every aspect of health and illness. Women are more vulnerable to HIV infection than men not only because of their biological characteristics but also because of their relative inability to protect themselves from HIV infection. The lack of widespread accessibility to female controlled barrier mechanisms (such as female condoms) and the socially constructed roles of male-dominated heterosexual relationships make women even more susceptible to infection (Vijayakumar, Mabude, Smit, Beksinska, & Lurie, 2006; Welbourn, 2006; Mantell et al., 2006). African American women may find it more difficult to refuse sex and negotiate condom use than White women because of their relational orientation, power differentials, and other factors such as the male-female ratio imbalance (Jarama, Belgrave, Bradford, Young & Honnold, 2007).

The HIV/AIDS epidemic in women is an illustration of how women are stigmatized in terms of disease transmission. Women are largely viewed as transmitters of disease who subject their male partners and children to infection and are often seen as “dirty, diseased and undeserving” (Lawless, Kippax and Crawford, 1996, p. 1371). This idea is ironic since women are two to four times more likely to acquire HIV/AIDS infection from men based on the biological configuration of women and the high HIV/AIDS viral load detected in semen (Turmen, 2003). Nevertheless, these facts tend to be ignored in favor of the idea that men are ultimately the victims (Lawless et al., 1996).



### *Discrimination and Racism.*

Racism and discrimination continue to affect the health outcomes of minority populations in the United States. Health inequities are the result of structural racism that continues to pervade the health care system. Racial and ethnic disparities affect access to health care, education, and social services (Buseh et al., 2006; Reid, 2000). A history of racism, oppression and lack of trust in governmental agencies present barriers to effective HIV prevention strategies among blacks (CDC 2007c). Historically, racism has affected the masculine ideologies of black men resulting in a skewed concept of masculinity and sense of self. Denied access to economic power and the idealized masculinity of the dominant group through slavery and later institutionalized discrimination, black men have constructed alternate concepts of masculinity. Sexual promiscuity, aggressiveness, and thrill-seeking, have been hypothesized as characteristics of the masculine ideologies of black men (Bowleg, 2004). The social construction of black masculinity and the creation of a black machismo identity are direct responses to racism and discrimination that have translated into HIV-risk behaviors such as the nondisclosure of homosexual activity and multiple sex partners (Bowleg, 2004; Miller et al., 2005). Clearly, HIV risk behaviors must be analyzed through the lens of racism and discrimination, factors that continue to influence health behaviors.

### *HIV/AIDS-Related Stigma.*

HIV-related stigma is also an element of marginalization that influences the HIV/AIDS morbidity and mortality among blacks. According to Aggleton & Parker (2002), HIV stigmatization is a social process of devaluation that reinforces negative thoughts about persons living with HIV and AIDS and presents one of the greatest

barriers to dealing with the epidemic. HIV-related stigma has negative consequences on HIV prevention and care within communities riddled with stigma and discrimination. Stigmatization can create barriers to HIV testing, adoption of preventive behaviors, reception of HIV prevention messages, condom use, and disclosure of sexual orientation and HIV status to sex partners (Brooks, Etzel, Hinojos, Henry & Perez, 2005). Within the black community HIV/AIDS is highly stigmatized. These attitudes lead to concealment of homosexual behavior, lack of HIV testing, failure to seek treatment, and the generation of myths about HIV transmission.

Many of these issues may in fact result from the prevalence of HIV stigma in the black community and the negative attitudes that accompany stigmatization and discrimination. Often, marginalized groups are the victims of stigmatization and though their risk behaviors may influence HIV transmission, stigmatization nourishes persistent negative attitudes towards these individuals and creates challenges to addressing the epidemic within these groups as well as the larger community. Stigmatization of marginalized groups also propagates the perception that individuals who do not identify with these groups are not at risk of contracting the disease. These factors create a vicious cycle of stigma and discrimination that make prevention efforts even more challenging.

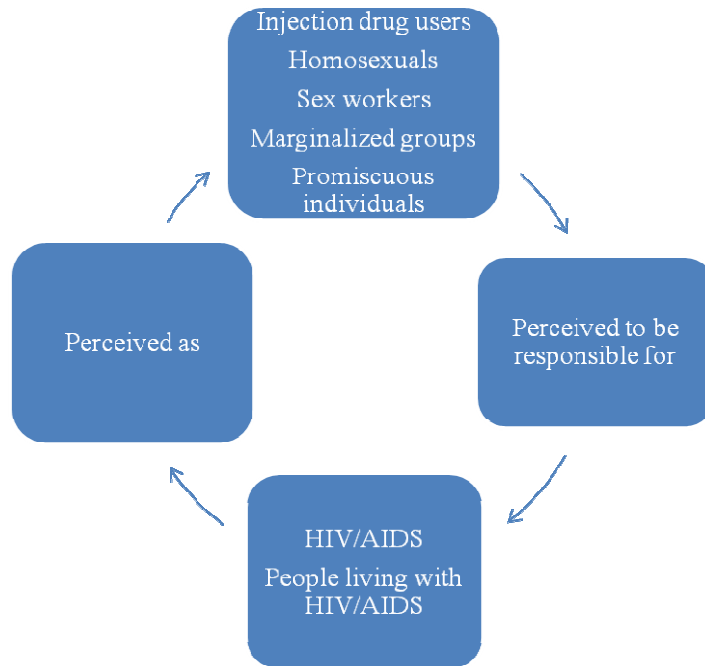


Figure 1. The Cycle of HIV/AIDS Stigma and Discrimination  
Source: Parker, Aggleton, Attawell, Pulerwitz & Brown, 2002.

### *Immigration Status*

Immigrants in the United States face significant barriers to health education, access to care, and treatment. In the United States, immigrants comprise a vulnerable population at risk for negative health outcomes. Undocumented immigrants face even more challenges because of their illegal residential status. Among immigrants, major barriers to HIV education, care and treatment include inability to pay for services, stigma by the health care system, language and low-literacy, immigrants' health seeking attitudes, cultural beliefs, fatalistic views about HIV, fear of deportation, lack of knowledge of the health care system, employment issues, and fear of isolation (Potocky, Dodge & Greene, 2007; Othieno, 2007). Undocumented immigrants are particularly less likely to access services because they fear being reported to the authorities and ultimately being deported. In a study conducted among Haitians in Palm Beach County, undocumented immigrants reported that they could not seek health care for fear of deportation. Their fear of deportation was greater than their fear of dying (Potocky et al., 2007). In addition, immigrants are less likely to be knowledgeable of available health care resources and are therefore less likely to seek education and care. These barriers contribute to lack of HIV testing, education, and treatment and continued transmission of the virus within immigrant populations.

Social factors act synergistically to influence HIV/AIDS attitudes, beliefs and risk behaviors within the black population. While individual level factors are important determinants of health behavior, HIV risk behaviors must be viewed within the context of the social environment. Without this lens, we run the risk of failing to recognize

important contextual and social factors that may be critical in the conceptualization and development of effective strategies for curbing the epidemic among minority populations.

### *Cultural Factors*

Another factor that influences health behavior is culture. Culture is defined as “a shared system of knowledge and beliefs by which people order their perceptions and experiences and make decisions, and in terms of which they act. It is a shared system of ideas, a conceptual code that people use to interpret themselves and the world and to formulate behavior” (Vivelo, 1978). Matthews (2004) defines culture as a set of rules, standards, or beliefs shared by the members of a group that when acted upon by those members, produces behaviors that fall within a range considered acceptable and proper by those members. Within the context of HIV transmission, culture is defined as the way of life among a social group, inclusive of the norms, beliefs, and traditions within that group that put group members at risk for HIV (Wilson & Miller, 2003). Among blacks and subgroups of the black population, there are culturally determined factors that may be influential in HIV risk and prevention.

Among African Americans, the cultural context of HIV risk is characterized by homophobia, culturally defined masculine and feminine ideologies, notions of the self, gender norms, culturally determined expressions of manhood and womanhood, HIV conspiracy beliefs, distrust of the medical system, and religious beliefs. In the African American community, a culture of silence exists concerning HIV/AIDS. Perceptions that HIV is a “gay disease” lead to moral judgments against those who are infected. This attitude in turn leads to homophobia which results in the rejection and isolation of gay and bisexual men by family, friends and social networks (Buseh et al., 2006; Morin et al.,

2003). Fearful of rejection and physical harm, black men may not disclose their bisexual behaviors thus putting women at risk for infection.

From a cultural perspective, African Americans place significant value on family, social networks and religious standing (Harawa et al., 2006) The threat of losing these support systems may prevent African American men from disclosing their sexual identity. The result is men who have sex with men but identify as heterosexual, a phenomenon more commonly known as “down low” in the African American community. Heterosexism and the notion that gay or bisexual men are not real men, discourage black men from identifying as gay or bisexual. These ideologies of masculinity define normative masculine behavior within the black community and deviation from these culturally determined ideologies are viewed as “weak”, “embarrassing”, “sinful” and “unnatural” (Brooks et al., 2005 p. 738). Operario, Smith & Kegeles (2008) found that beliefs of African American masculinity reinforce the portrayal of a tough masculine image and the nondisclosure of same-sex behavior. In addition, since same-sex behavior was perceived to be unplanned and spontaneous, condom use was less likely during same-sex intercourse. Therefore, gender ideologies are central to HIV risk in the black community. The emphasis on toughness and heterosexuality as the ideal portrayal of masculinity within the black community may reinforce secrecy about same-sex relationships, and unprotected, spontaneous sexual encounters which lead to greater risk for HIV and other STI transmission among male and female partners.

The term “Down Low” denotes secrecy and has been used in African American vernacular since the early 1990s. First introduced in African American music, the term

has evolved to refer to black men who publicly present as heterosexual but privately engage in sexual relationships with other men. The connotation of this behavior is that these men spread HIV to their unsuspecting female partners (Ford, Whetten, Hall, Kaufman & Thrasher, 2007; Millett, Malebranche, Mason & Spikes, 2005). Closely related to the “down low” phenomenon is the “homothug” identity which is characterized by: 1) heavy involvement in the hip hop culture; 2) strong masculine identity; 3) homophobia and disapproval of femininity in men 4) gangster image 5) secret sex with men (Ford et al., 2007; Mays et al., 2004). Often, African American men engage in “compensatory sex” with women in order to prove to their community that they are not gay (Buseh et al., 2006 p. 4).

These behaviors place female partners at greater risk for infection. Studies have found that heterosexually identified HIV-infected African American men who had sex with men had a high frequency of unprotected anal sex with their female partners and were at great risk of transmitting HIV to opposite sex partners (Wohl et al., 2002; Wolitski, Jones, Wasserman & Smith, 2006). A CDC study found that while 34% of black men reported having sex with men and women, only 6% of black women acknowledged having a bisexual partner (CDC, 2008d). This finding highlights the fact that many black women are either in denial or unaware of their partners’ high-risk sexual behaviors. In addition, failure to disclose sexual orientation and internalized stigma may lead to lack of participation in HIV prevention programs. Black men who have sex with men (MSM) often do not identify with prevention messages designed for gay men, creating additional barriers to HIV prevention within this marginalized population.

Among African Americans, condom use may have socio-cultural implications that prevent consistent use. Studies have shown that male initiation of condom use may conjure suspicions of infidelity among their female partners (Whitehead, 1997; Brooks et al., 2005). In addition, women may be reluctant to insist on condom use because they fear rejection by male partners. Negotiation of condom use is also difficult because women who suggest condom use are suspected of infidelity (Worth, 1989; Heise & Elias, 1995). This situation puts women at risk for abandonment and even violence. Bowleg, Lucas and Tschann (2004) found in their study of condom use among African American women that men controlled the initiation and refusal of condom use regardless of whether women wanted to use condoms. As Wingood and DiClemente (2000) argue, women who have low self-efficacy for using condoms and negotiating condom use are more likely to engage in high risk sexual behaviors. The social connotations of condom use have also been found to deter protective sexual behavior. Whitehead (1997) found that condoms are traditionally used with women who are “dirty” or “diseased”. Therefore, women may not negotiate its use with male partners for fear of being viewed as promiscuous or infected.

Having multiple sex partners is also a significant risk factor for HIV transmission. For black men, sexual contact remains the main HIV risk factor. According to the CDC, male-to-male sexual contact was the primary risk factor for 48% of black men with HIV/AIDS at the end of 2005 while high-risk heterosexual contact was the primary risk factor for 22% of black men (CDC, 2008c). Black women are most likely to be infected by heterosexual contact. Many women are unaware that their sex partners are engaging in unprotected sex with multiple partners, thus putting them at greater risk for HIV. Sadly, black and Hispanic women account for 81% of women living with HIV/AIDS who



acquired the disease by heterosexual contact (CDC, 2008d). In Florida, through 2006, 85% of black women living with HIV/AIDS acquired the disease via heterosexual contact (Florida Department of Health, 2008). In their study of sexual relationships among rural African Americans, Adimora et al (2001) found that black men having multiple sex partners was a common occurrence. Study participants reported that the male-female sex ratio imbalance cultivates this high-risk behavior. In addition, concurrent sexual partnerships were particularly prevalent among unmarried individuals. Sexual behaviors such as multiple sex partners present a significant risk for HIV transmission. Unfortunately, these risky behaviors are prevalent within the black community, leading to higher rates of HIV transmission.

Family values and cultural norms that determine manhood and womanhood may also influence HIV risk. Among African Americans, the socially constructed meanings of pregnancy may have implications for HIV prevention. Worth (1989) found that among minority women in New York City, fertility defined their social roles and self-esteem. Therefore, the use of condoms is seen as a barrier to women fulfilling their role of motherhood. Since children are an affirmation of adulthood, African Americans may be reluctant to use condoms (Bowser, 1992). Bedimo et al. (1998) also found that African American women in their study population valued pregnancy because it entitled them to material possessions they would not otherwise receive. Therefore, the use of condoms prevents pregnancy which in turn prevents social and economic privilege.

HIV/AIDS conspiracy beliefs in the African American community may create a barrier to HIV prevention efforts. Klonoff and Landrine (1999) found that 27% of blacks in their study population believed that HIV is engineered by the government to

exterminate the black population. Likewise, Bogart and Thorburn (2005) and Gadon & Rios (2001) found that a significant proportion of the African Americans in their studies did not trust the government and believed that HIV/AIDS was engineered to wipe out the black population. Black men were especially suspicious of the government's role in the spread of the HIV epidemic, believing that HIV is a man-made virus and the cure for AIDS is being withheld from the poor. Endorsement of conspiracy beliefs was also found to be strongly related to negative attitudes to condom use. Clearly, HIV/AIDS conspiracy beliefs persist in the black community and may negatively impact HIV prevention messages. Historical discrimination and manipulation by the U.S. medical system, as exemplified by the Tuskegee Syphilis Study (CDC, 2009c) in which black men who had syphilis did not receive the proper treatment for their illness, may contribute to HIV conspiracy beliefs in the black community. These beliefs must be more fully investigated within the context of historic and current discrimination within the health care system.

Within the Haitian population living in the U.S., cultural factors such as relationship power imbalances, traditional gender roles, patriarchal belief systems, and cultural concepts of health and illness increase vulnerability to HIV infection. Folk beliefs are often used to describe the origins and transmission of HIV. Gadon & Rios (2001) found that male Haitian migrants attributed HIV infection to religious disobedience and spirits of the dead. HIV is seen as punishment to the “*desobeyian*” (p. 797). Likewise, Martin, Rissmiller & Beal (1995) found that Haitians incorporate traditional beliefs about health and illness into their beliefs about HIV disease. HIV is therefore seen as a sickness sent from God to people who engage in bad behavior. HIV is also perceived as a product of *Voudou* (Haitian for Voodoo), a form of magic or sorcery

practiced by some Haitians. In the context of voodoo, HIV is seen as a means of sending death or sickness for revenge or vengeance. *Kout mo* or *mo SIDA* (supernatural AIDS in Creole) is viewed as the unfortunate, supernatural fate of the victim (Adrien, Cayemittes & Bergevin, 1993). In addition, some Haitian beliefs such as having sex with a virgin will cure HIV and lining a woman's vaginal canal with barks and twigs will prevent HIV from penetrating are pervasive in the Haitian community (Potocky, Dodge & Greene, 2007).

In addition to the health beliefs that may influence acceptance and practice of Western biomedical HIV prevention strategies, the socio-cultural milieu within the Haitian community also affects HIV-risk behaviors. Similar to African American ideals, having children is important to Haitian men and women. Therefore, conception is often more important than condom use and HIV transmission. In addition, patriarchal beliefs facilitate tolerance of promiscuous male behavior within the Haitian population. As a result, men often have multiple sex partners, premarital sex, and practice unofficial polygamy, behaviors that are widely tolerated (Magee, Small, Frederic, Joseph & Kershaw, 2006).

Stigma of HIV/AIDS in the U.S. Haitian community contributes to secrecy and failure to disclose HIV status to sex partners. Historically, Haitians have been stigmatized as a high-risk group for HIV transmission. In the early years of the epidemic, Haitians were included in the "4-H club" of high risk populations: homosexuals, Haitians, heroin users and hemophiliacs. In addition to being perceived as unwanted immigrants, black peasantry, boat people, voodoo worshippers, criminal aliens, Haitians were also seen as the member of the "4-H" club (Nachman & Dreyfuss, 1986). These labels led to

discrimination and isolation of the population. AIDS-related stigma and discrimination create significant barriers to HIV education, prevention, testing and treatment. Coreil, Lauzardo & Heurtelou (2004) posit that stigmatization and racism towards Haitians in South Florida create socially based burdens that negatively affect access to health care services. Haitians therefore avoid seeking treatment and fail to disclose status for fear of rejection and isolation by the community. The legacy of stigma, discrimination, humiliation, and isolation towards the Haitian population has impacted the self concept and esteem of the community. Santana & Dancy (2000) found that as a result of AIDS-related stigma, Haitians felt that they are rejected by the dominant society and by fellow Haitians. Stigmatization can have deleterious effects on families and communities. Within the Haitian community, the effects of former labeling still linger as Haitians often feel isolated and rejected by the larger society. This rejection has been internalized by Haitians leading to feelings of less self worth. Moreover, AIDS-related stigma may negatively affect HIV-risk behaviors specifically related to disclosure of status, accessing HIV prevention services, and condom use. Further research is needed to explore the effect of AIDS-related stigma and discrimination on sexual behaviors in this historically marginalized community.

In sum, the intrapersonal and socio-cultural dynamics within populations can greatly influence the sexual behaviors that prevail. These factors can have a significant impact on HIV-risk behaviors, behavior change, gender ideologies, negotiation of safer sex, cultural concepts of health and illness, and culturally determined beliefs and behaviors. Understanding the interpersonal and socio-cultural factors that affect sexual

behaviors is paramount to better understanding the determinants of risk and identifying effective strategies for HIV prevention among black populations.

*Behavioral Health: Substance Abuse and HIV Risk*

*Substance Abuse.*

Behavioral health was first coined in the 1980's to describe the combination of the fields of mental health and substance abuse. It focuses on the study of behavioral health problems such as depression, eating disorders, substance abuse, domestic violence, and anxiety disorders. This study will focus on substance abuse as a crucial behavioral health risk factor for HIV transmission. Since injection drug use is the second leading cause of HIV infection for both black men and women, this study will focus specifically on substance abuse as a behavioral health problem. There is a need to further explore the influence of substance use among sub-groups of black heterosexual men and the correlation with high risk behaviors. The unique aspect of this exploration is the discovery of differences in substance abuse behaviors between the subgroups being studied. According to the CDC, chronic and casual substance users are more likely to participate in high-risk behaviors such as unprotected sex with multiple partners and sharing needles. In addition, HIV-infected substance users are less likely to adhere to antiretroviral treatment (CDC, 2008c).

Behavioral health issues are major risk factors for HIV. The threat of HIV among persons with substance abuse problems is significant and the spread of HIV disease in the United States is fueled by the substance abuse epidemic (Parry, Blank & Pithey, 2007). HIV is transmitted directly by sharing injection-drug paraphernalia and indirectly by sexual contact with HIV-positive injection drug users (U.S. Department of Health and

Human Services, 2005). In addition, the use of illicit substances impairs judgment and affects sexual decision-making and risk-taking. From an epidemiological perspective, injection drug use has directly and indirectly accounted for more than one-third of the AIDS cases in the United States. Racial and ethnic minorities are disproportionately affected by drug related AIDS. In 2000, injection drug use accounted for 26% of all AIDS cases among African Americans and 31% of cases among Hispanics compared to 19% among whites (CDC, 2002). Non-injection drug use, such as cocaine, also contributes to the AIDS epidemic because it impairs judgment making users more likely to engage in risky sexual behaviors. In addition, users may exchange sex for drugs and money and in this context are less likely to practice safe sex (CDC, 2007a).

The link between substance abuse and sexual risk behaviors has been established. Several studies show the link between substance use and high-risk behaviors. Individuals who are high or drunk are less likely to engage in safe sexual activity increasing the likelihood of exposure to HIV (Cederbaum, Coleman, Goller and Jemmot, 2006). Another study conducted by Brooks and colleagues (2008), found that heavy alcohol consumption was a strong correlate of sexual risk. Alcohol abuse is highly correlated with having multiple sex partners, unprotected sexual intercourse, and sex with high-risk individuals. In another study among substance-abusing African American men, Eissen, Meshack, Peters, Ogunbade & Osemene (2005) found that African American men were often having unprotected sex with women while under the influence of drugs and alcohol. In addition, African American crack using men are more likely to have multiple partners and exchange sex for drugs. The drug epidemic has fueled the incarceration trends now seen in the black community. With the “war against drugs”, more black men have been

incarcerated for drug possession and/or usage. This reality has had a significant effect on the social organization of the black community. With a significant number of black men behind bars, the sex-ratio imbalance and situational sex have prevailed within black communities increasing the risk for HIV transmission. Moreover, the drug epidemic itself is a risk factor for disease transmission.

#### *Purpose of the Inquiry*

The purpose of this study is to conduct exploratory research to generate formative data on factors that influence HIV-risk behaviors among black men who identify as heterosexual. This study further seeks to explore potential variability in HIV-risk behaviors among ethnic subgroups (U.S.-born and Haitian-born immigrants) of black heterosexual men. Few studies address the socio-cultural and behavioral factors that influence HIV-risk behaviors in the black heterosexual male population. Even fewer studies have addressed the influence of these factors on sexual behavior within ethnic subgroups of the black male population. The invisibility of this population in the social science literature needs to be addressed (Bowleg, 2004). In addition, the rising proportion of U.S. blacks who are foreign-born is expected to affect the health profile of the black population in the U.S. (Read, Emerson & Tarlov, 2005; Read & Emerson, 2005). While there are different and similar socio-cultural experiences across population sub-groups, the differences need to be identified and specific interventions and prevention messages developed accordingly. There is a need to tailor HIV/AIDS education and prevention efforts to address the complex cultural, social and contextual ecologies which shape beliefs and behaviors (Stevenson, Davis, Weber, Weiman, & Abdul-Kabir, 1995).

This study, therefore, furthers the body of knowledge as it allows for an in-depth exploration of the socio-cultural and behavioral factors that influence the HIV-risk behaviors of subgroups (U.S.-born and Haitian-born) of black heterosexual men living in the U.S. The results of this formative study may be used to design quantitative instruments for future studies and broader application. Study results may also provide insight for HIV education and behavioral interventions to reduce HIV/AIDS disparities within ethnically diverse black populations in Florida and nationwide.

#### *Theoretical Frameworks Informing the Inquiry*

This study draws on three conceptual frameworks: The Socio-ecological Model of STD Risk and Protective Factors, the Health Belief Model (HBM) and the Theory of Gender and Power. The overarching theory for this study, the socio-ecological model of STD risk and protective factors, emphasizes an interdependent, multidimensional and multilevel concept of individual behavior (Grzywacz & Fuqua, 2000). The Health Belief Model and the Theory of Gender and Power will be used to theorize intrapersonal and relational factors that affect behavior respectively. The Health Belief Model is appropriate for this study because it explores important constructs that influence knowledge, attitudes and beliefs. The Theory of Gender and Power is suitable for this study because it addresses structural factors such as gender and power and places gendered relationships between men and women within a social context.

#### *Socio-ecological Model of STD Risk and Protective Factors*

Adapted from Urie Bronfenbrenner's ecological model of human development, the socio-ecological model of STD risk and protective factors involves examining behavior within the context of the individual's social and physical environment. Socio-



ecological factors that might influence behavior include cultural, family, relational, peer and societal influences (DiClemente et al., 2005). In the past few years, researchers have begun to utilize the socio-ecological perspective to examine health behaviors. Realizing that cognitive approaches may not fully explain behavior, researchers in the social sciences have begun to look at public health problems through an ecological lens.

In his classic work, *The Ecology of Human Development*, Bronfenbrenner (1979) explains the importance of interrelated ecological levels for human development. The ecological environment is conceived as a set of nested structures, each existing inside the next. Further, a person's development is affected by events occurring in settings in which the person is not even present. Another critical tenet of social ecology is that within each culture, environmental settings tend to be similar, however, between cultures they tend to be strikingly different. The nested structures hypothesized in the theory are described as the *microsystem*, *mesosystem*, *exosystem* and *macrosystem*. The *microsystem* is the immediate setting in which the individual exists. This level is the innermost level of the nested structures which represents the context in which an individual is behaving at any given time. Bronfenbrenner (1979) defines the microsystem as "a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics" (p. 22). The *mesosystem* is a set of microsystems and represents a higher level in the social environment. The *mesosystem* represents the interrelations among major settings in which a person exists. According to Bronfenbrenner (1979), the mesosystem "comprises the interrelations among two or more settings in which the developing person actively participates (such as family, work, social life)" (p. 25). The next level, the *exosystem*, is composed of contexts that do not directly

involve the developing person but influences the person's behavior and realities in some way. Lastly, the *macrosystem* is the highest level of the ecology of human development which involves culture, belief systems, large institutions and public policy (Bronfenbrenner, 1979; Grzywacz & Fuqua, 2000; Lerner, 2005).

DiClemente et al. (2005) developed the socio-ecological model of STD risk and protective factors, an adaptation of Bronfenbrenner's ecological model that explains STD risk and protective factors for adolescents. Depicted in Figure 2 below, the model is comprised of five concentric spheres of influence.

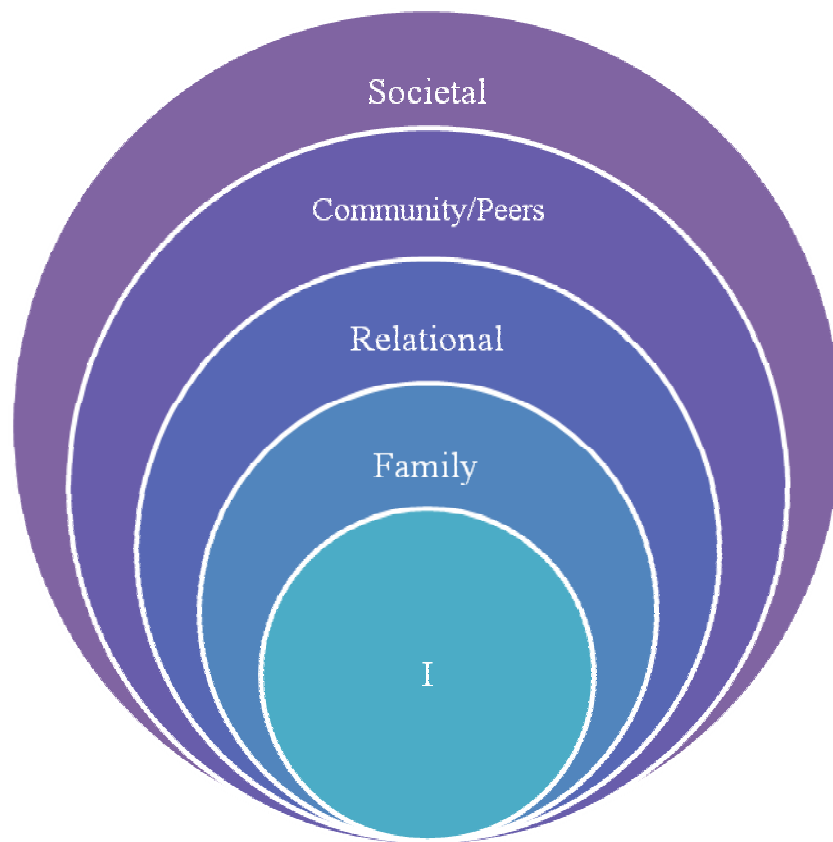


Figure 2. The Socio-ecological Model of STD risk and protective factors.  
Source: R.J. DiClemente, L.F.Salazar, R.A. Crosby, & S.L. Rosenthal, 2005.

The innermost circle, labeled “I” represents the individual and the psychological characteristics that are intrinsically driven. The next sphere, the family, refers to the familial influences on individual behavior. The relational realm refers to the influence that intimate partners may have on an individual’s decision making and resultant behavior. The community and societal spheres represent the peer, community and societal influences on behavior.

DiClemente’s conceptualization of the socio-ecological influences on individual behavior is synonymous with Bronfenbrenner’s concepts of the microsystem, mesosystem, exosystem and macrosystem. Figure 3 depicts the factors within each sphere that affect sexual behavior as postulated by DiClemente juxtaposed with Bronfenbrenner’s ecological levels. Synonymous with Bronfenbrenner’s *microsystem*, the innermost sphere represents the intrapersonal level which includes the individual and related psychological and behavioral processes. The next two ecological levels, the *mesosystem*, represent the family and relational influences on health behavior. These influences include family structure, family support, and partner communication. Next the *exosystem* includes community and peer influences on STD risk and protective behaviors. These influences include access to condom distribution sites, drug culture, community culture, peer norms, and social capital. Lastly, the *macrosystem* or the societal level includes characteristics of the larger society such as socio-economic status, media, and healthcare policies that affect behavior on a broader level.

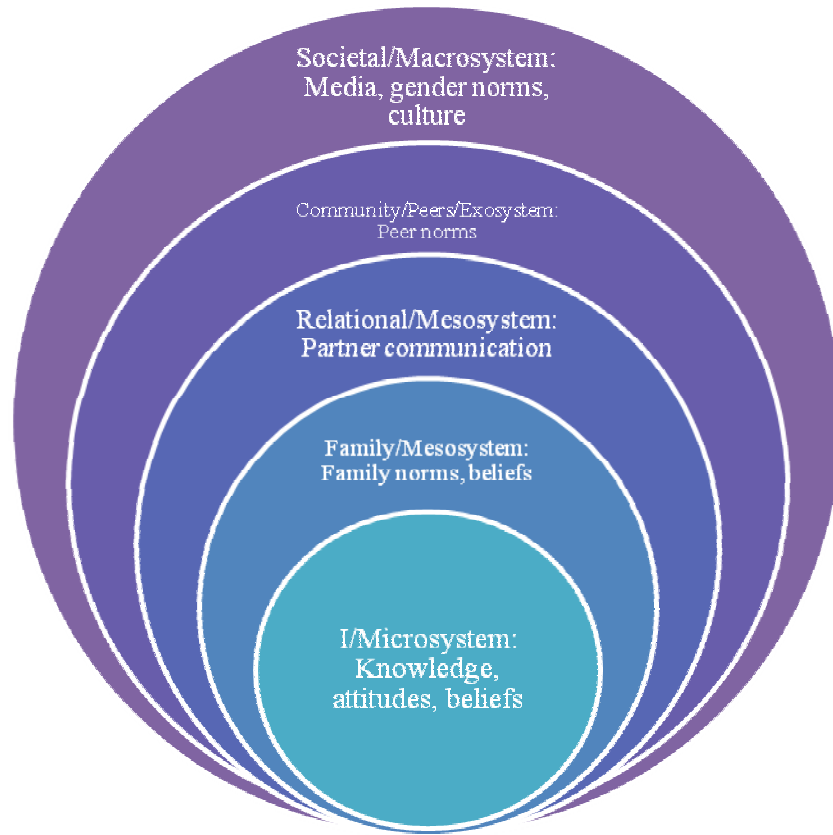


Figure 3. Modified Socio-ecological Model of STD risk and protective factors applied to research study. Source: Lerner, 2005; R.J. DiClemente, L.F.Salazar, R.A. Crosby, & S.L. Rosenthal, 2005.

While the socio-ecological model of STD risk and protective factors has not been widely used to assess HIV risk behaviors, it provides a novel approach for investigating the multilevel factors that may determine HIV risk. The individual level, cognitive approaches to understanding HIV risk are not sufficient to address the multidimensional factors such as families, institutions, policy, and social norms that affect behavior. Addressing risk behavior at the intrapersonal level lacks sufficient breadth to promote sustained behavior change. The socio-ecological model provides a theoretical framework within which HIV risk and prevention can be viewed through a multilevel, multidimensional lens.

The study was grounded in the tenets of the socio-ecological model of STD risk and protective factors. The Health Belief Model was used to provide a theoretical framework for the intrapersonal factors that influence HIV risk behaviors. Finally, the Theory of Gender and Power provided a framework for the assessment of the macrosystem factors, specifically gender and power, which influence HIV risk.

#### *The Health Belief Model*

The Health Belief Model has been widely used in the study and conceptualization of individual health behavior and the determinants of health behavior change. According to Kasl and Cobb (as cited in Rosenstock, 1974a) health behavior is an activity that is performed by a person perceived to be healthy for the purpose of preventing disease or for detecting disease in an asymptomatic stage. For over four decades, the HBM has been used to conceptualize and analyze health behavior and to develop health promotion interventions (Strecher & Rosenstock, 1997). Since its development, the HBM has been applied to a variety of health problems in an attempt to explain the health behavior of the

individual. The model has been used to conceptualize health behavior pertaining to infectious diseases, cancer, influenza, dental disease, polio, HIV/AIDS, and other health problems.

The original concepts postulated by the HBM were *perceived susceptibility*, *perceived seriousness or severity*, *perceived benefits of taking action*, *perceived barriers to taking action* and *cues to action*. The model discussed the concepts of motivation and modifying factors of behavior such as demographic, socio-psychological, and structural variables.

*Perceived susceptibility* refers to the individual's acceptance of his or her personal likelihood of contracting a disease or condition (McCormack Brown, 1999). Within this conceptual definition, individuals fall into a spectrum or continuum of possible levels of *perceived susceptibility*. At one end of the spectrum is the individual who denies any level of susceptibility to a condition. In the middle of the spectrum is the individual who sees the statistical possibility of contracting a disease or condition but does not see him/herself as personally susceptible. On the other end of the spectrum is the individual who perceives a real danger of contracting the disease (McCormack Brown, 1999; Rosenstock, 1966). Therefore, there are various levels of *perceived susceptibility* into which an individual may fall. The level of susceptibility depends on the individual's subjective perception of the risk of acquiring a certain condition (Janz & Becker, 1984).

The second central concept of the model is that of *perceived seriousness or severity*. This construct involves the individual's beliefs about the effect a disease or condition would have on one's life. This dimension includes the individual's perception of the medical consequences such as pain, death, and physical and mental disability as

well as the social consequences such as economic loss, and negative effects on family life and social functioning (Glanz et al., 1997; Janz & Becker, 1984; Rosenstock, 1974b).

*Perceived benefits of taking action* and *perceived barriers to taking action* are also pivotal concepts of the model. *Perceived benefit* refers to the individual's perception of the benefits of performing a certain behavior. Even though *perceived susceptibility* and seriousness are important factors, it is actually the *perceived benefit* of a behavior that will determine the final course of action taken (Glanz et al., 1997). Therefore, according to Janz and Becker (1984), an individual who is "sufficiently threatened" will not perform a recommended health behavior unless it is perceived as beneficial, effective, and feasible.

*Perceived barriers to taking action* are the roadblocks to performing a healthy behavior. Therefore, an individual may perceive an action to be beneficial to health status but the action may not be performed because there may be barriers to action that outweigh the *perceived benefits*. For example, if the beneficial action is expensive, difficult, painful or inconvenient it is highly likely that the action or behavior will not be performed (Rosenstock, 1974b). Glanz et al., (1997) suggest that within this stage there is an unconscious cost-benefit analysis that the individual undertakes. This analysis involves an assessment of the costs of the alternative actions necessary to reduce the threat of disease.

The model also postulates the concept of *cues to action*. These cues or triggers are necessary for health behavior to occur. The original developers of the theory argued that readiness to perform a behavior was largely influenced by cues or triggers for action. The previous concepts discussed are not enough in and of themselves to bring about a health

behavior. Instead, there are cues that must be combined with the previous concepts in order to induce health behavior. These triggers or cues include the media, posters, brochures, a postcard from the dentist, and social networks. These cues are the crucial factors that set the health behavior in motion (Rosenstock, 1974b). This consideration is also very important since the cues to action are very influential within the lived experience of the individual.

The model also discussed other variables such as demographic, structural, and socio-psychological factors. Demographic factors include age, sex, and ethnicity. Structural factors include existing knowledge about a condition and prior experience with a disease. Socio-psychological factors include socioeconomic status, peer influence and social networks, and personality dispositions. These factors are seen as indirectly related to health behavior. The concept of motivation was also introduced in the original model. However, it was soon removed but was later reintroduced (Rosenstock, 1974b). The model argues that motivation is necessary for action. The concepts of *susceptibility* and *severity* combine to impart the motivation for a health related behavior or action (Brown, DiClemente & Reynolds, 1991). Motives influence the manner in which an individual perceives the environment (Rosenstock, 1966). Maiman and Becker (1974) assert that the concept of motivation is operationalized by two specific dimensions of the model: the individual's state of readiness to perform the action and the extent to which the health behavior is perceived to be beneficial. Motivation is therefore, an internal inclination that promotes a desire to perform and maintain a health behavior and to avoid future illness.

The concepts discussed above are the original dimensions of the HBM. They explain critical elements of the health behavior process. These elements act together to



instigate an action from the individual. There must be a combination of the proposed variables to promote a behavior or action. The HBM is summarized in figure 1. It shows the connectivity between the variables and visually explains the movement from individual perceptions to likelihood of actions.

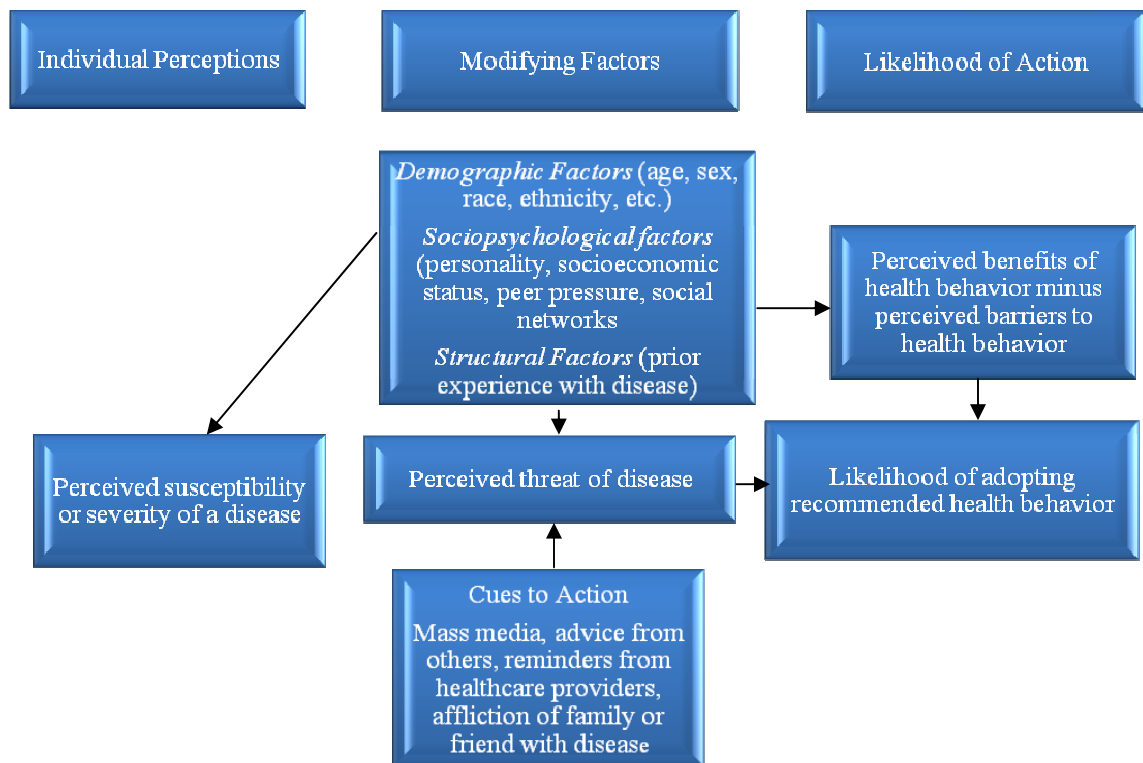


Figure 4. The Health Belief Model  
 Source: Becker et al. as cited in Rosenstock, 1974b.

### *Theoretical Additions to the Health Belief Model*

The concept of *self efficacy* was introduced by Bandura in 1977. This concept was added as an additional dimension of the HBM. The concept of *self-efficacy* has added a vital component to the explanation of the adaptation and maintenance of health behavior.

Albert Bandura (1977) defined *self-efficacy* as “the conviction that one can successfully execute the behavior required to produce the outcomes” (p. 193). The *self-efficacy* construct is based on the underlying notion that psychological processes create and strengthen expectations of *self-efficacy*. The acquisition of a health behavior not only includes *self-efficacy*, it also includes the dimension of *outcome expectancy*. *Outcome expectancy* is the belief that a given behavior will result in a given outcome (Strecher, DeVillis, Becker & Rosenstock, 1986).

Bandura explicitly differentiates between outcome expectations (similar to *perceived benefits*) and efficacy expectations. This distinction is evident in the fact that an individual may have high outcome expectations of a behavior but may never perform the behavior because they do not deem themselves to have the efficacy or capability to undertake the action (Bandura, 1977 and Strecher et al., 1986). Bandura argues that efficacy expectations determine the level of effort an individual will put into a behavior as well as the length of time for which the behavior will be sustained. Therefore, the stronger the *self-efficacy*, the more likely it is that the health behavior will be initiated and practiced for an extended period. According to this theoretical orientation, *self-efficacy* plays a major role in determining the behaviors undertaken by different individuals, the level of effort they will allot to a behavior, and the sustainability of the behavior (Bandura, 1977).

Behavior change is therefore determined by two factors: *self-efficacy* and *outcome expectations*. *Self-efficacy* influences the acquisition of new behaviors, affects choices of behavior, and affects an individual's emotional reactions and cognitive processes concerning a behavior or action. Glanz et al. (1997) view the lack of *self-efficacy* as a barrier to taking a required health action or behavior. They argue that the original HBM did not include this construct because the model was initially developed to explain single performances of a health behavior such as immunization or taking a screening test. As such, *self-efficacy* was not seen as a vital construct to be included in the formulation of the model. It may have been assumed that people who do participate in these single health actions have adequate self- efficacy to undertake the behavior (Glanz et al., 1997). However, since its development, the HBM has been used to explain prolonged health behavior. *Self-efficacy* seems to predict the success of short-term as well as long-term behavior (Strecher et al., 1986). For behaviors such as smoking cessation, exercising, and sexual habits, *self-efficacy* becomes an important cognitive construct for the individual who performs the health behavior. Therefore, in addition to *perceived susceptibility*, *severity*, *benefits*, and *barriers*, the individual must also perceive themselves to possess the required self efficacy to perform the behavior. Thus they must realize the efficaciousness of the behavior or action (Glanz et al., 1997). Therefore, in more modern depictions and explanations of the HBM, *self-efficacy* is an added dimension.

#### *Application of the Health Belief Model to Health Behaviors*

Since its initial development, the HBM has been applied to numerous health behaviors. This section will analyze some of the health behaviors to which the HBM has been applied. The health behavior studies that will be discussed are studies examining

preventive health behavior including screening behaviors, sick role behaviors, and HIV risk behaviors.

In applying the HBM to HIV risk behaviors, many studies have investigated the relationship between the reduction of risk behaviors and the variables that have been conceptualized in the model (Montgomery et al., 1989). Some studies have supported the use of the model to explain why some individuals are successful in changing their risky sexual habits. Basen-Enquist (1992) tested a model of safer sex behavior using variables from the HBM and other theories. In terms of HBM, she found that *perceived susceptibility* was significantly related to the intention to use a condom. *Perceived barriers* were inversely related to condom use where the greater the barriers the less frequently condom use was reported. *Self-efficacy* was also an important variable. It was significantly related to the intention to discuss AIDS and past sexual history with current sexual partners (Basen-Enquist, 1992). Klein et al. (as cited in Montgomery et al., 1989) conducted a study among homosexual male physicians and university students. The study found that the subjects who believed that they were vulnerable or susceptible to infection were more likely to report decreased levels of high risk sexual behavior.

Valdisseri (as cited in Montgomery et al., 1989) found that homosexual men who were concerned about the personal threat of AIDS were more likely to use condoms during sex. *Perceived threat* includes the dimensions of *perceived susceptibility* and *perceived severity*. Therefore, this study showed the significance of two variables in the reduction of risk behavior. Valdisseri also found that the barriers to condom use among homosexual men included perceptions that condoms affected the pleasure received from the encounter, were embarrassing to purchase, were disliked by their partners, and were

more of a contraceptive method for heterosexuals. Therefore, *perceived barriers* prevented the use of condoms in this population. Likewise, Maes and Louis (2003) found in their study among older adults that low personal vulnerability to AIDS, which produces low perceived threat to AIDS, explained why their study sample did not use condoms to prevent HIV transmission.

*Self-efficacy* has been shown to have a considerable influence on the performance of healthy sexual behaviors. Janz and Becker (1984) have argued that low self efficacy has the same effect as *perceived barriers*. An individual who does not perceive the recommended behavior as efficacious is less likely to perform the behavior. In their study of HIV preventive behavioral intentions in college students, Zak-Place and Stern (2004) found that of all the HBM constructs, self-efficacy was the only significant predictor of intended condom use. They also found that self-efficacy was a significant predictor of other preventive behaviors such as STD and HIV testing while perceived susceptibility was negatively related to HIV testing intentions.

Rosenstock, Strecher and Becker (1994) proposed hypotheses for testing the HBM in relation to HIV and AIDS. These hypotheses were recommended as improvements to the application of the HBM to HIV/AIDS risk behaviors that have been done in the past. Rosenstock and colleagues suggested that *perceived severity* is necessary for *perceived susceptibility* to be a significant predictor of HIV-preventive behaviors. In addition, *perceived susceptibility* will not be significantly related to AIDS-preventive behavior. Rather, it will be a strong determinant of intention to practice safe sexual behaviors. A high level of *perceived threat* is also necessary for *perceived benefits* and *barriers* to be strong predictors of change in behavior. *Self-efficacy* will also be a

strong predictor of health behaviors especially those that require some level of skill. Therefore, *self-efficacy* may be a strong predictor of condom use. In addition, cues to action will have a greater effect on behavior if there is a high level of *perceived threat* (Rosenstock, Strecher & Becker (1994). Therefore, Rosenstock and colleagues have provided a guideline that can be used by researchers to assess HIV/AIDS risk behaviors using the HBM. The guide references the elements of the model that are strongly related and pinpoint the health behaviors that can be predicted by the different variables.

#### *Theory of Gender and Power (TGP)*

This study was also conceptualized according to the Theory of Gender and Power. In 1987, R.W. Connell developed an integrative Theory of Gender and Power. According to Connell, there are three constructs that characterize gendered relationships between men and women: the sexual division of labor, the sexual division of power, and the structure of cathexis (Connell, 1987). The sexual division of labor is the allocation of different types of work to men and women. Women often are delegated “women’s work”, such as child care, elderly care and housework. Since these jobs are uncompensated, women often depend on men for financial resources. Even in situations in which men and women are equally skilled, men tend to be more highly remunerated than women. Often, women are also discriminated against in training and promotion opportunities. This reality often leaves women economically dependent on men. The sexual division of power refers to the ability of men to exert influence over women. This power exists at the societal, institutional, and interpersonal levels, and is manifested by violence against women, the construction of male dominated hierarchies of authority, and patriarchal belief systems. Closely related to the sexual division of labor is the sexual division of

power which supplies the infrastructure for control and coercion of women. Power structures are manifested in government, business hierarchies, institutional and interpersonal violence, and sexual regulation and surveillance (Chapman Walsh, Sorensen, & Leonard, 1995; Raj, Silverman, Wingood & DiClemente, 1999; Wingood & DiClemente, 2002)

The structure of cathexis refers to the emotional or affective dimensions of social relationships. This structure dictates appropriate sexual behavior for women and defines the moralistic expectations of women's sexual expression. Connell argues that expectations of sexual behavior within social relationships are not merely different, but they are specifically unequal. Heterosexual women are sexualized as an object in ways that heterosexual men are not. These three structures define the gendered roles of men and women in society (Connell, 1987).

Connell posits that these structures, though distinct, overlap each other and can be used to explain the cultural dimensions of gender roles assumed by men and women. These structures are rooted in the fabric of societies and serve to determine the gender-related norms that are learned within each culture. Moreover, these structures exist not only at the societal level but also at the institutional level such as in schools, work sites, families, relationships, the media, and in healthcare delivery systems (Connell, 1987). The presence of these social mechanisms has significant implications for women's economic, political, and social positions in society by creating inequities in women's economic potential, control of resources, and expectations of societal roles.



### *Application of the Theory of Gender and Power*

The theory of gender and power has been used to conceptualize public health issues such as domestic violence against women (Raj et al., 1999). This study assessed the relationship between social and economic power and incidence of male-perpetrated domestic violence against low-income African American women. The authors hypothesized that sexual division of labor (operationalized by receiving government assistance, receiving income from male partner, low educational level and having children) would be highly associated with relationship abuse. They also posited that sexual division of power (partner jealousy, lower levels of perceived empathy) would be associated with higher levels of abuse. Finally, the authors hypothesized that structure of cathexis variables (greater religiosity, emphasis on childbearing and perceptions of sex ratio imbalance) would also be associated with higher levels of abuse. The study findings indicate some support for using the TGP to explain levels of domestic violence among African American women. In particular, sexual division of labor constructs were strong determinants of domestic abuse. Sexual division of power variables were also strongly related to higher levels of abuse. Therefore, higher incidence of male jealousy was strongly related to domestic abuse.

The structure of cathexis construct was also highly associated with domestic abuse. Women who had higher levels of perceived male unavailability, and placed great importance on childbearing were likely to have less relationship power and more likely to experience domestic violence. This study provides an example of the application of the TGP to a prevalent public health issue. The study showed that women who are disenfranchised and disempowered may be more vulnerable to male inflicted abuse.

### *Criticisms of the Theory of Gender and Power*

The theory of gender and power has not been widely utilized in the social science literature. Chapman Walsh et. al. (1995) criticize the theory for framing questions that focus on the social progress of men being achieved at the expense of women rather than focusing on solutions for a society that can provide good quality of life for all members. Wingood & DiClemente (2002) further criticize the theory for being difficult to test empirically. This difficulty arises because the constructs are difficult to operationalize. It is also difficult to isolate and quantify the effect a particular structure may have on women's health. Nevertheless, this theory provides a unique framework for analyzing women's position in society and the factors that may contribute to negative social outcomes for women.

### *TGP Applied to HIV Risk and Women's Health*

Wingood and DiClemente (2000) expanded the Theory of Gender and Power to develop a public health model that examines exposures, risk factors, and biological factors that adversely affect women's health. This expanded framework will provide a theoretical underpinning for this study. According to the expanded model, exposures are acquired risks that increase the probability of acquiring a disease. Risk factors are those elements such as knowledge, attitudes, beliefs, and skills that are associated with indulging in risky behaviors. Risk factors operate at the interpersonal level and can be socioeconomic, behavioral, or personal in nature. Biological factors are the physiological factors that may predispose an individual to contracting a disease. Wingood and DiClemente (2000) argue that the social structures of division of labor, power, and cathexis produce gender disparities in public health and the social sciences. These

inequities are manifested as gender based differences in exposures, risk factors, and biological properties that increase women's vulnerability to diseases such as HIV. The following is an analysis of Wingood and DiClemente's expanded model of the Theory of Gender and Power which conceptualizes the relationship between the original theoretical tenets, exposures, risk factors and biological factors.

According to Wingood and DiClemente (2000), the inequalities that result from the sexual division of labor are manifested in the public health field as economic exposures and in the psychosocial domain as socioeconomic risk factors. The economic exposures refer to women who live in poverty, have limited access to health care, are homeless, have less than a high school education and have a high demand/low control work environment. Women who experience these exposures and risk factors will have adverse health outcomes.

Closely linked to the sexual division of labor is the second theoretical construct: the sexual division of power. As previously discussed, this construct exists at the institutional and interpersonal levels. At the individual level, women who have limited or no power in their relationships are likely to depend on their male partners for economic resources. At the institutional level, women are often portrayed by the media as dependent, oversexed, and degrading. These portrayals add to the negative perceptions of women's roles in society. The sexual division of power is manifested in the public health field as physical exposures to disease. These exposures, which can exist at the institutional and interpersonal levels, include a history of sexual or physical abuse, significant exposure to sexually explicit media, a high-risk sexual partner, a partner who resists practicing safe sex, and lack of access to drug treatment or to HIV prevention

education. In the psychosocial domain, the sexual division of power is manifested by behavioral risk factors such as alcohol and drug use, poor assertive communication skills, low condom use/negotiation skills, low self-efficacy to avoid HIV, and limited perceived power in the sexual relationship (Wingood and DiClemente, 2000).

The structure of cathexis, the final tenet of the theory, refers to the structure of social norms and affective attachments. The disparities, resulting from the social mechanisms of social norms and affective attachments, are manifested in public health as social exposures and in the psychosocial domain as personal risk factors. Social exposures include women who have older partners, women who want to conceive, family influence that does not support HIV protective behaviors, mistrust of the medical system, conservative cultural and gender norms, and religious affiliation that forbids contraceptive use. The personal risk factors include limited knowledge of HIV prevention, negative attitudes and beliefs about condoms, and a history of mental distress and depression (Wingood and DiClemente, 2000). Table 1 outlines the conceptualization of the Theory of Gender and Power as it relates to women's health.

Table 1: Theory of Gender and Power as it Relates to Women's Health

| <i>Societal Level</i>                             | <i>Institutional Level</i>           | <i>Social Mechanisms</i>                                                         | <i>Exposures Public Health Domain</i>                                                                               | <i>Risk Factors Psychosocial Domain</i>                                                                                                                     | <i>Biological Factors</i>                            | <i>Disease</i> |
|---------------------------------------------------|--------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------|
| Sexual division of labor                          | Work site, school, family            | Manifested as unequal pay produces economic inequities for women                 | Economic exposures-poverty, low educational level, unemployment, limited health care, no health insurance, homeless | Socio-economic risk factors-ethnic minorities, younger women                                                                                                |                                                      |                |
| Sexual division of power                          | Relationships, medical system, media | Manifested as imbalances in control produce inequities in power for women        | Physical exposures sexual or physical abuse, high-risk steady partner, limited access to HIV prevention             | Behavioral risk factors-alcohol and drug abuse, poor assertive skills, low self-efficacy, limited control over condom use                                   | Anatomical features, genetic determination, hormones | HIV            |
| Cathexis : social norms and affective attachments | Relationships, family, church        | Manifested as constraints in expectations produce disparities in norms for women | Social exposures-older partner, conservative gender norms, mistrust of medical system, family influence             | Personal risk factors – lack of HIV prevention knowledge, negative safer sex beliefs, perceived invulnerability to HIV/AIDS, depression and mental distress |                                                      |                |

Source: Wingood, G.M. & DiClemente, R.J. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Education & Behavior* 27(5), 539-565.

## CHAPTER THREE: METHODS

### *Purpose of the Inquiry*

The purpose of this study was to conduct exploratory research to generate formative data on factors that influence HIV-risk behaviors among black heterosexual men living in the U.S. This study further seeks to explore potential variability in HIV risk behaviors among ethnic subgroups of black heterosexual men (U.S.-born and Haitian-born). Therefore, this study furthers the body of knowledge as it allows for an in-depth exploration of the social, cultural, intrapersonal and behavioral factors that influence HIV-risk behaviors within subgroups of black heterosexual men (U.S.-born and Haitian-born). The study also allows for comparison of the perspectives of black men versus that of black women from similar ethnic subgroups. The results of this study provide insights for HIV education and behavioral interventions to reduce HIV/AIDS disparities within ethnically diverse black populations in Florida and nationwide (limited to the populations in this study). From a methodological perspective, the findings of this formative study may be used to inform the design of future quantitative HIV behavioral studies on subgroups of heterosexual black men.

## *Research Questions*

### *Phase I: In-depth Interviews with Heterosexual Black men*

Research questions were guided by research objectives which sought to explore and understand the intrapersonal, socio-cultural, and behavioral factors that influence HIV risk behaviors in subgroups of black men (U.S.-born and Haitian-born) who identify as heterosexual.

*Objective 1:* To understand the intrapersonal factors (knowledge, attitudes and beliefs) that influence HIV-risk behaviors in subgroups of black men (Native born African Americans and Haitian-born immigrants) who identify as heterosexual.

#### *Research Question:*

1. What are black men's knowledge, attitudes and beliefs about HIV/AIDS transmission?

*Objective 2:* To understand the socio-cultural and behavioral health factors that influence HIV risk behaviors in subgroups of black men (Native born African Americans and Haitian-born immigrants) who identify as heterosexual.

2. What are the HIV-risk behaviors practiced by black men who identify as heterosexual?
3. What cultural norms influence sexual behavior among black men who identify as heterosexual?
4. How do gender norms influence sexual behavior among black men who identify as heterosexual?

*Phase II: Focus Groups with Heterosexual Black Women*

*Objective 3:* To discover how black women conceptualize and perceive the socio-cultural, intrapersonal and behavioral factors that influence black men's HIV-risk behaviors.

5. What are black women's perceptions of the risk behaviors practiced by black men who identify as heterosexual?
6. What are black women's perceptions of the gender and cultural norms that influence sexual behavior among black men who identify as heterosexual?
7. What are black women's perceptions of the ways in which black men's sexual behaviors affect their own health?



**Table 2: Research Questions and Theoretical Concepts**

| <b>Research Questions</b>                                                                                                                                                                                                                                                                                                                                                                   | <b>Theoretical Constructs Being Assessed</b>                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. What are black men’s knowledge, attitudes, and beliefs about HIV/AIDS transmission?                                                                                                                                                                                                                                                                                                      | Socio-ecological Model /Health Belief Model<br><i>Perceived susceptibility/perceived threat/perceived benefit of protective behaviors/perceived barriers/self-efficacy/perceived severity.</i> |
| 2. What are the risk behaviors practiced by black men who identify as heterosexual?<br>3. What cultural norms influence sexual behavior among black men who identify as heterosexual?<br>4. How do gender norms influence sexual behavior among black men who identify as heterosexual?                                                                                                     | Socio-ecological Model/ Theory of Gender and Power<br><br><i>Sexual division of labor, sexual division of power, cathexis.</i>                                                                 |
| 5. What are black women’s perceptions of the risk behaviors practiced by black men who identify as heterosexual?<br>6. What are black women’s perceptions of the gender and cultural norms that influence sexual behavior among black men who identify as heterosexual?<br>7. What are black women’s perceptions of the ways in which black men’s sexual behaviors affect their own health? | Socio-ecological Model/Theory of Gender and Power<br><br><i>Structure of Cathexis, Sexual division of labor, Sexual division of power, Cathexis: social norms and affective mechanisms.</i>    |

Socio-ecological Factors

## *Qualitative Research*

*I think metaphorically of qualitative research as an intricate fabric composed of minute threads, many colors, different textures, and various blends of material.*  
(Creswell, 1998)

With the continued emergence of multifaceted public health problems, the need for multiple approaches to analyze public health problems has become more evident. According to Ulin and colleagues (2005), qualitative approaches help to fill a gap in the “public health toolbox” (p. xiii). Qualitative methods can be used to discover attitudes, beliefs, perceptions, culture, and lived experiences in a naturalistic manner. Qualitative methods help to provide deeper insight and meaning to public health problems within the context of the lives of the individuals being studied. Qualitative research is defined by Creswell (1998) as:

“an inquiry process of understanding based on distinct methodological traditions of inquiry that explore social or human problems. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting”.

Many public health problems such as HIV are deeply embedded in the social and cultural fabric of society. Confronting these issues and developing effective interventions require multilevel, multidimensional approaches that may be discovered by using qualitative methods. In addition, qualitative methods may be used to complement quantitative techniques and allow for deeper discovery of answers to the research questions being studied. Qualitative research allows the researcher to explore the social realities and understandings of study participants from a holistic perspective.

### *Overview of the Research Design*

This study was an exploratory inquiry using qualitative research methods. The purpose of the study was to conduct exploratory research to generate formative data on factors that influence HIV-risk behaviors among black heterosexual men. This study further sought to explore potential variability in HIV risk behaviors among ethnic subgroups of black heterosexual men (U.S.-born and Haitian-born). In addition, the study explored black women's perceptions of the factors that influence the sexual risk behaviors of black heterosexual men. To explore black men's knowledge, attitudes, beliefs, and behaviors, semi-structured in-depth interviews were conducted with male participants in the initial phase of the study. Subsequently, in the second study phase, focus groups were conducted to explore women's perceptions specifically with regard to the responses and information gathered from the male interviews. Themes from the male interviews were used to develop the focus group guide for the second phase of the study.

### *Study Population*

The study population was black men and women from two predominant ethnic subgroups (U.S.-born and Haitian-born blacks) 18 years of age and older. These two ethnic subgroups were chosen for several reasons:

1. The epidemiological data as discussed earlier show that there are high rates of HIV/AIDS in the black population in Florida and in the Hillsborough County area.
2. Epidemiological data also show that there are also high infection rates in the Haitian population in Florida. Even though they comprise 1.05% of Florida's

population, they account for 15% of HIV cases reported through 2008 (Florida Department of Health, 2008c).

3. The influx of Afro-Caribbean individuals into Florida and Hillsborough County warrants an investigation of the cultural and social implications for HIV transmission and prevention. Most notably, the Haitian population in Hillsborough County has more than doubled in the past several years (Lush, 2002).
4. There are distinct cultural differences between the African American and Haitian cultures that may manifest in significantly different beliefs and practices around sexual behavior. For example, unlike African American culture, Haitian culture incorporates the concept of *voudou*, a form of magic that often dictates beliefs around illness and health behavior.

The age group 18 years and older was selected because in the state of Florida AIDS is the leading cause of death for black men and women ages 25-44 years (FDOH, 2007b). However, HIV/AIDS is now a growing problem among middle aged and older adults. For example, among Haitians, men and women 50 years and older have the highest prevalence of HIV/AIDS cases (FDOH, 2008c). A total of 29 men were interviewed, 15 U.S.-born black men and 14 Haitian-born black male immigrants who have been living in the U.S. for at least three years.

For the focus groups, phase II of the study, U.S.-born and Haitian-born black women 18 years and older were included in the sample. AIDS is the leading cause of death for black women aged 25-34 years, the 3<sup>rd</sup> leading cause for black women aged 35-44 years, and the 4<sup>th</sup> leading cause of death for black women aged 45-54 years (CDC,

2008b). In Florida, AIDS is the leading cause of death among black women ages 25-44 (FDOH, 2008a).

The data support the assertion that these age groups within the black population are at high risk for contracting and transmitting HIV. Based on these observations, it is imperative that behavioral research is conducted among this population to determine factors that contribute to risk in order to develop appropriate interventions to curb the spread of the virus.

#### *Location of the Study*

This study was conducted in Hillsborough County, Florida. Hillsborough County ranks among the top 5 Counties in Florida for persons living with HIV/AIDS. Through September 2006, there were 6170 reported cases of AIDS in Hillsborough County. In addition, 48% of the adult HIV cases and 69% of the pediatric cases are among blacks (Hillsborough County Health Department, 2006). The Florida Department of Health (2006) reports that 1 in 85 blacks are living with HIV/AIDS in Hillsborough County compared to 1 in 375 whites and 1 in 309 Hispanics.

#### *Immigration in Florida*

According to the Federation for American Immigration Reform, Florida is the seventh largest growing state in the nation in terms of influx of immigrants. Since 1997, over 3 million new residents settled in Florida, one-third of who were immigrants. Likewise, Hillsborough County has experienced an influx of immigrants. According to the U.S. Census Bureau (2000), 11.5% of the population in Hillsborough County is foreign-born including significant numbers from the Caribbean. Therefore, the influx of

Afro-Caribbean individuals into Florida and more specifically, Hillsborough County, is significant and may have cultural and social implications for HIV prevention.

#### *Phase I: In-Depth Semi-Structured Interviews with Men*

Given the sensitive nature of the questions explored, semi-structured interviews were appropriate for the male study participants. In addition, since the study questions elicited socially desirable responses, an individual interview format minimized biases in male participants' responses (Debus, n.d.).

#### *Inclusion Criteria for Individual Interviews*

Eligibility criteria for inclusion in this study included: a) male sex; b) self-identify as non-Hispanic black and/or African American; c) self-identify as heterosexual; d) reside in Hillsborough County; e) self-declare ancestry from the U.S. (African American) or Haiti; f) able to speak English and; g) 18 years and older; h) reside in the U.S. for at least three years.

#### *Exclusion Criteria for Individual Interviews*

Men who were younger than 18 years of age were not included in the study. Men were not considered for the study if they did not identify as non-Hispanic black, African American, or Haitian. Further, the study excluded men who did not identify as heterosexual and did not reside in Hillsborough County and did not live in the U.S. for at least three years. Because the researcher was English speaking and did not have the capacity to interpret Haitian-Creole, non-English speaking individuals were not included.

#### *Sample for Individual Interviews with Men*

Unlike quantitative research, the goal of qualitative research is to gather information-rich data from a sample most qualified to provide the information. In

qualitative inquiry, the individuals who have lived the issues being studied are considered the experts. The sample chosen for this study was able to provide the most accurate and holistic information on the study topic. The intent was to select participants who could provide a range of experiences and perspectives that are relevant to the topic at hand (Ulin et al., 2005). According to Neuman (2003) it is important for the qualitative researcher to focus on a sample that reflects social life. Qualitative research emphasizes the context of the problem. As Lincoln and Guba (1985) note, the objective of naturalistic inquiry is not to focus on generalizations, “but to detail the specifics that give the context its unique flavor” (p. 201).

Non-probability sampling techniques were employed to determine the sample for this inquiry. The logic of non-probability or purposeful sampling is to select information-rich cases that can provide meaningful information for the questions being studied (Gall, Gall, & Borg, 2003; Patton, 2002). This inquiry employed quota, snowball, and convenience sampling techniques. Quota sampling is used to achieve a preset number of cases in predetermined categories that will reflect the diversity of the population. The number of cases in each category of the sample is fixed (Neuman, 2003). A quota sampling matrix was used to delineate the predetermined categories and the number of cases needed for the inquiry. However, data were collected until saturation was reached (Lincoln & Guba, 1985). The actual study population for phase I of the study is detailed in Table 3 below.

Table 3: Phase I - Study Population

| <b>Phase I: Males</b>        |             |                          |              |
|------------------------------|-------------|--------------------------|--------------|
| <b>Ethnic Subgroup</b>       | <b>Age</b>  | <b>No. per age group</b> | <b>Total</b> |
| U.S.-born (African American) | 18-24 years | 5                        | 15           |
|                              | 25-44 years | 5                        |              |
|                              | 45-54 years | 5                        |              |
| Haitian-born                 | 18-24 years | 4                        | 14           |
|                              | 25-44 years | 5                        |              |
|                              | 45-58 years | 5                        |              |
| <b>Total</b>                 |             | <b>29</b>                | <b>29</b>    |

Snowball and convenience sampling were used to select study participants. Snowball sampling involves asking qualified people (e.g. gatekeepers, key informants) and research participants to recommend cases for the study. Using community connections, the researcher contacted key informants in the Tampa Bay area who were resourceful in recommending and referring participants for the study. This recruitment method was particularly helpful for recruiting Haitian men who may be less visible and accessible in the general community. The researcher also located informants by asking each participant to suggest others who they thought might be well-suited to address the questions being asked. This process continued throughout the study and allowed the



researcher to recruit a sample (N=29) of information-rich cases (Ulin et al., 2005). According to Patton (2002), this sampling technique produces good interview participants and makes the study more credible. These sampling techniques are useful and typical for qualitative research (Neuman, 2003).

Purposeful sampling has several characteristics that are unique to qualitative inquiry. First, the sampling design was emergent. This means the sample was not “drawn” prior to the study but while the study was being conducted. The snowball sampling technique also facilitated this emergent, serial selection sampling design. The study sample was continuously adjusted or focused throughout the data collection phase. Second, as perspectives and insights were gained, the researcher refined the sample in order to obtain the most information-rich and relevant participants. These naturalistic sampling techniques are designed to produce information-rich samples. The point of qualitative inquiry is not to facilitate generalization, rather it aims to gather deeper insight and meaning within a holistic context. The sampling techniques chosen were appropriate to achieve these qualitative research goals.

#### *Phase II: Focus Group Interviews with Women*

To explore the perspectives of women, four focus groups were conducted among female research participants. The themes derived from the male interviews were used to inform the focus group discussions. The purpose of a focus group is to listen and gather information from individuals based on their experiences. Focus group participants were selected based on similar characteristics as they relate to a particular issue or experience. One advantage of focus groups is that the participants influence or feed off of the information shared within the group. This interview format is appropriate to explore the

perceptions and feelings of black women as they relate to the sexual behaviors of black men. Very importantly, focus group participants were asked to react to the responses gained from the male interviews. Each focus group consisted of between 3 and 10 women. While Krueger and Casey (2000) recommend a maximum of eight women per focus group, adjustments had to be made to facilitate 10 women within one instance due to over recruitment and an unanticipated show rate of 100%.

#### *Inclusion Criteria for Focus Groups*

Eligibility criteria for inclusion in this study included: a) female sex b) self-identify as non-Hispanic black and/or African American or Haitian; c) self-identify as heterosexual; d) reside in Hillsborough County; e) self-declare ancestry from the U.S. (African American) or Haiti; f) able to speak English and; g) 18 years or older; h) reside in the U.S. for at least three years; i) must have had at least one African American or Haitian male sex partner.

#### *Exclusion Criteria for Focus Groups*

Female informants who were younger than 18 years of age, did not identify as non-Hispanic black, African American, or Haitian, did not identify as heterosexual, live in Hillsborough County, or speak English or did not reside in the U.S. for at least three years and did not have at least one African American or Haitian male sex partner were excluded from the study.

#### *Sample for Focus Groups with Women*

Similar to the sampling technique used for the male individual interviews, non-probability sampling was employed to determine the sample for the focus groups. Quota sampling and convenience sampling techniques were also utilized in this second phase of

the study. Quota sampling was used to achieve a preset number of cases in predetermined categories that reflected the diversity of the population. A quota sampling matrix was used to delineate the predetermined categories and the number of cases needed for the inquiry. The actual study population recruited for Phase II of the study is detailed in Table 4 below.

Table 4: Phase II – Study Population

| <b>Phase II: Females</b>     |             |                            |                            |              |
|------------------------------|-------------|----------------------------|----------------------------|--------------|
| <b>Ethnic Subgroup</b>       | <b>Age</b>  | <b>No. of focus groups</b> | <b>No. per focus group</b> | <b>Total</b> |
| U.S.-born (African American) | 24-27 years | 1                          | 5                          | 15           |
|                              | 43-65 years | 1                          | 10                         |              |
| Haitian-born                 | 20-27 years | 2                          | 3                          | 8            |
|                              |             |                            | 5                          |              |
| <b>Total</b>                 |             | <b>4</b>                   | <b>23</b>                  | <b>23</b>    |

### *Recruitment for Phases I and II*

Participants were recruited from local community-based agency contacts, community stakeholders, health fairs, and participant referrals. Community venues such as a college campus in Tampa, and a local barbershop were used as recruitment venues where recruitment flyers were posted. Gatekeepers and key informants within black communities were asked to refer participants for the study. Through my professional involvement in the community, I was able to identify gatekeepers such as the executive director of the Haitian American Alliance, the coordinator of the Haitian Breast and Cervical program at a local cancer center, the coordinator of a local charity-based organization, coordinator of the “Knowledge is Power” healthy lifestyles program as well as community activists and advocates. These individuals I have been able to identify through my professional relationships developed in the community through the Tampa Bay Community Cancer Network, a group of community-based organizations that work to address cancer health disparities.

Because the stigma associated with HIV/AIDS might have discouraged participants, HIV/AIDS was not mentioned on recruitment flyers. The flyers invited U.S.-born and Haitian-born black men and women to participate in a confidential study about “sexual health, and relationships in the African American and Haitian community” (Appendix C). Flyers targeting Haitians were designed to be culturally appropriate and included information in both English and Haitian Creole. Recruitment materials encouraged prospective participants to call a local phone number to determine whether they met the eligibility criteria for the study (refer to inclusion/exclusion criteria section

above). Participants received a \$25 cash incentive, educational brochures on HIV prevention and information on local HIV testing services.

The research assistant contacted interested individuals to conduct an initial eligibility assessment to determine whether interested callers were eligible for the study. Once eligibility was determined, based on the inclusion criteria described above, the research assistant scheduled a convenient time and place (public facility such as libraries, community center and fast food restaurants) to conduct the interviews and focus groups. Twenty-four hours prior to the interview/focus group, potential participants were called to remind them of their appointments.

#### *Strategies to Address Researcher Safety*

Conducting sensitive research has the potential to significantly impact the psychological and/or physical safety of the researcher (Dickson-Swift, James, Kippen & Liamputtong, 2008). Since this study explored sensitive topics and was conducted by a female researcher, it was important to consider issues related to researcher safety. Often, in social research, we rightly address participant safety, but fail to address the safety of those conducting the research. Dickson-Swift and colleagues (2008) note that the Social Research Association has identified several factors that should be considered by researchers:

1. Risk of physical threat or abuse
2. Risk of psychological trauma
3. Risk of being in a compromising situation
4. Increased exposure to risks of everyday life
5. Risk of causing psychological or physical harm to others

To address researcher safety in this study, several strategies were used. First, to address potential psychological threats, I used informal and formal support networks of trusted friends, family members, and colleagues for debriefing throughout the research process. Second, to address physical safety, I conducted interviews in public locations such as libraries and fast food restaurants. While conducting the interviews, I carried a mobile phone that was easily accessible. Third, I remained astute and aware of my surroundings at all times. Researchers who do not appear confident and aware may increase risk of personal danger (Pearson, Gregory & Thorne, 1999). It was also important to wear clothing that was appropriate to the setting in which the research was being conducted. Finally, as Pearson et al. (1999) note, researchers should trust their instincts and conclude the dialogue if they feel uncomfortable or sense that something is wrong. However, there was no occasion during my research to prematurely conclude an interview or focus group. These strategies were adopted to increase personal safety while conducting research in the field.

### *Data Collection Procedures*

#### *Phase I: Individual Interviews with Black Men*

As discussed above, participants were recruited by distributing culturally tailored flyers (Appendix C) in various selected community-based locations. Flyers instructed interested individuals to call a local phone number. Once the researcher was contacted, an eligibility checklist was used to determine whether interested callers were eligible for the study (Appendix D). At this time, pertinent demographic information was collected.

### *Setting.*

Once eligibility was determined, based on the inclusion criteria described above, the researcher scheduled a convenient time and place (public locations) to conduct the interview. Most interviews were conducted at fast food restaurants, local libraries and meeting rooms at a local university. Twenty-four hours prior to the scheduled interview, potential participants were called to remind them of their appointment. Once at the interview, the researcher developed rapport with the participant and reviewed and discussed the informed consent form (Appendix F), purpose of the study, the time the interview would take (30-45 minutes), plans for using the interview results, answered any questions from the participant, and collected the signed consent form (Creswell, 1998). The interviewee was given a copy of the consent form.

### *Demographic Data.*

Prior to the conduction of the interview, each interviewee was asked to complete a demographic survey which contained closed-ended questions about age, race, ethnicity, sexuality, marital status, educational level, employment status, and income (Appendix E). All participants completed the survey.

### *Individual Semi-Structured Interviews.*

In-depth interviews were used to collect information from male study participants. According to Ulin et al. (2005), highly sensitive topics, such as sexual behavior, may warrant use of the individual interview format. In-depth interviews involve conversational exchange between an interviewer and respondent. Interviews are essentially “conversations with a purpose” (Ulin et al., 2005 p. 82). The semi-structured interview included a number of questions that were developed using an iterative process

and pilot testing (described below). Questions were asked sequentially, but the researcher also probed beyond the responses provided (Berg, 2004).

#### *Interview Procedure.*

The interview questions were open-ended, intended to elicit the experiences and opinions of the participants. Interviews were conducted using an interview guide which was fully developed and finalized after the instrument was pilot tested and guidance was received from the expert panel (dissertation committee members). The interviews commenced with an icebreaker to develop rapport with the interviewee. Gall et al. (2003), assert that it is important for the researcher to develop rapport with participants especially when probing for personal or sensitive information. The researcher used the interview guide to keep the dialogue focused and structured and to elicit responses that specifically addressed the research questions. The researcher read each question aloud to each participant and engaged in a dialogue to gain information on the perspectives and meanings of life events and sexual behaviors as constructed by the participants (Grbich, 1999). Interviews lasted between 45 minutes and an hour. After the interview was concluded, the researcher once again explained the intended use of the data and the confidentiality procedures that would be used to store and manage the data collected. Finally, the researcher thanked the participants for their time, efforts and information and wished them well.

#### *Categories of Interview Questions.*

To fully explore men's thoughts, perceptions and lived experiences, the interview questions were framed to include descriptive questions and probing questions. Descriptive questions moved from easy to more complex and were designed to elicit



detailed descriptions of knowledge, attitudes, beliefs, and lived experiences. Probing questions were used to derive a more detailed discussion of responses provided in response to descriptive questions (Grbich, 1999; Ulin et al., 2005).

*Development and Refinement of Interview Guide.*

Based on the tenets of the Socio-ecological Model, the Health Belief Model, and the Theory of Gender and Power, the interview guide was developed using an iterative process. These guides help the interviewer organize thoughts and cover the topics in sufficient depth (Creswell, 1998; Ulin et al., 2005). The interview guide is also important to create a more systematic and comprehensive data collection process (Patton, 2002). Guided by a review of the literature, the objectives of the study, and the theoretical frameworks informing the inquiry, a set of interview questions were drafted. Once drafted, the interview guide was reviewed by members of the dissertation committee. Based on feedback from the committee, the instrument was revised and pilot tested among a small sample (N=4). Feedback from the pilot testing was then used to develop a final version of the instrument (See Appendix H). Questions included in the interview guide were organized into two categories: descriptive and probing questions. Descriptive questions were asked during the early stages of the interview and as the dialogue progressed, probing techniques were introduced. Descriptive questions logically moved from easy and less threatening to complex in nature. Probes are follow-up questions that are intended to elicit deeper responses to previously asked questions (Grbich, 1999; Ulin et al., 2005).

### *Pilot Study.*

Pilot testing was conducted prior to the implementation of the study. In qualitative research, pilot testing is important to determine the appropriateness of interview guides, or other data collection tools (Ulin et al., 2005). The interview guide was tested among a small sample (N=4) of black men, one Haitian-born and three U.S.-born men. All pilot study participants lived in the US for at least 3 years and have had at least one African American and/or Haitian female sex partner and were between the ages of 27-57 years. Pilot study participants were therefore representative of the study population. They were asked to provide feedback on data collection instruments and techniques and to discuss themes and concepts that are important around the topic of HIV transmission, risk behaviors, behavioral health, and socio-cultural determinants of sexual behavior. By conducting this pilot study, I was able to determine whether or not the instrument addressed the relevant issues related to the topic, whether participants would respond honestly and openly, and whether potential questions were easily understood. Because of my gender (female), I asked participants to share their feelings and comfort level discussing intimate issues with a female researcher. Pilot interviews were recorded and transcribed. The findings of the pilot study were used to guide the development of data collection instruments and techniques.

### *Incentives.*

All male study participants were given a \$25 cash incentives. In addition, participants were given an educational packet consisting of low literacy HIV prevention brochures, a listing of HIV testing sites, and male condoms.

## *Phase II: Focus Groups with Black Women*

Focus groups were used to explore the views and opinions of the women in the study and to confirm the responses provided by male interviewees. A focus group is a qualitative research technique in which participants are interviewed in a group-discussion setting. This technique promotes open discussion and self-expression especially among marginalized groups (Neuman, 2003). Since women were asked for their perceptions of men's sexual behavior in general, focus groups allowed for an interactive exploration of these views. The use of focus groups for this phase of the study was appropriate because the researcher sought to elicit the range of ideas, feelings, and perceptions women have about men's sexual behaviors. In addition, since differences in perspectives, based on nativity, was a central focus of this study, focus groups allowed for this discovery in a limited time.

### *Setting.*

Focus group participants were contacted by a research assistant who determined eligibility for the study. Once a group of eligible women were identified, the researcher chose a central, public location at which to conduct the focus group. Group sessions were conducted in local community-based organizations, meeting rooms at a local university, and a private residence.

### *Demographic Data.*

Prior to the inception of the focus group discussions, each participant was asked to complete a demographic survey which contained closed-ended questions about age, race, ethnicity, sexuality, marital status, educational level, employment status, and income (Appendix E). All participants completed the survey.

### *Focus Group Procedure.*

The researcher ensured that the meeting room and recording equipment was set up and ready prior to the arrival of focus group participants. As participants arrived, they were welcomed. The discussions began with “purposeful small talk” (Krueger & Casey, 2000, p. 103) which helped to put the participants at ease. Once all participants were present, the researcher welcomed the group, explained the purpose of the study, informed consents, discussed ground rules, and asked whether there were any objections to audio-taping. All participants signed the focus group consent form (Appendix G). A focus group guide was used to guide the questioning route of the discussion (Appendix I). The guide was fully developed and finalized after the instrument was pilot tested and guidance was received from the expert panel (dissertation committee members). Focus group discussions lasted for approximately one hour. After the focus group, the researcher once again explained the intended use of the data and the confidentiality procedures that would be used to store and manage the data collected. Finally, the researcher thanked the participants for their time, efforts and information and wished them well.

### *Multiple-category design.*

Using the multiple-category design (Kreuger & Casey, 2000), 2 focus groups were conducted among U.S.-born women and 2 groups among Haitian-born women. The multiple-category design allows the researcher to conduct groups within several target audiences, either sequentially or simultaneously. By utilizing this method, the researcher is able to make comparisons between groups and/or within groups. In this case, the researcher compared perspectives between U.S.-born and Haitian-born groups. To ensure

accurate data collection and analysis, all focus groups were audio-taped and transcribed. Focus groups lasted for approximately one hour.

*Development and Refinement of the Focus Group Guide.*

Using theoretically driven approaches, the focus group guide was carefully developed using the guidelines suggested by Krueger & Casey (2000). Questions were informed by the research questions and the theoretical frameworks and were clear, short, open-ended, and one-dimensional. The focus group guide began with general questions and gradually moved to more specific questions as the discussion developed. Questions were categorized as opening, introductory, transition, key, and ending questions. Opening questions were designed to develop rapport and increase the comfort level of the participant. Introductory questions introduced the topic and urged participants to think of how the topic was related to their lives. Transition questions were used to move the discussion into the focal questions of the study (Krueger & Casey, 2000). Once the focus group guide was drafted, the questions were reviewed by members of the expert panel (dissertation committee) and then tested among a small sample of women (N=2). During the development of the instrument, the expert panel and the pilot testing participants were specifically asked to review the focus group questions for clarity, appropriateness, and relevance to the research questions. Based on the findings of the pilot testing and feedback from the expert panel, the focus group guide was revised and finalized (Appendix I).

*Pilot Study.*

Similar to phase I of the study, pilot testing was conducted prior to the initiation of focus groups. The focus group guide was tested among a small sample (N=2) of black

women, one Haitian-born and one U.S.-born. All pilot study participants lived in the U.S. for at least 3 years and had at least one African American and/or Haitian male sex partner. Pilot study participants were therefore representative of the study population. They were asked to provide feedback on the focus group instrument and data collection techniques and to discuss themes and concepts that are important around the topic of HIV transmission, risk behaviors, behavioral health, and socio-cultural determinants of sexual behavior. As previously mentioned, pilot study participants were also asked to assess the focus group questions for level of understanding, clarity, applicability and relevance to the research goals.

#### *Incentives.*

All female study participants received a \$25 cash incentive and lunch or a gift card for lunch. In addition, participants were given an educational packet consisting of low literacy HIV prevention brochures, a listing of HIV testing sites, and condoms.

#### *Technical Research Process*

##### *Audio-taping Interviews and Focus Groups*

Before the interviews and focus groups began and after consents were obtained, participants were asked if they objected to the discussions being audio-taped. Audio-taping helps to supplement memory and provides a record of events that occur during the interview process. Audio-taping aids researcher recall and preserves the data collected which can be reviewed by others after the interview has been conducted. (Gall et al., 2003; Neuman, 2003). To prevent participant reluctance to express their feeling freely and any other undesirable notions of tape recording, the researcher fully explained the

purpose of audio-taping in order to gain the trust of participants. In this study there were no objections to audio-taping.

### *Transcription*

A professional transcription service was used to transcribe the semi-structured interviews. The researcher worked closely with the transcriber to ensure that the transcripts accurately reproduced the interviews. All focus group discussions were transcribed by the researcher. Once complete, the researcher read the transcriptions while the audiotapes were played back to ensure accuracy.

### *Field Notes*

The researcher recorded field notes throughout the data collection process. It is important that good, clear, and detailed field notes are taken to enhance the inductive research process of qualitative inquiry (Ulin et al., 2005). The field notes taken included both descriptive and reflective notes. Descriptive notes describe the natural setting, interview activities and occurrences. Field notes were dated and included specific observations such as who were present, what social interactions took place, and what activities occurred. Reflective notes were used to document the interview process and reflections on personal feelings regarding specific interview or focus group activities (Lincoln & Guba, 1985).

### *Establishing Trustworthiness*

Similar to the concept of validity in quantitative research, trustworthiness refers to the confidence one can have in the findings of naturalistic inquiry (Ulin et al., 2005).

Lincoln and Guba (1985) provide four criteria for evaluating the trustworthiness of

qualitative inquiry: credibility, transferability, dependability, and confirmability. These criteria were applied in this study.

### *Credibility*

Synonymous with the concept of face validity, credibility refers to the soundness of the design and methods of a qualitative study. Credibility refers to the confidence one may have in the findings of naturalistic inquiry that the data accurately represents the social phenomenon being studied (Neuman, 2003; Ulin et al., 2005). Credibility of the researcher refers to the training, experience and the presentation of self. Establishing credibility requires the use of rigorous methods that produce rich data (Patton, 2002). In this study, peer debriefing was used to establish credibility. Peer debriefing is the process by which the researcher and a colleague/s analyze the data collected to clarify the researcher's interpretations. The debriefer in this study was a health educator and behavioral science researcher with extensive experience in health education within minority populations who during the debriefing process probed the inquirer's meanings, posture and potential biases. According to Lincoln & Guba (1985), the debriefing process allows for the analysis of the research design as the study progresses to identify needs for methodological modifications which may not be apparent to the researcher. Finally, debriefing and obtaining an outsider's perspective allowed me to clear my mind of biases and emotions that may have created barriers to objective interpretation of the data.

### *Transferability*

Analogous to the concept of generalizability in quantitative research, transferability refers to the degree to which study findings are applicable in another setting given that there is similarity or "fittingness" between the contexts (Neuman, 2003



p. 584). Because qualitative research is highly context specific, it is sometimes difficult to determine the level of transferability. However, as was done in this study, the researcher provided rich descriptions of the research context, the study participants, the social interactions, and the physical environment so that other researchers can decide how transferable the findings might be to another study context. According to Lincoln & Guba (1985) it is not the researcher's responsibility to decide the index of transferability; rather the inquirer must provide the proper rich description that allows others to make judgments on the transferability of the findings.

### *Dependability*

Dependability in naturalistic inquiry is synonymous with the concept of reliability in quantitative research. Dependability refers to whether the results of the study are consistent with the data collected. According to Grbich (1999), reliability in qualitative research is “assessed by the reader and lies in the capacity of the researcher to present a coherent, complete and meticulously checked exploration of all aspects of the topic under investigation” (p. 59). To establish dependability, independent researchers with expertise in socio-cultural HIV research were asked to analyze the methodological process, the data collected, findings, and interpretations. These investigators, members of the doctoral committee as well as a health educator and researcher with expertise in health behaviors among minority populations, acted as auditors to examine the product of the inquiry through their own investigative lens. Any disagreements between the researcher and the independent auditors were thoroughly discussed until consensus was reached.

## *Confirmability*

Confirmability is established by determining whether the researcher has maintained the distinction between their own beliefs and that of the research participants. This determination is done by allowing external inspection and verification of the study process (Ulin et al., 2005). One approach to establishing confirmability is the audit trail. According to Grbich (1999), an audit trail involves “tracing the conceptual development of the project from the raw data through data reduction, analysis and reconstruction” (p. 62). To establish confirmability, six categories of information were collected to produce a good audit trail (Lincoln & Guba, 1985; Ulin et al., 2005):

1. *Raw data*, including written field notes, tape recordings, and interview results.
2. *Data reduction and analysis products*, theoretical notes, list of codes.
3. *Data reconstruction and synthesis products*, notes showing how themes relate; themes, definitions and relationships; interpretations and inferences; final report showing connection between existing literature and study findings.  
*Process notes*, methodological notes; trustworthiness notes; and audit trail notes.  
A good audit trail allows others who read the data to determine if the interpretations are grounded in the data collected.
4. *Materials relating to intentions and dispositions*, the study proposal, reflexive notes, personal notes about study motives and expectations, and IRB documents.
5. *Instrument development information*, interview guide, focus group guide, data collection protocols.

### *Researcher Bias*

Interviewer effect refers to errors in measurement that can be attributed to specific characteristics of the interviewer (Davis, Couper, Janz, Caldwell, Resnicow, 2010).

Neuman (2003) posits that interviewer bias occurs when there is a deviation from the “true” response in the response received and recorded by the interviewer. Neuman (2003) outlines six categories of interviewer bias: 1) errors by the respondent; 2) unintentional error or interviewer sloppiness; 3) intentional deviations by the interviewer; 4) interviewer’s expectations of how a respondent should answer; 5) failure of the interviewer to appropriately probe answers; and 6) influence on the answers due to the interviewer’s appearance and demeanor.

*Errors by the respondent* refers to the interviewee, forgetting, misunderstanding or editing responses. Davis et al. (2010) argue that the presence of the interviewer can affect how the respondent forms and answer or edits a response before communicating it. Further public health interviews may be especially open to response edits as individuals may perceive social harm by sharing information on stigmatized behaviors or health conditions. To minimize this bias, the researcher developed rapport with all study participants by creating an atmosphere for open dialogue prior to beginning interviews and focus groups. By doing so, the researcher created an open and nonthreatening atmosphere whereby participants could share their experiences freely.

*Unintentional errors or interviewer sloppiness* refers to interviewer errors such as misreading a question, omitting questions, recording wrongs answers to questions or misunderstanding the responses of study participants (Neuman, 2003). The researcher controlled this bias by ensuring that questions were not misread or omitted. The

researcher had extensive knowledge of the interview and focus groups questions and followed the semi-structured interview and focus group guides throughout the data collection process. In addition, interviews were tape recorded and recordings and transcripts were carefully reviewed and audited to ensure that transcripts accurately reflected the recordings.

*Intentional subversion by the interviewer* involves purposeful modification of answers, and omission or rewording of questions (Neuman, 2003). As previously noted, this bias was controlled by careful adherence to the interview and focus group guides as well as careful transcription and auditing of transcripts. The fourth category, *influence due to the interviewer's expectations*, refers to the interviewer's expectations about a respondent's answers based on the characteristics of the respondents such as appearance, age, race, or previous answers. The researcher addressed this bias by ensuring that respondents were not judged or stereotyped.

The fifth category, *failure of the interviewer to probe or to probe properly*, was minimized by ensuring that probes were used to more deeply explore specific answers to questions. To ensure that questions were properly probed, probing questions were included in the interview and focus group guides. In addition, the researcher was adequately trained through relevant coursework, professional experience and pilot studies, to properly administer interviews and focus groups.

The final category as defined by Neuman (2003) is, *influence on the answers due to the interviewer's appearance, attitude, reactions and comments*. This bias was minimized first because the researcher is of the same race as the study participants. The researcher ensured that her physical appearance was non-threatening and allowed her to

blend in with the research participants. In addition, the researcher minimized the use of comments that were not directly related to the interview schedule, and ensured that her tone, attitude and body language were nonjudgmental and neutral.

### *Data Analysis*

Results were analyzed using thematic analysis. Thematic analysis is a process of analyzing qualitative data through encoding and generating themes or patterns in the information (Boyatzis, 1998). Hand-coding and a qualitative software package (*Atlas.ti version 6*) were used to generate, organize and classify codes. Ulin et al. (2005) note that qualitative computer software programs assist with the analysis process by performing useful data manipulation procedures such as creation and insertion of codes, indexing, and selective retrieval of text (p. 151). Interview responses were recorded, transcribed, and coded for emergent themes. Ulin et al. (2005), propose five basic steps in qualitative data analysis that allow for an inductive research process: 1) reading; 2) coding; 3) displaying; 4) reducing; and 5) interpreting. These steps were followed to conduct a thorough thematic analysis of the data. The first step, reading, involves immersing oneself in the data to ensure complete understanding of the data collected. During and after data were collected, the researcher reviewed interview and focus group transcripts from all study participants. Then, the researcher again reviewed each respondent's transcript to identify significant statements within the scripts.

Themes were identified using the constant comparative method in which the themes were compared within and across interviews and focus groups. Constant comparative analysis involves comparing data elements of each interview or focus group and comparing them with all others to derive similarities or differences. The themes from

each transcript were compared with all other transcripts with particular emphasis on identifying commonalities across respondents. The final result is the determination of relations between different pieces of data (Thorne, 2000). As the data were read, the emergent themes were identified and coded. Coding involves attaching labels to the pieces of text that represent emergent themes. Extensive coding techniques were utilized to apply relevant codes to the data collected. *Open coding* involved word-by-word and line-by-line analysis of the data. This allowed the researcher to categorize segments of the data based on emergent concepts. *Axial coding* involved the development of expanded categories based on the smaller categories identified in the open coding phase. Finally, *selective coding* involved the validation of the relationship between identified categories (Grbich, 1999).

During the coding process, transcripts were first divided into meaningful units of text. Next, based on carefully reviewing interview and focus group recordings and rereading of the transcripts, codes were created, and units of text from the transcripts were assigned to one or more codes.

#### *Reliability of Coding*

The researcher solicited two additional researchers with graduate degrees in Public Health and extensive experience in qualitative research methods and data analysis to review and code 20% of the interview transcripts (N=6) and 25% of the focus group transcripts (N=1). The first secondary coder is a health educator and doctoral candidate with extensive health education, qualitative data analysis and project evaluation experience. Her qualitative data analysis experience includes coding and analyzing data from research projects centered on African American and Haitian populations. One

example of her experience includes her research on assessing the feasibility of using barbershops as a venue for prostate cancer education. She was also chosen to assist with coding for this study because of her extensive experience conducting community-based projects in the Haitian and African American communities.

A third coder was chosen to independently code a subset of the male interviews. A public health doctoral student at a university in the southeastern United States, she is experienced in conducting qualitative research and has worked on multiple projects conducting qualitative data analysis. One such project includes her research conducting and analyzing focus group data which explored the community's perceptions and beliefs about access and services at a local cancer center. The three researchers (including the principal investigator) independently reviewed and coded the transcripts. The researchers then met to discuss codes and rationale for the codes assigned. Any discrepancies regarding the codes were discussed and resolved once all parties came to a mutual agreement. Coders discussed emerging codes as they were identified. Coding disagreements were discussed until consensus was reached. Throughout the coding process, codes were constantly compared and revised as the researcher derived new understandings of the data (see Appendix J).

The data were then displayed to detail each category identified and reduced to the most essential points. The data was interpreted by searching for the meanings of thoughts and feelings as described in the text. Finally, an overall interpretation of the data was compiled outlining the themes identified and the relationship between these themes.

Demographic data were analyzed by using the Statistical Package for the Social Sciences (*SPSS*) analytical software. Descriptive statistics were used to summarize the

data and report findings. Descriptive statistics reported include mean age, income, educational level, marital status and race/ethnicity.

### *Data Interpretation*

“Interpretation is a complex and dynamic craft, with as much creative artistry as technical exactitude and it requires an abundance of patient plodding, fortitude, and discipline” (Crabtree & Miller, 1999, p. 128). As postulated by Crabtree & Miller, the interpretive process consists of five iterative phases: a) describing, b) organizing, c) connecting, d) corroborating/legitimizing, and e) representing the account.

Describing is a reflective phase in which the researcher steps back from the research and analyzes how the inquiry is progressing, how the research process has affected interpretation, how the researcher’s thinking has been challenged, and what the next research steps should be. In this phase, the researcher revisited the research questions and the overall paradigm of the inquiry and assessed whether the data collected was rich and representative of the context and behaviors being studied.

In the organizing phase, the researcher uses the appropriate organizing style or scheme for relating to the text. Organization gives structure and provides a systematic process for analyzing and interpreting the data. In this phase, *Atlas Ti Version 6* was used to organize the text and identify emergent themes.

Connecting is the process whereby the researcher discovers themes and patterns and makes connections and linkages between categories. After the data are connected and linked, the next iterative phase is corroborating or legitimizing. “The corroborating/legitimizing phase consists of reviewing the text after initial or later analysis, seeking to corroborate the multiple “truths” or perspectives voiced in the texts”



(p. 136). In this phase, the researcher seeks to uncover the meanings and lived experiences of the participants, and evaluate the credibility and accuracy of the data collected. As previously discussed, member checking was conducted to legitimate the data.

The final phase, representing the account, consists of “sharing the new understandings and interpretations, finding some way to represent an account of what has been learned in the research” (p. 137). The critical aspect of this phase is presenting an honest and accurate account of the data collected. The researcher focused on presenting the information using a critical, ecological framework while respecting the multiple voices of the study participants. Figure 5 below depicts the iterative steps in the interpretation process.

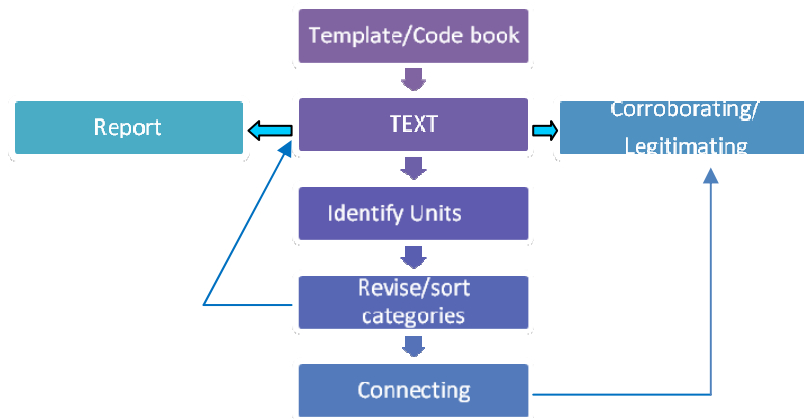


Figure 5. Template Organizing Style of Analysis  
 Source: Crabtree, B.F., & Miller, W.L. (Eds.). (1999). *Doing qualitative research* (2<sup>nd</sup>ed.).

### *Management of the data*

Using appropriate confidentiality procedures, the data were stored and managed in a safe and secure manner. Each participant was assigned a separate file including: informed consent, transcript, eligibility checklist, interview guide, demographic survey, researcher log and debriefing notes that were kept in a locked filing cabinet. All electronic files such as *Atlas ti Version 6* files and interview audio files were kept on a password protected computer accessible by the principal investigator only. Once the audio files were downloaded from the recorder to the secure computer, the files were deleted from the recorder. The researcher ensured that all measures were taken to make protect the confidentiality of research data.

### *Protection of Human Subjects*

An IRB application was submitted to the IRB at the University of South Florida. The application included: a description of the purpose, design, methods, data collection, and analysis procedures of the study. Informed consent was obtained from each study participant. Once at the interview or focus group, the researcher developed rapport with the participant, reviewed and discussed the informed consent form (Appendices F & G). The interviewee was given a copy of the consent form. Key elements of the informed consent process were explained to the participant including: 1) purpose of the study; 2) confidentiality of responses; 3) the voluntary nature of the study; and 4) the right to withdraw from the study at any time.

## CHAPTER FOUR: RESULTS

### *Phase I Results: Semi-structured individuals interviews with black men*

Comprised of individual semi-structured interviews, phase I of the study was designed to address the following objectives: 1) to understand the intrapersonal factors (knowledge, attitudes and beliefs) that influence HIV-risk behaviors in subgroups of black men (U.S.-born and Haitian-born) who identify as heterosexual and; 2) to understand the socio-cultural and behavioral health factors that influence HIV risk behaviors in subgroups of black men (U.S.-born and Haitian-born) who identify as heterosexual. An additional component of this section is a presentation of the demographic profile of the study population. In this section, the results of the content analysis of the qualitative data are presented by research question.

### *Demographic Information: Phase I*

A total of 29 black men who identified as heterosexual between the ages of 18 and 58 years of age ( $M = 34.6$ ,  $SD = 14.2$ ) participated in the study. All men identified as black or African American, 52% were U.S.-born and 48% were Haitian-born. Of the male study participants, 65.5% were never married, 35% had some college education, 35% had a college degree or higher, 28% reported a household income of under \$15, 000 per year, and 69% were employed for wages. Detailed demographic data on educational level, marital status, household income, race and ethnicity are presented in Table 5 below.

Table 5: Demographic Characteristics of Male Sample (N=29)

| Demographic Characteristics                         | N  | Percent |
|-----------------------------------------------------|----|---------|
| Age (range 18-58 years)                             |    |         |
| 18-24 years                                         | 9  | 31%     |
| 25-44 years                                         | 10 | 34.5%   |
| 45-58 years                                         | 10 | 34.5%   |
| Marital Status                                      |    |         |
| Married                                             | 7  | 24.1%   |
| Divorced                                            | 2  | 6.9%    |
| Widowed                                             | 0  | 0%      |
| Separated                                           | 0  | 0%      |
| Never married                                       | 19 | 65.5%   |
| Member of unmarried couple                          | 1  | 3.4%    |
| Ethnicity                                           |    |         |
| Hispanic or Latino                                  | 1  | 3.4%    |
| Not Hispanic or Latino                              | 28 | 96.6%   |
| Race                                                |    |         |
| American Indian or Alaska Native                    | 0  | 0%      |
| Asian                                               | 0  | 0%      |
| Black or African American                           | 29 | 100%    |
| Native Hawaiian or other Pacific Islander           | 0  | 0%      |
| White                                               | 0  | 0%      |
| Educational Level                                   |    |         |
| Never attended school or only attended kindergarten | 0  | 0%      |
| 8 <sup>th</sup> grade or less                       | 0  | 0%      |
| 9 <sup>th</sup> to 11 <sup>th</sup> grade           | 4  | 13.8%   |
| High school graduate or GED                         | 5  | 17.2%   |
| Some college or technical school                    | 10 | 34.5%   |
| College graduate or higher degree                   | 10 | 34.5%   |
| Household Income                                    |    |         |
| Under \$15,000 per year                             | 8  | 27.6%   |
| \$15,000 - \$24,999 per year                        | 5  | 17.2%   |
| \$25,000 - \$34,999 per year                        | 4  | 13.8%   |
| \$35,000 - \$44,999 per year                        | 5  | 17.2%   |
| \$45,000 - \$59,999 per year                        | 3  | 10.3%   |
| \$60,000 - \$75,000 per year                        | 2  | 6.9%    |
| \$75,000 or more per year                           | 2  | 6.9%    |
| Employment Status                                   |    |         |
| Employed for wages                                  | 20 | 69%     |
| Self-employed                                       | 4  | 13.8%   |
| Out of work for more than 1 year                    | 1  | 3.4%    |
| Out of work for less than 1 year                    | 0  | 0%      |
| A homemaker                                         | 0  | 0%      |
| Student                                             | 2  | 6.9%    |
| Retired                                             | 0  | 0%      |
| Unable to work                                      | 2  | 6.9%    |
| Sexual Orientation                                  |    |         |
| Heterosexual                                        | 29 | 100%    |
| Bisexual                                            | 0  | 0%      |
| Homosexual or gay                                   | 0  | 0%      |
| Other                                               | 0  | 0%      |

Analysis of the demographic data by subgroup reveals that within the U.S.-born sample, the respondents' ages range from 19 to 54 years of age ( $M = 32.7$ ,  $SD = 14.3$ ). Of the U.S.-born male study participants, 100% identified as non-Hispanic, black or African American, 80% were never married, 27% had some college education, 27% had a college degree or higher, 33% reported a household income of under \$15,000 per year, 80% were employed for wages, and 100% identified as heterosexual. Detailed demographic data on educational level, marital status, household income, race and ethnicity for the U.S.-born sample are presented in table 6 below.

Table 6: Demographic Characteristics of U.S.-born Male Sample (N=15)

| Demographic Characteristics                         | N  | Percent |
|-----------------------------------------------------|----|---------|
| Age (range 19-54 years)                             |    |         |
| 19-24 years                                         | 5  | 33.3%   |
| 25-44 years                                         | 5  | 33.3%   |
| 45-54 years                                         | 5  | 33.3%   |
| Marital Status                                      |    |         |
| Married                                             | 0  | 0%      |
| Divorced                                            | 2  | 13.3%   |
| Widowed                                             | 0  | 0%      |
| Separated                                           | 0  | 0%      |
| Never married                                       | 12 | 80%     |
| Member of unmarried couple                          | 1  | 6.7%    |
| Ethnicity                                           |    |         |
| Hispanic or Latino                                  | 0  | 0%      |
| Not Hispanic or Latino                              | 15 | 100%    |
| Race                                                |    |         |
| American Indian or Alaska Native                    | 0  | 0%      |
| Asian                                               | 0  | 0%      |
| Black or African American                           | 15 | 100%    |
| Native Hawaiian or other Pacific Islander           | 0  | 0%      |
| White                                               | 0  | 0%      |
| Educational Level                                   |    |         |
| Never attended school or only attended kindergarten | 0  | 0%      |
| 8 <sup>th</sup> grade or less                       | 0  | 0%      |
| 9 <sup>th</sup> to 11 <sup>th</sup> grade           | 2  | 13.3%   |
| High school graduate or GED                         | 4  | 26.7%   |
| Some college or technical school                    | 4  | 26.7%   |
| College graduate or higher degree                   | 5  | 33.3%   |
| Household Income                                    |    |         |
| Under \$15,000 per year                             | 5  | 33.3%   |
| \$15,000 - \$24,999 per year                        | 4  | 26.7%   |

|                                  |    |       |
|----------------------------------|----|-------|
| \$25,000 - \$34,999 per year     | 2  | 13.3% |
| \$35,000 - \$44,999 per year     | 2  | 13.3% |
| \$45,000 - \$59,999 per year     | 0  | 0%    |
| \$60,000 - \$75,000 per year     | 1  | 6.7%  |
| \$75,000 or more per year        | 1  | 6.7%  |
| <b>Employment Status</b>         |    |       |
| Employed for wages               | 12 | 80%   |
| Self-employed                    | 0  | 0%    |
| Out of work for more than 1 year | 0  | 0%    |
| Out of work for less than 1 year | 0  | 0%    |
| A homemaker                      | 0  | 0%    |
| Student                          | 1  | 6.7%  |
| Retired                          | 0  | 0%    |
| Unable to work                   | 2  | 13.3% |
| <b>Sexual Orientation</b>        |    |       |
| Heterosexual                     | 15 | 100%  |
| Bisexual                         | 0  | 0%    |
| Homosexual or gay                | 0  | 0%    |
| Other                            | 0  | 0%    |

Within the Haitian-born sample, a total of 14 men between 18 and 58 years of age ( $M = 36.6$ ,  $SD = 14.3$ ) participated in the study. Of the Haitian-born male study participants, 93% identified as non-Hispanic, 100% identified as black or African American, 50% were married, 50% were never married, 43% had some college education, 36% had a college degree or higher, 21% reported a household income of under \$15,000 per year, 57% were employed for wages, 29% were self-employed, and 100% identified as heterosexual. Detailed demographic data on educational level, marital status, household income, race and ethnicity are presented in table 7 below.

Table 7: Demographic Characteristics of Haitian-born Male Sample (N=14)

| Demographic Characteristics                         | N  | Percent |
|-----------------------------------------------------|----|---------|
| Age (range 18-58 years)                             |    |         |
| 18-24 years                                         | 4  | 28.6%   |
| 25-44 years                                         | 5  | 35.7%   |
| 45-58 years                                         | 5  | 35.7%   |
| Marital Status                                      |    |         |
| Married                                             | 7  | 50%     |
| Divorced                                            | 0  | 0%      |
| Widowed                                             | 0  | 0%      |
| Separated                                           | 0  | 0%      |
| Never married                                       | 7  | 50%     |
| Member of unmarried couple                          | 0  | 0%      |
| Ethnicity                                           |    |         |
| Hispanic or Latino                                  | 1  | 7.1%    |
| Not Hispanic or Latino                              | 13 | 92.9%   |
| Race                                                |    |         |
| American Indian or Alaska Native                    | 0  | 0%      |
| Asian                                               | 0  | 0%      |
| Black or African American                           | 14 | 100%    |
| Native Hawaiian or other Pacific Islander           | 0  | 0%      |
| White                                               | 0  | 0%      |
| Educational Level                                   |    |         |
| Never attended school or only attended kindergarten | 0  | 0%      |
| 8 <sup>th</sup> grade or less                       | 0  | 0%      |
| 9 <sup>th</sup> to 11 <sup>th</sup> grade           | 2  | 14.3%   |
| High school graduate or GED                         | 1  | 7.1%    |
| Some college or technical school                    | 6  | 42.9%   |
| College graduate or higher degree                   | 5  | 35.7%   |
| Household Income                                    |    |         |
| Under \$15,000 per year                             | 3  | 21.4%   |
| \$15,000 - \$24,999 per year                        | 1  | 7.1%    |
| \$25,000 - \$34,999 per year                        | 2  | 14.3%   |
| \$35,000 - \$44,999 per year                        | 3  | 21.4%   |
| \$45,000 - \$59,999 per year                        | 3  | 21.4%   |
| \$60,000 - \$75,000 per year                        | 1  | 7.1%    |
| \$75,000 or more per year                           | 1  | 7.1%    |
| Employment Status                                   |    |         |
| Employed for wages                                  | 8  | 57.1%   |
| Self-employed                                       | 4  | 28.6%   |
| Out of work for more than 1 year                    | 1  | 7.1%    |
| Out of work for less than 1 year                    | 0  | 0%      |
| A homemaker                                         | 0  | 0%      |
| Student                                             | 1  | 7.1%    |
| Retired                                             | 0  | 0%      |
| Unable to work                                      | 0  | 0%      |
| Sexual Orientation                                  |    |         |
| Heterosexual                                        | 14 | 100%    |
| Bisexual                                            | 0  | 0%      |
| Homosexual or gay                                   | 0  | 0%      |
| Other                                               | 0  | 0%      |

Compared to the U.S.-born men, Haitian-born men in this study sample were more likely to be married, more likely to have some college education or a college degree, more likely to have a higher household income, and more likely to be self-employed. Table 8 below shows the themes that emerged in Phase I of the study.

Table 8: Emergent Themes: Phase I

| <b>Domain of Inquiry: Intrapersonal Factors</b><br><b>Themes:</b>                    | <b>Subgroups</b> |              |
|--------------------------------------------------------------------------------------|------------------|--------------|
|                                                                                      | U.S.-born        | Haitian-born |
| <b>Perceived seriousness and severity of HIV/AIDS</b>                                | Yes              | Yes          |
| <b>Conspiracy Beliefs</b>                                                            | Yes              | Yes          |
| <b>Resentment for historical blaming of Haitians for HIV/AIDS</b>                    | No               | Yes          |
| <b>Women's negative attitudes to condom use</b>                                      | Yes              | Yes          |
| <i>Domain of Inquiry: HIV Risk Behaviors</i>                                         |                  |              |
| <b>Themes:</b>                                                                       |                  |              |
| <b>Inconsistent condom use</b>                                                       | Yes              | Yes          |
| <b>Perceived level of trust determines condom use</b>                                | Yes              | Yes          |
| <b>Primary concern for contraception versus disease prevention</b>                   | Yes              | Yes          |
| <b>Immediate condom availability determines condom use</b>                           | Yes              | Yes          |
| <b>Lack of sexual pleasure with condoms</b>                                          | Yes              | Yes          |
| <b>Condoms unnatural</b>                                                             | No               | Yes          |
| <b>Condom use contradicts religious beliefs</b>                                      | No               | Yes          |
| <i>Domain of Inquiry: Cultural Norms</i>                                             |                  |              |
| <b>Themes:</b>                                                                       |                  |              |
| <b>Parental religiosity as barrier to family communication about sexual behavior</b> | Yes              | Yes          |
| <b>Parental embarrassment creates barrier to sexual family dialogue</b>              | Yes              | Yes          |
| <b>Violence against homosexuals and bisexuals</b>                                    | No               | Yes          |
| <i>Domain of Inquiry: Gender Norms</i>                                               |                  |              |
| <b>Themes:</b>                                                                       |                  |              |
| <b>Women need to feel empowerment</b>                                                | Yes              | Yes          |
| <b>Women need to have better knowledge of sex partners</b>                           | Yes              | Yes          |
| <b>Need for female self-esteem</b>                                                   | Yes              | Yes          |
| <b>Female promiscuity and self-degradation contribute to risk</b>                    | Yes              | Yes          |
| <b>Women to use the female condom</b>                                                | No               | Yes          |



*Objective 1:* To understand the intrapersonal factors (knowledge, attitudes and beliefs) that influence HIV-risk behaviors in subgroups of black men (Native born African Americans and Haitian-born immigrants) who identify as heterosexual.

To assess knowledge, attitude and beliefs about HIV/AIDS the following questions were asked:

1. When you think about HIV & AIDS, what comes to your mind?
2. What can increase a person's risk of getting HIV/AIDS?
3. What can a person do to protect themselves from HIV?
4. Where do you believe HIV originated or how do you believe it first started?

Participants were evaluated as possessing high levels of HIV/AIDS knowledge if they answered correctly to questions two and three based CDC information. According to the CDC (2010), major risk factors for HIV include: 1) not using a condom during sexual intercourse (anal or vaginal) with an HIV-infected person; 2) having multiple sex partners; 3) unprotected oral sex; 4) sharing needles, syringes and other equipment used for injecting illicit drugs and; 5) perinatally acquired. Less common modes of transmission include: 1) being stuck by a contaminated needle; 2) blood transfusions and unsafe medical or dental practices; 3) eating pre-chewed food from an HIV-infected person; 4) tattooing and body piercing and; 5) being bit by a person with HIV (skin must be broken). Next, the results of the male interviews will be presented by research question.

*Question 1: What are black men's knowledge, attitudes and beliefs about HIV/AIDS transmission?*

U.S.-born and Haitian-born black men portrayed high levels of knowledge about HIV risk and protective behaviors and perceived HIV to be a serious disease. In addition, men from both subgroups endorsed HIV conspiracy beliefs, including notions that HIV is a government-driven form of genocide designed to eradicate the black community.

*U.S.-born men*

*Knowledge of HIV risk and protective factors.*

Overall, U.S.-born men interviewed portrayed high levels of knowledge about HIV risk and protective factors as 87% (13) identified HIV risk and protective factors consistent with the CDC's listing noted above. They identified key risk factors such as injection drug use, sharing needles, unprotected sex, promiscuity, multiple sex partners, exposure to infected blood and bodily fluids, and lack of education or knowledge about HIV. U.S.-born men also possessed high levels of knowledge about methods and strategies for preventing HIV transmission such as abstinence, condom use during sexual intercourse, abstaining from injection drug use, engaging in open and honest communication with sex partners, and practicing monogamy.

When asked to describe risk and protective factors for HIV, a single 45-year-old participant described his perceptions and experience with a family member with AIDS, an event that taught him about HIV and AIDS.

*Not practicing safe sex means that you're having multiple partners. Not using contraceptives or anything like that. And basically not being knowledgeable about your sexual partners or knowing the people you actually have. Abstinence is the biggest thing. The other part is being knowledgeable of your partners, as I was talkin' about. A lot of people have a different perspective of how they can contract AIDS, but AIDS can't be contracted through*

*touch and everything like that. Basically through the blood of sexual intercourse. So, I mean, that's stuff I've learned over the years, 'cause my brother, he had died from AIDS. I was one of his main caregivers, because some of my family was naïve about AIDS. They thought 'cause he had AIDS if you touch a cup or anything like that, they could get it. So it's like me learning everything I could about AIDS.*

A younger U.S.-born participant, aged 21, shared his insights on HIV protective behaviors.

*To protect themselves you know condoms are you know made for a reason, you know. Don't have unprotected sex. Abstinence, but you know I don't do that anymore. You know, I got a kid. Be open with everybody because a lot of people get it and know they got it, but don't ever say nothing about it, you know, just keep continuing to sleep with other people and keep passing it on.*

Men also perceived that HIV/AIDS is a serious disease that is ultimately fatal.

Men described HIV as a “chronic disease”, “disease that kills”, “death sentence”,

“terrible disease” and the words HIV and AIDS invoked feelings of “fear” and “worry”.

Gaps in HIV knowledge existed with relation to HIV testing. None of the U.S.-born male participants mentioned HIV testing as an important factor in HIV prevention. While there has been a national effort to educate the community on the importance of HIV testing, the men in this study sample did not seem to perceive HIV testing as an important factor.

This lack of awareness about the importance of HIV testing may be attributed to several factors including: 1) men may not want to know their status and; 2) heterosexual men may not perceive themselves to be at risk for HIV and hence may not perceive the need for testing, the importance of knowing their status or that of their partners.

*Conspiracy beliefs.*

The inquiry found that conspiracy beliefs play an important role in men's conceptualization of the HIV epidemic. These beliefs emerged when men were asked to

describe their beliefs about the origin of HIV/AIDS. Among the U.S.-born men, 47% (7) believed that the HIV epidemic may be attributed to government experimentation or conspiracies to control the black population. In addition, several participants believed that there is a cure for HIV/AIDS that is only accessible to the wealthy and privileged. When asked about his beliefs regarding the origin of HIV, a 25-year-old participant noted:

*It started, well I seen a video. It was, it was some white doctors experimenting on some Africans, and I guess they was using them as test dummies or something. But Africans was looking at it as, you know, they was trying to help them, but it was poisoning them..... You know there is thinking that HIV might have been created to destroy blacks..... I believe so.*

Another 29-year-old participant of middle socioeconomic status (SES) described his beliefs about HIV.

*I believe HIV started in a lab actually. And in my, in me reading about the different things, and I learned there are a lot of different contradictory information about it, and for me it's hard to understand if, you know why is there so much conflicting information. So my personal belief is that [HIV] was created in a lab [for] population control.*

Yet another participant, 54 years old of low SES and HIV positive, blamed government experimentation for the spread of the virus.

*They say it came...government was experimenting with something and the virus got out in there and a animal or mosquito something...bit someone and that's how they contracted the virus not knowing they had contracted to their partner...and their partner not knowing. Took the government a while before they realized what it was.*

A 51-year-old participant of low SES shared his views about a cure for HIV/AIDS. He talked about his beliefs as well as those of his friends and family members.

*We have discussions. I mean, we agree that once you get it, you got it until there's a cure. Not yet, there hasn't been one. Not for us poor folks, anyway.*

A 19-year-old father of low SES conveyed his strong feelings about the existence of a cure for HIV/AIDS.

*I believe it was something from the white man that led that and everything. They have a cure but they don't want to give it out because if they had a cure so many people would be trying to get it, and you know, they want to tax people for it and stuff.*

Having taken care of his brother who was dying from AIDS, another 45-year-old participant stated his beliefs about a cure.

*After watching somebody die of AIDS, the suffering and everything they been through, it's something that, you know, when God feels it's my time to go, that's something that I don't wanna go through. Because you slowly dyin' of what's happenin'. You know you gonna die. I mean they doin' multiple researches...but it's still right now 'til the government actually...and I believe that they have a cure. That's my belief. But in being that we're both African American and stuff like that, I believe they want us to die off a little bit more before they actually put a cure out. 'Cause I believe there's a cure. Me personally, I believe there's a cure. If they research so much other stuff, I know for a fact that money that they done put in since 1982 when [HIV] was actually put out there and everything like that, you can't tell me that in almost 30 years that they haven't found a cure in almost 30 years. That's my beliefs.*

Findings reveal that U.S.-born black men are knowledgeable of the behaviors that put them and their partners at risk for HIV and are aware of HIV preventative behaviors. As shown by the data presented above, HIV conspiracy beliefs were pervasive in the study sample. Participants shared a range of beliefs along the conspiracy continuum such as attributing the origin of HIV to government experimentation and population control, to beliefs that the government has a cure for HIV/AIDS that is not accessible to the general population and especially to the black community.

## *Haitian-born men*

### *Knowledge of HIV risk and protective factors.*

Haitian-born men also portrayed high levels of knowledge about HIV risk and protective behaviors as 79% (11) accurately identified factors included in the CDC guidelines noted above. A 20-year-old Haitian man indicated that there are multiple factors that put an individual at risk for HIV and several ways to protect oneself from the disease.

*...if you wanna get intimate with somebody, I think you should take it upon y'all selves, both of us, both of y'all, to like go and get tested for any type of STD, as to such-and-such, and stuff like that. And, yeah, always use protection, or well, then again, abstinence is always the best way. But, like, it's always good to use protection. And um....yes, that's about it. That's the way I see it.*

He also described factors and behaviors that increase risk for HIV transmission.

*Needles, blood transfusion. I would say oral sex with cuts, especially like, I mean, with protection or condom or stuff like that it's way less likely. And but with...to me like oral sex, you have to really know the person and like, it's more of an obligation to go and get tested.*

Another 20-year-old Haitian man emphasized the importance of abstinence or condom use.

*Number one...number one thing is to be abstinent. And also to...and if you're not going to be, you also should know your partner, your partner's history. And also, always, always, always wear a condom or some kind of contraceptive when you're having sex, that's going to protect you from HIV and AIDS instead of just pregnancy. 'Cause some do just protect against pregnancy and not HIV and AIDS. But number one thing is abstinence like I said and also knowing your partner.*

Collectively, Haitian men identified sharing needles, promiscuity, multiple sex partners, lack of education, and homosexuality as risk factors for HIV. Haitian men were

also knowledgeable of HIV protective behaviors such as abstinence and condom use. Similar to U.S.-born men, Haitian men perceived HIV/AIDS to be a serious and severe disease. A 22-year-old Haitian immigrant who lost a relative to AIDS attached a death sentence to the disease.

*It's [HIV] real. People die. It's real. I had an aunty. She used to be big, big and then she started to lose weight....I was shocked. She got skinny. HIV can live inside of you as long as you live and you will be big and then decrease until you pass.*

According to an 50-year-old Haitian man,

*When I see HIV, I see like a disease that's pretty dangerous, that can kill me. And I know there's no real treatment for it, so it's a dangerous disease for me.*

Unlike U.S.-born men, older Haitian men ascribed a moral or religious component to HIV transmission. According to a 54-year-old participant:

*We always call it SIDA [AIDS]. People who involve in this kind of term is a kind of people lack of moral.*

Further, he indicated that contracting HIV can be attributed to “a kind of lack of behavior” and “people who don't respect themselves”. A 50-year-old Haitian participant noted that HIV is a disease of people who do not care about themselves. He also implied that God protects against HIV especially within the sanctity of marriage.

*I think it happen to people who don't care about themselves. I remember since I was in my country, before I left my country, I told that to my wife. I told my wife they say good favor God give me, I'm going to leave Haiti to come here and my wife with me. We come together. At this time, I said if I come to U.S. and I pick something like that, like HIV, I can't blame God. It's on me who don't respect myself, who don't know who I am. And I said to her, I think she think to do the same way because even you not married, you still got some precaution you can take to make you don't pick something like that. But even if you married but God give you more and more protection. HIV is people who don't care about their life and they family.*

### *Conspiracy Beliefs.*

Similar to their U.S.-born counterparts, Haitian-born men expressed HIV conspiracy beliefs about the creation and origination of HIV. These beliefs and attitudes emerged as Haitian men were asked to describe their beliefs about the origin of HIV/AIDS. Moreover, 50% (7) of Haitian participants conveyed their anger and resentment that historically, Haitians has been blamed for HIV. Many participants referred to the 4 H's whereby homosexuals, hemophiliacs, heroin addicts, and Haitians were identified as high risk groups and blamed for the spread of HIV/AIDS (Nachman & Dreyfuss, 1986; Santana & Dancy, 2000).

*Some say [HIV] comes from Haiti and that makes me mad. I am not sure how that could be.*

A 36-year-old participant voiced his views on the historic recrimination of Haitians.

*I think we always know most of the blame, whatever's going on, Haitians we...I think kinda just accept pretty much everything they throw at us. But knowing, well, it's not the truth. He also believed that HIV was created from research experiments. Aside from...I guess for me, my knowledge really I think [HIV] was definitely, really formed in a lab.*

When asked where he believed HIV originated, a young 22-year-old Haitian man stated:

*Africa. That's what they say but I don't believe its Africa. American started that. It was a white guy. ...It's not Africa. They say the water gave you HIV, but it's not true because black people are not like that. It's the white man started that.*

U.S.-born and Haitian-born men portrayed high levels of knowledge about HIV risk and protective factors with 83% (24) of the sample accurately identifying risk and protective behaviors. Men also perceived the seriousness and severity of HIV and AIDS. A deeper exploration of HIV beliefs revealed that a 48% (14) of the total study sample



held AIDS-conspiracy beliefs. Moreover, Haitian-born men expressed their resentment for the historic stigmatization and labeling of Haitians as AIDS-carriers.

*Objective 2:* To understand the socio-cultural and behavioral health factors that influence HIV risk behaviors in subgroups of black men (Native born African Americans and Haitian-born immigrants) who identify as heterosexual.

*Question 2: What are the risk behaviors practiced by black men who identify as heterosexual and what factors are associated with these behaviors?*

The inquiry found that HIV risk behaviors were prevalent among the men represented in this study. U.S.-born men primarily reported risk behaviors such as inconsistent/lack of condom use, multiple sex partners, and alcohol use prior to sexual intercourse. Haitian-born men reported inconsistent or lack of condom use during sexual intercourse. Emergent within this portion of the study was the theme of the role of women's attitudes to condom use. Men from both subgroups indicated that if their female partners did not endorse condom use, they were less likely to use condoms during a sexual encounter.

To explore HIV risk behaviors practiced by black men, the researcher inquired about concurrent/multiple sex partners and condom use. The CDC (2009) identifies multiple sex partners, unprotected sex, and substance abuse as risk factors for HIV transmission. Within this study population, high levels of knowledge, perceived severity and, perceived seriousness did not result in HIV protective behaviors.

#### *U.S.-born Men*

U.S.-born men reported risk-taking behaviors such as multiple sex partners, inconsistent condom use, and alcohol and substance use/abuse prior to sexual intercourse.

Overall, 47% (7) of U.S.-born men reported current and past partner concurrency behaviors and 53% (8) reported inconsistent or lack of condom use.

*Multiple Sex Partners.*

A 20-year-old participant explains the feeling of engaging in sexual relationships with 3-5 different girls within a 5-month time frame.

*At that time man, it was there. Like man, there's no greater feeling to a guy as when you have 3 to 4, 5 different women that likes you. And all they wanna do is, you know, get some and go. And well, my stage back then, you know, like I say, I was...I like to make people laugh. I like to be honest most of the time, so I guess that's what a lot of women like. And a lot of people know women hormones are way stronger than us guys are. And just makin' 'em laugh and bein' honest with 'em turns them on. So I guess that's what I did and just had multiple...a lot of them liked me.*

A 19-year-old father of low socio-economic status recounted his past promiscuous behavior. "I used to be on it!" After the relationship with his child's mother dissolved he claims, "when we broke up I had (pause) five? Five, three, four, five, five or six, five or six [female partners]". While acknowledging his current monogamous relationship, a 27-year-old participant questioned his level of commitment. When asked how committed he was to his current partner, he stated:

*If I had to give it a number from 1 to 10, I would definitely say a 7.5. To be honest, I'm a male, you know. We are visually attracted to different women.*

He also rationalized the concept of black men having multiple sex partners.

*For me it's not I think that nowadays, you know, the traditional marriage and husband and wife is over. With women now having jobs, and doing everything that a man can do, sometimes some men need to validate themselves. By validating themselves they have to please more than one woman. That's why I think it is different now. You know, it's not just this generation where African American men have had more than one relationship. It's been going on for a very long time. It's just that in African American*

*society, whatever happens at home stays at home. But now, it's more out in the open.*

While ultimately wanting a committed relationship with a “*God-fearing woman*”, a 45-year-old participant described his open relationship with a woman whose lifestyle is unacceptable to him.

*We are friends with benefits. My part, it works pretty good. On her part, she kinda have a problem with it, 'cause of the simple fact that some women like to play...and men do too.... She is very sexually active with other people...she kinda want a serious relationship, but she can't change her lifestyle.*

A 54-year-old U.S.-born participant shared his risky behaviors despite his HIV-positive status. While he reported using condoms during every sexual encounter and informs his partners of his HIV status, he admitted to having multiple sex partners, an average of 7 within the past 12 months.

*I'd say that I done had relationship with a female, especially since it probably ain't right since we not married, about maybe 7.*

When asked about his level of commitment to any of his partners he responded,

*No, no. I ain't committed. I ain't committed.*

Among U.S.-born men who participated in this study, a large proportion (40%) reported having concurrent sex partners indicating that this high risk behavior is fairly prevalent in the study population. As shown, the practice of having multiple female partners seems to give men a sense of validation. The encouraging finding is that most U.S.-born men (60%) did not report having multiple sex partners. However, while U.S.-born men seem to understand the risks associated with multiple partners, partner concurrency is a fairly common sexual behavior among black men represented in this inquiry.

### *Condom Use.*

This inquiry also explored the condom use behaviors practiced by black men. While U.S.-born men reported high levels of knowledge about the risks associated with unprotected sex, study results show knowledge levels do not translate into consistent condom use. In fact, 60% (9) of U.S.-born men reported inconsistent or low condom use.

When asked whether he always uses condoms during sexual intercourse, a 19-year old father who had previously contracted an STD indicated:

*No. I feel I need to work on that. He reflected on his reasons for not using condoms. Because, my first time when I didn't have a condom it felt good, so I got used to the, you know I feel I need to work on that. Thinking back to a sexual encounter when he did not use a condom he remembered thinking, Man, this is wet! Dang! However, after the encounter he regretted not using a condom. Damn, I should have used a condom.*

Participants described several barriers to condom use including: 1) immediate condom availability; 2) perceived trust in a sex partner and; 3) the belief that condoms remove the spontaneity from sexual intercourse. Men also tended to report greater concern for contraception rather than disease prevention. Therefore, condom use was deemed less critical if their female partner used other forms of birth control such as oral contraceptives. A 27-year-old man asserted that he may not use condoms if they are not readily available. He described an experience in which he had unprotected sex.

*Basically it was a moment in time where me and my partner was together, and we were out for an evening, and at the end of the evening we chose to take a stroll on the beach. At that point in time, there are no gas stations or any kind of convenience stores where you may be able to buy or purchase condoms. At that point in time, the fact that we were going to have sex was not on my mind, so I didn't think to bring anything. It was one of those moments that was very spontaneous. I don't even think she thought it was going to happen. So that's the moment I can think of right now where there was a point where we didn't use any protection.*

A 29-year-old father who has been in a long-term relationship expressed his negative feelings about condoms.

*I think it definitely takes away the pleasure of the experience. Sometimes some females don't you know, it gives them irritation, or you know, they can't use them, so, and it breaks the mood if you are, you know, you know trying to have relations and stuff like that, so it kind of interferes with the flow of the mood.*

He also expressed his minimal concern for STD or HIV transmission within his relationship.

*I'm not as concerned because like I had mentioned, we have been in a relationship for a long time, and there is a certain level of trust there, but you know, that makes me pretty much less, um, you know worried about contracting STDs and stuff like that.*

A 25-year-old man who plans to return to college in the near future articulated his reasons for not using condoms with his ex-girlfriend.

*It was like, she don't want to get pregnant. You know, she's doing the school thing, and I understood that, you know, and that was the smart thing to do. But it was to the point that we didn't have no condoms and then, that's what happened, so. And it, after the first time, and then it was, it happened again and again, so...but you know I ended up using condoms again, but I guess I felt more comfortable, I felt more comfortable that she was a virgin...I didn't use it [condom] because I, you know I cared about her and I loved her. I had that trust, you know, I had that trust in her.*

Similarly, another 27-year-old U.S.-born participant attributed his low condom usage to his high level of trust in his partner and the fact that his partner uses alternate forms of birth control.

*I've used the male condom before, but it's hard for me to have opinions because I haven't used it as often. But I'm not sayin'...It's just because most of my sexual partners, you know, we used to get tested together. And the ones before...and we just had a level of trust. And then they would get the...what's it called. I forgot what it's called. Nuva Ring or somethin' like that.*

He described the concept of “going raw” and explained how he and his peers evaluate women with whom they would “go raw” or have unprotected sex.

*Would you go for it? It's like, “Oh Halle Berry? Oh, I might have to go raw!” You know, I might have to take that chance. You know? So there's things like that, they're [peers] always like, “I don't know. She's so fine. I don't have a condom; I might have to raw dog it.”*

According to the above evaluation, condom use may be determined by the perceived beauty of a potential female sex partner. The more beautiful or “fine” the woman, the less concern men might have about HIV and STD risk.

Older men also reported inconsistent condom use. When asked why he did not use condoms consistently, a 51-year-old single man expressed his reasons for not using condoms.

*Ignorance. Don't have them. Too lazy to get them. The moment.... You have to struggle with them sometimes if it's not the right- To me it [condom use] was like a waste of sperm.*

Prior to his HIV-positive diagnosis, a 54-year old man recalled his past feelings about condom use.

*I was young, naïve, thinkin' that could never happen to me. And the old sayin', that protection don't feel good. I like it raw in other words. And raw will get you messed up.*

Results show that while condoms are recommended as a public health strategy for preventing HIV/STI transmission during penetrative sexual intercourse, condom use may not be a typical behavior among U.S.-born heterosexual men who participated in this study. Several factors may create barriers to condom use: a) trust in a sexual partner; b) use of alternate forms of birth control; c) perceived lack of sexual pleasure with condom

use; d) desire for spontaneity and; e) immediate unavailability of condoms during a sexual encounter.

#### *Women and Condom Use.*

Women's attitudes to condoms may also create a barrier to condom use among heterosexual couples. Men reported that their female partners may not encourage or address the issue of condom use giving them less impetus to use condoms. As a 20-year-old man explained,

*A high percentage of women don't tell us anything about putting condoms on. 'Cause there'd be times I have sex and if I don't bring out the condom, she don't say a word.*

A 21-year-old father who is not ready to have more children questioned his partner's motives for not supporting condom use in their relationship.

*To her, she feels you know because she loves me, but I love her but I don't love her to that point and you know [she says] "let's try without a condom". No. So she feels that you know I'm in love with you and this and that, she thinks or she is under the impression we are going to be together for the rest of our lives. I only met her 5 months ago so...I really do think she wants to have a kid, that's why she wants to do it raw [without a condom] so bad. I think she just wants, she just wants to have my kid so bad that she just wants to do it without a condom, and I already have one daughter. You know, she's a handful by herself, so to me it's, let's take it slow. Once the time comes when we are a little more stable, you know we've made it to that point of you know if we get a kid we can have a kid and all that stuff like that and I feel that much more comfortable, then okay.*

Another 25-year-old participant gave an account of an encounter in which his casual female partner tried to convince him to have sex without a condom.

*You know I take that [condom use] seriously because there was a time, you know, we didn't have no condoms and she was like, it was like she was giving me oral sex, right. And so I was looking for the condoms, you know I thought she hid them or something, and she said they ran out. And then she was like, you know, showing*

*me her pussy and I was like, "I'm sorry, you've got the wrong person!" I say that because you know I take that very seriously and she was like, you know, she took several tests and said okay, that's nice but I was never you know, that's not my thing, you know, and so that was just...I don't know about her. It's like I can say, I can say yes she takes it seriously, but I'm not sure, you know what I'm saying, because we're not in a relationship and, you know, she tried to pull a stunt on me. So, you know, that's a question right there.*

Similarly, a 29-year-old interviewee shared his primary partner's attitude to condom use.

*Well she don't mind not using condoms. Usually, it's me, for things that most of the stuff like birth control and stuff like that, she's a little, I have to say that she really is against that. But when it comes to condoms and stuff like that, you know, most of the time it's me, you know, to make sure that I have one, or state different rules like that. I don't think actually in my whole life I don't think I ever met a female that would stop, "hey, you have a condom?" you know, I never really met a female that even said that before.*

A 45-year-old participant who is dating a dancer with a history of drug addiction is concerned about her resistance to condom use.

*Now in my sexual lifestyle over the past 30 years, every woman I done ran across never wanted me to use contraceptives. They get upset over it. He shares the reasons women give him for not wanting to use condoms. "Oh, I use birth control." You know and everything like that. "It don't give you the same feelin'." You know I told 'em, "Well, if that should be your case, then I'm the wrong person for you."*

Women's attitudes to condom use play a key role in male condom use behaviors.

Negative attitudes to condoms held by female partners may hinder condom use in heterosexual relationships. This study reveals that both heterosexual men and women may have negative attitudes to condom use leading to high levels of unprotected sex within the study population.



*Behavioral Health – Alcohol and Substance Use.*

Among the U.S.-born male sample, behavioral health issues such as heavy alcohol use and substance abuse were commonly. Study findings reveal that alcohol use was prevalent in the U.S.-born study population as 87% of U.S.-born male study participants admitted to intoxication in past and current experiences. Some participants reported heavy drinking and frequent intoxication. Men between the ages of 45-60 years tended to report a history of drug and alcohol abuse. Critical to this inquiry is the finding that intoxication during sexual intercourse was a prevalent behavior. Denial of alcohol impairment was commonly reported within the behavioral health domain, as 46% of participants who admitted to intoxication during sexual intercourse perceived that their behavioral skills relevant to safer sex were not impacted by alcohol or drug use. As such, some men perceived that they were able to think about and use condoms during sexual intercourse while high or intoxicated.

*With weed, you are slowing down, so you know, it's like you got time just to be sitting there. You might sit there for a little bit and get a condom, strap up, this and that.*

Another 27-year-old participant who claimed that he and his female partners are sometimes intoxicated prior to sexual intercourse asserted that his condom use decision-making skills are not impaired.

*The difference between alcohol or any kind of recreational drug use, it basically, basically gets rid of all of your inhibitions. It makes them smaller. The things that are not important to you are lesser important. But you have to remain in that fact and that state that using condoms doesn't, it gets to the point where it doesn't just protect you from receiving anything, it protects you from having her pregnant. No matter, I mean, I can only speak for myself. Me myself, that is very, very important to me. That is something that I decided when I was very young that I won't have children until I am married. So no matter what state I am in, that is*

*very, very important to me. So I, I can speak for myself, only myself included, that that is not a deterrent.*

A 25-year-old U.S.-born participant attributed his ability to make safer sex decisions while drunk or high to his “strong mind”.

*I'm more of the type, you know, if I'm going drinking, I'm at home, I'm going to drink, I'm not going nowhere, you know. When you're not at the house, you know. And even with sex, like if I'm drunk or high, you know, I still know better. Like I'm not going to let that take over my mind and you know go ahead and do it, like whatever. Like—I'm a strong minded person.*

Men between the ages of 45-60 years provided insights on their experiences with substance abuse and impairment of their behavioral skills. 100% of U.S.-born men interviewed within this age group reported that substance and alcohol use prior to sexual intercourse inhibits their ability to practice safer sex behaviors. A 45-year-old man with a history of alcohol abuse shared his experience with alcohol and its effect on his sexual decision-making.

*The people, my friends from a program, some of 'em come in and out...And it plays a big part because some of my closest friends are alcoholics, as well as the girl that I'm dating. So ninety-nine percent of the people except for my son's mother, either rare abusive alcohol drinkers or drug users. Some of the people that I deal with on a daily basis are still drug users and alcohol users. So, it plays a big part in my life even though I understood about what my mom taught about fearing God, and everything like that. It's just that, you know, when I was in college and everything, everything was fraternity. It was drink, it was doin' some bud, everything like that. So it's natural when I got out or when my friends got out, that's what they did in college, so after a long day of work, why don't I come home and open up and drink some wine or some beer, smoke a bud and go to sleep. And then on the weekends, it's like okay, whatever. You know, that's the thang. Monday through Friday, you have people who like everyday people who work Monday through Friday, but once 6 o'clock get there...the weekend here, and sometimes it throw caution into the wind, regardless. And that's where a lot of people wake up on Monday, "Oh, my God. I can't believe on the way to work, that I*

*did that." I consider risky use comin' with alcohol and drugs and can play a big part of not really thinkin'. "Okay, well I don't have to use a condom this time."*

HIV-positive men in the 45-60 age range reflected on their past drug and alcohol use and incarceration histories and attributed their HIV status to their past risky behaviors.

*Past relationships. That's how I got HIV. Drinking and partying and not having protected sex. Here, there, everyday. For one thing, I used to be a dope boy when I was younger. So you went out there partying. Stack some money here. Stay in a motel 3 and 4 months like that. That party life'll do it too. You never look back. "Oh, it ain't gon' happen. Pass me that Cavasier, that E & J, Cognac. Poll me up a blunt, lace me one. I been there and did that. ...Alcohol'll tell you anything. Weed. You not clear. When you sober [thinking back], "Awe man. Did I do that man? Who is that chick there man? Who is her?" ... You don't even know if you did it or not. Or how many you did. For real!*

Another 54-year-old participant related his experience with drug and alcohol abuse.

*Well, I'm gonna tell you how it started. When I was in prison, I was doin' 15 years. I did about 7 of them. And I used to jog a lot...I'ma try to make this quick as possible. And a guy...they have crack in prison, heroine...anything you want on the street, you can get in prison. So I was runnin', guy holla'd at me, told me to come here. So that's when I used to read about it. That was back in the 80's. It was good. That crack was out there then. And I went in his room. There was a homosexual sittin' on his bed, right? And he was in there, he went in the bed, and pulled out a can...coke can with holes and ashes on it. I say, "Man, that's that stuff I been readin' about in the paper." He said, "Shut up, man." So I'll try anything, so "Try this, man." And I tried it and it had my sexually aroused also. And that's how I started. So ever since then, it been havin' an effect on me since I got out of prison. I used to drink. Since I take medication, I don't drink.*

Likewise, a 53-year-old recovering alcoholic and drug abuser who is HIV-positive admitted to the debilitating effects of alcohol and drug use.

*Quite a bit. Because I remember my last relapse of...I had it about 6 years ago...and I relapsed. And the lady that I relapsed with jokingly said, "Well, I relapsed on ecstasy." And she say, "Well, he used ecstasy as like Viagra." 'Cause it was like a sexual stimulant.*

*And they would wanna run around and watch lights and stuff like that. And that really wasn't my cup of tea. I was interested in the um...'cause it would...and it would make her do things. Make her sexual...um...act better, you know, and more enjoyable. You know? So, yeah. Then the alcohol, I was a big drinker. I know it released people inhibitions and they were free to not be so shy and the same way with the women. And the other drugs like crack and everything, people was just outta control. 'Cause they'll be out there doing anything. I've heard some women 15 to 20 people a night. And they're just tryin' to get the next one. And you can imagine being exposed to all kinds of germs.*

### *Haitian-born Men*

#### *Multiple Sex Partners.*

Compared to their U.S.-born counterparts, Haitian-born men were less likely to report partner concurrency. The results of this inquiry show that 71% of Haitian-born men reported monogamy. Young Haitian men were more likely to report serial monogamy. A 34-year old participant shares his views on monogamy.

*I'm the type of guy who likes to be with one person at a time. And unless it's like that, I don't like to be with this person today and tomorrow. Because you don't know some individuals you meet, where they've been. So for me, I think it's better to be with a person for a long time before you get to the sexual intercourse. At least, that's how I was raised.*

Men over 45 years also tended to report high levels of commitment to their wives or partners. A 50-year-old married Haitian-born man stated that he would never be unfaithful to his wife.

*For my wife also, I say thanks to the God. Because maybe the same way...I think the same way she think also. Okay, I don't go everywhere she go. I can't say one hundred percent she is perfect, but for this one I see, this one I knew. I know she keep her respect like I do.*

Another married interviewee expressed his views about being faithful to one partner.

*If you married, you got your wife, you got your husband, you don't go anywhere else...okay, that's it. That's the only real chance you got. Otherwise, whoever it is, you go with it, you just taking a chance.*

Haitian men were likely to report steady, monogamous relationships. Very few men in this subgroup reported partner concurrency. In fact, only two men admitted to having multiple sex partners. Therefore, in contrast to the U.S.-born sample, Haitian men were more likely to be married and less likely to report having multiple sex partners.

#### *Condom Use.*

Although Haitian men acknowledged the benefits of using condoms, this knowledge did not translate into consistent condom use. In fact, 71% (5) of single Haitian-born men (N=7) and 100% of married men (N=7) in the study sample reported inconsistent or no condom use. Study findings reveal that Haitian-born heterosexual men may choose not to use condoms for several reasons including: a) trust in a female partner; b) perceived faithfulness in a relationship; c) decreased sexual pleasure with condoms and; d) the “natural” feeling obtained during unprotected sexual intercourse. As a 20-year-old participant stated:

*I think it [condoms] affects sexual...I mean erection a little bit. And then as in like, it's not the same sensitivity.*

A young Haitian man of low socio-economic status and lower English literacy and proficiency explained his experience of contracting a sexually transmitted infection after not using condoms.

*I did one mistake I didn't use condoms but luckily I wasn't infected I only got that thong that called um...like when you keep waking up and peeing back and forth. That's my first time. I never knew, I just wake up and start going back to the bathroom. At first I thought I drank water but no I ain't drink no water. So I went to the doctor. He told me you got that little thing...it's not really like a big effect.*

*He gave me some medication and after that I always use one. Even though it didn't go in but I think the girl stuff was kind of...her underwear was dirty and I just got it like from a dirty thing. I had called her and said "what's going on"? And she said "well I feel the same way too". I said well... 'cause the underwear she was wearing wasn't hers. It was hers but her cousin used it...that's how I got it. So I went to the doctor and they gave me medication and I got clean and I was clean. After that, I watch out man. But that was my first time. That was scary. I wasn't scared, scared but I was waking up in the middle of the night. I was like what the hell is going on?*

Based on his account, this 22-year-old, sexually active Haitian man did not have a clear understanding of the biomedical transmission of STIs. While he realized that he had contracted a disease, the mode of transmission was not fully understood as he perceived that he contracted disease because his partner's underwear was "dirty".

A 36-year-old Haitian-born man who has been involved in a sexual relationship with a steady sex partner for over 3 years expressed that condom use in his relationship is driven by levels of trust and pregnancy prevention concerns rather than by HIV/STI prevention concerns.

*'Cause I guess there'd never really be any kind of objection [to not using condoms]. "Okay, then well don't use it," or "Yeah, use it." Or, "Okay, no." And I think the same feeling that I have, I think it's the same for her. It's just okay, hey, you know...I mean, I think given that we've been in the relationship I guess three and a half years, so I think it's just more, "Okay, well we don't wanna have kids." So I think both of us really, I would say, have been tested, so we know exactly where we are. So I think now it's more, "Okay, I don't wanna have kids right now." And then, so...*

Likewise, a 32-year-old graduate student shared his feelings about condoms and the role trust plays in condom use decision-making. He also provided insight on the broader perception of condom use within the Haitian culture.

*No, it's not easy to use because of the fact that it's foreign to your body in the first place. And then it diminishes what you're actually*

*trying to do. So, I would think that if you're only shagging, like people say, "Hey, I'm using this protective barrier just to do it." But if you're actually making love to somebody that you love, and you don't want her to get pregnant, it feels that there's always this layer between you and that person. So it's something that is just a sacrifice. If we were living in a world where it was disease free, condom wouldn't have to exist. But it's either you get used to it or you play that Russian roulette until you actually get a bullet. You know? So, it's not that easy to use, but I'm thinking that with technology they will have something that is like a micro meter size that it...you don't even feel, you just spray something and it's "Shhhh," that's it. You know?*

*I almost always [use condoms]. The only time is probably when I was dating somebody for a long time, but even then, because of the fact that I didn't feel like we needed to actually get anybody pregnant, so why use condoms.*

*But if you actually take a Haitian that was like from a different part, let's say in a rural part where the mindset is mostly the more kids that you have the better because some economic factor that's no longer the truth. Because in the past, if you have 2, 3 kids you probably would be able to actually grow more crops, then sell more, and then get more money. Etcetera, etcetera. But now it's no longer the same question, because we're not growing anymore crops. But they still making as many babies as before. So they would come here and a lot of them probably would not use condoms. Because they believe that, "Well, I'm supposed to...I don't like the feel of it. I didn't use it back home.*

A 55-year-old married participant who admitted to his infidelity, acknowledged his negative feelings toward condoms and gave an account of his failure to use condoms with an “outside partner”.

*To be honest with you, that's a man thing. The main problem I have with condom, I'm not comfortable with it. Then I have to get...I got to have it. That's one reason I stop messin' around, because last time I'd wanna go without it, and when I put it on, I don't feel comfortable with it. So, to me, it's not really enjoyment. So, it don't feel good with it....Oh, like I said, the reason why I didn't use it because I feel like...Number 1, I meet the first woman...the person I know, I know this person not too much really. Mess around with people, you know. I think it was safe for me to mess with her without it [condom]. She was like outside partner, but she was still kinda tied with me, so I just takin' a chance. I feel like, well, maybe I should've started usin' it with her, then I use it,*

*you know what I mean? But in the beginning I start not to use it for a while. Yeah.*

He further commented on the unnatural feeling he gets when he uses condoms and difficulty finding condoms that are durable.

*Because, to me, it look like...uh, fake. You know, it's not real. It don't feel like its me. It look like something else. I'm tryin' to use the best they have. But see, a couple of times I had a problem with it, 'cause they be bustin' on me and stuff. I be lookin' for the largest and sometime they still mess up. When I wear 'em a certain time when I start usin' 'em, they bust.*

Another participant attached a religious perspective to condom use.

*According to my belief, you know, Catholic church doesn't believe in the protection that science gives us. We got our own protection. We can talk together how we can make it.*

Study findings reveal that condom use may not be a preferred sexual behavior among Haitian-born men in the study sample. Several factors related to condom use emerged in the exploration of condom use behaviors among Haitian men: a) trust in a female partner; b) perceived faithfulness in a relationship; c) decreased sexual pleasure with condom use and concerns about the aesthetic feel of condoms and; d) the “natural” feeling obtained during unprotected sexual intercourse. In addition, Haitian men conceptualize and rationalize condom use within the context of the Catholic religion wherein condom use is not endorsed.

#### *Women and Condom Use.*

Similar to the U.S.-born sample, within the Haitian-born study population, condom use is also driven by women's attitudes to condoms. A 22-year-old aspiring musician described his experience with contracting an STI after his female partner insisted against using a condom.



*...sometimes the girl says “put it in, put it in”. And pap, pap we didn’t go all the way but the tip of my penis touch the girl around her area. It didn’t go in it just touch the area and I think her area she didn’t clean it and I felt like something was biting me, like mosquitoes biting my thing. I feel like I don’t feel right peeing back and forth for no reason. So I went to the doctor and he told me I had that thing. I was like oh crap.*

Another participant, 55 years of age, described the ease with which he convinced his extramarital sex partner not to use condoms during sexual intercourse.

*Yeah, some ask me to [use a condom], but sometime I say, “Awe, no baby. You know I don’t like it”. They like, “Okay!” You know? I mean, but it’s true.*

#### *Behavioral Health – Alcohol and Substance Use.*

Alcohol and substance use were not found to prevalent behaviors among Haitian-born men. Most Haitian men reported no or minimal alcohol or drug use. One 32-year-old participant reported that alcohol use is “*frowned upon*” within Haitian culture and because there is no legal drinking age in Haiti, children grow up experiencing small amounts of alcohol at an early age making alcohol less appealing and mysterious in later years.

*Same way that my mom actually opened my...I mean, just like talked about human reproductive systems, etcetera, with me or how people actually just like come about, is the same way that she did not try to make alcohol taboo. And because I’m from a French type of base culture, a kid that is 10, 11 years old on Sundays could actually have a small amount of wine while eating. So it wasn’t something I was totally foreign to, like, “Oh my God, I’m not supposed to touch any alcohol and everything.” And I think that’s the reason why you don’t see the issues that we have here with students binging on alcohol compared to other places in the world. Because you’ve been with alcohol all your life, you know the danger of it and then you actually know that, “Okay, I drank it with my mom. Okay, when I’m 15, 16, I could actually drink a beer.” Because at 16, the drinking age...there’s not really any drinking age in my country, but you know better not to actually become an alcoholic, you know? Especially when it comes to*

*drugs. This is something that is frowned upon in my country as well. So, it never really played a on my part.*

Within the Haitian male study sample, one 55-year-old participant reported alcohol use prior to sexual intercourse and noted the inhibitive and mind-altering effect of alcohol and other drugs.

*Let me tell you somethin'. Let me tell you somethin'. When you really...I don't know about nobody else, but I'm tellin' the fact...I like to tell the truth. When you use alcohol or drugs, you don't really care about none of that [condom use]. You know, 'cause all you here about is, "I'm gonna enjoy myself. I'm gonna be havin' fun." And just goin' off. Because the first thing you gon' think in your mind is you don't have it[a condom]. If you don't really into it, like using it all the time...that means you don't have it. You gon' say, "Awe, that's okay. It ain't gon' hurt one time." It's like, "I'll get over it." And if you have it sometime, you might say, "Well..." Or you might have one, 'cause this happened to me before. I might have one the first time I use it, then I run with her like that. "Okay, now I'm out. I don't have no more. So let's do it without it. Okay. So you don't really focus these things.*

Though the men (U.S.-born and Haitian-born) in this study acknowledged the benefits of using condoms, 72% (21) participants reported inconsistent condom use into their sexual relationships. Several intrapersonal and contextual factors seem to influence condom use among U.S.-born and Haitian-born heterosexual men. Some men complained about the lack of sexual pleasure when using condoms. A recurrent theme around condom usage was the concept of trust whereby the more a man trusts his partner, the less likely he is to use condoms. Likewise, men who perceive that their female partners are faithful are less likely to use condoms. In addition, condom use was found to be motivated by pregnancy prevention rather than HIV/STI protection. Other barriers to condom use were immediate unavailability of condoms and the belief that condoms remove the spontaneity from sexual intercourse. Among Haitian men, additional barriers

to condom use included the perception that condoms are unnatural and are not endorsed by religious beliefs. In addition, women's attitudes to condom use seem to play a critical role in condom use decision-making within heterosexual relationships. Several men reported that their female partners held negative attitudes toward condoms giving them even less motivation to use condoms during sexual intercourse.

In terms of emergent themes around behavioral health issues, the theme of uninhibited behavioral and cognitive skills emerged among U.S.-born men who reported alcohol and/or drug use prior to sexual activity. U.S.-born men in the younger age ranges (18-44 years) reported a perceived ability to cognitively and behaviorally apply safe sex behaviors while under the influence of drugs and alcohol. Conversely, U.S.-born men within the 45-60 age range reported the inhibitive and mind-altering effects of alcohol that significantly affect safer sex behavioral skills. Haitian-born men were less likely to report any alcohol or drug use. This low prevalence of substance abuse issues may be related to cultural norms that ascribe negative attitudes toward alcohol and drug use resulting in less participation in these substance use behaviors.

*Question 3: What cultural norms influence sexual behaviors among black men who identify as heterosexual?*

A key component of this inquiry was an exploration of the cultural norms that may influence HIV risk and protective behaviors among U.S.-born and Haitian-born heterosexual men. Findings reveal that social, ecological, and cultural factors play a role in men's conceptualization and adoption of HIV risk and protective behaviors: 1) family attitudes and communication about sexual behavior; 2) peer norms; 3) hip-hop culture and; 4) cultural attitudes to homosexuality and bisexuality.

## U.S.-born Men

### *Family Attitudes and Communication about Sexual Behavior.*

Of the U.S.-born male participants in this study, 60% (9) reported that they never discussed condom use with their parents and/or family members. A 20-year-old young man commented on the risky sexual behaviors he observed among his father and brothers and his beliefs that his personal religious faith prevents him from adopting similar behaviors.

*Oh, my family. Well, speaking from my family, my father is...he's a player himself. I'm not gon' lie. As I said, I am the fifth child out of ten kids. And my dad was gettin' it on. You know? And my brothers, they're so sexually active. So it's like, you know, it's kinda funny. And him coming, you know, 'cause my brother comes from the islands. And he came to the U.S., and the first thing he was feigning for is some women. "I need some women, I need some women, I need some women." And me, it was kinda...it's kinda hard. It was kinda hard, because I'm really different from everybody in my family. I'm more humble, wise type. But I'm funny, also. But I'm just so humble and wise. But everybody in my family is just so...whatever they can get, they can get. The only person who stands out in my family is my mother and my two little brothers, because we are so religiously strong. You know, it's that we don't stand against most of that stuff. But as far as my father and my brothers, man, they get it on.*

A 21-year-old father reflected on the lack of family communication about condoms use and HIV prevention. Seemingly, this lack of family dialogue led to him and his younger cousin experiencing fatherhood at a fairly young age.

*No one really said anything. Everybody says the same thing . My cousin, one of my little cousins was the main one that was just like he'd been with this girl for a couple years, and he used to be like, "man, it feels so much gooder without a condom," and this and that, and I used to tell him all the time to strap up with a condom, and now his girl is pregnant...I think it was...for one thing, I think my dad was nervous about talking to us about it. My mom really had too much on her plate to really deal with trying to talk about it, so she didn't, I mean they just never did. I think my*

*dad said one thing and I was like 18, like you know, “use a condom when you have sex” or something like that. But he never actually, you know, got into detail, you know, or talked about it, or anything like that, so.*

He continued to share that he received condom education in school and from peers.

*I would say school, just being around friends, you know, and growing up the way you grow up, you know you always find out about different stuff. You always find out about sex no matter what.*

Likewise a 26-year-old student reported that his family taught monogamy and abstinence until marriage.

*...They have instilled in us, you know, one partner, you know, it’s always there to wait until marriage, you know, even though that’s kind of unrealistic these days!*

Similar sentiments were echoed by a 29-year-old participant who noted his father’s silence about sexual issues and mother’s warnings not to “get a girl pregnant”.

*We never talk. I have a father, been in my life my 29 years and you know, we never talked about it [condoms]. Very church-going people, so they tend to not discuss some of those type issues because you aren’t supposed to be “doing it”.*

He recalled the external venues whereby he learned about condom use. He attributed his early initiation into fatherhood to the lack of sex education in the home environment.

*I learned about condoms, um, I learned actually through researching at school, you know I think everybody takes a health class that, you know, is going to give you a little information about protection and STI’s and stuff like that, so I guess that’s pretty much where I learned my, um, besides my mom, you know, would tell you, you know, tell me the “don’t get a girl pregnant, you shouldn’t be having sex” and stuff like that, but um, nothing in depth, so the majority of the information I learned from school in programs like health and stuff. So, um, me personally, I was raised with the old abstinence religion type issue. And actually I was talking with my sister about this earlier. We both had our children at a young age, 16 and 17. And I think if there was more emphasis on prevention, you know, with condoms and stuff and just a not a message of just abstinence and not to do it, then I think it, it would*

*have been, things would probably have been a little different. And I teach, well me, my personal beliefs, I'm going to teach my son, you know, to have something available if whenever he needs, and stuff like that, so. He won't have any issue, you know, HOPEFULLY he won't have any issues, some of the issues that I ran into when I was growing up, so. I definitely want to keep open communication when it comes to that type stuff.*

Not only does 29-year-old college graduate and father acknowledge a lack of family communication about condoms and HIV prevention, he also felt pressured by his uncles to initiate sexual activity at a young age.

*My family is like hardcore ancient. Like they need to start usin' condoms. I don't know what they're thinkin'. I have an uncle who has like seven kids with seven different women...The first time I ever heard about a condom, I think I was in...I was like in elementary school. And it was my older cousins. And they were just like, "You need to get a rubber." I'm like, "Get a rubber?" I'm thinkin' like rubber band or somethin'. And that was the first time they told me about condoms. That was probably...and then after that, it was school.*

*Like I said, when I said I was pressured before when I was younger and when I said I pressured into sex, this wasn't from my peers. This was from my uncles. I have 4 uncles and they've always pressured me into sex, but they've never pressured me into the use of condoms or anything like that. [They would say] "Hey, you gotta have sex. Have sex, have sex." They've never said anything to me about condoms ever. I really don't think any of my...Well, I have 4 uncles. I know for a fact 2 of them cheat on their wives. Well, one of them is not even married. I don't know if he's ever gonna get married. He's the one with the seven kids with seven different women. And then my other uncle, his wife just divorced him. So those 2, they just runnin' around like baby makin' machines.*

Another 25-year-old participant described his father's failure to communicate with him.

*My dad (sigh) like my dad's a working man, like he works 24/7. Like he's always on the go. He don't have time for nobody. Like, he talked, like we probably talked like not even ten minutes, you know, he started to see how you were doing. So we don't really have that relationship, like you know, oh let's go out and do this and that. So he's just busy-busy, call you when he has time. But he*

*never...he, I remember him talking about it [sex] like you know once in a blue, he's more like: "Stay out of trouble."*

Family communication around sexual behavior and condom use seems even less prevalent in the lived experiences of men in the 45-60 age range. As one HIV-positive 54-year-old participant indicated, when he was young there was no knowledge of condoms.

*When I came up, there was no such thing as using condoms. I was raised by my grandparents. That's real old school. You know how that is. That's how...nobody talk about condoms. I only heard about condoms when HIV already done hit and messed up a lot of lives.*

A 45-year-old father of two claimed he learned about condoms from his brother who died from AIDS.

*My mother and father...my father...condom, never. Never, never. They didn't know what a condom was. But my mother had to work. My brother contracted AIDS. Besides him teaching me, she was the one that actually wanted to know more about it herself. 'Cause I said when they were growing up, it [AIDS] wasn't somethin' that they worried about. The most they ever had to worry about is contracting, not herpes, but what is...syphilis. That's basically all they worried about. You know, so the concept of the AIDs and everything was somethin' me and my mother both learned about. She was also...talked to my other sisters and them about usin' contraceptives and stuff. And everything about that once...what happened with my brother. Like that saying, in the 80's it was a new thang.*

A 54-year-old HIV-positive participant expressed his discomfort discussing condom use and HIV with his family.

*We don't talk about it [condom use] Since they know about me, they don't never talk like that. 'Cause they always ask me, my sisters, my nieces, and my daughters, they'll say, "A I using condoms?" I tell them, "Yeah." ...I just don't feel comfortable talkin' to my family members. Which I should, but I don't.*

The study findings reveal that parental/family interactions and communications around HIV prevention and risk reduction are virtually non-existent. Men who reported minimal sexual dialogue within the family noted that the discussion primarily centered on abstinence. Therefore, children obtain sex education from avenues that are external to the family unit. Families are not educating their children and adolescents about HIV risk and protective behaviors. Parental religiosity emerged as a barrier to sexual dialogue and fathers often fail to communicate with their sons. The dearth of communication seems to have a generational effect whereby subsequent generations seem to be disengaged from the sexual behaviors of their children.

#### *Peer Norms.*

Findings reveal that peers engage in risky sexual behaviors such as inconsistent condom use and concurrent sex partners. Even though men reported that their peers discuss HIV and AIDS and perceive it to be a serious disease, their sexual behaviors do not reflect their HIV knowledge or perceptions of the disease.

*Condom Use.* 60% (9) of U.S.-born male study participants reported that their peers did not like to use condoms and used condoms inconsistently. A 20-year-old student described his peers' sexual behaviors.

*Well...yes it's something I talk about with my boys. Because you know, me being from the environment and the neighborhood I was from, oh my gosh. When I was a 5<sup>th</sup> grader, most of my homeboys was havin' sex already at the 5<sup>th</sup> grade. Yeah, they knew how to touch the women body in the right way and everything like that. And it was really crazy. We talked about it [HIV/AIDS]. Most of 'em do get scared. They are afraid that they do have it. Most of 'em refuse to take the test because they are afraid if they do have it that they might end up killing themselves. Like, for example, I had a friend...he was a real good friend of mine. We knew each other since the third grade and he had sex with this girl. I told him, you know to go and get it tested 'cause the girl he had sex with has*



*been sleepin' around with...this was back in high school, and he...the girl slept with mostly half of the football team. And so..also, me and my homeboys, we told him, "Gotta get it tested." And to find out, he did get tested and he was positive and end up shootin' the girl and went to jail for the rest of his life. However, he reports that most of his friends struggle with condom use. Some of them struggle with it [condom use]. Some of them really do struggle with it. 'Cause some of them they feel as if you put on a condom, you're not getting 100% feeling of it. Most of 'em struggle with it.*

Likewise, a 45-year-old participant stated that his peers have negative attitudes towards condom use. His friends say:

*It's [condom use] as waste of time and a waste of money. They like to, as they call it, raw dog. Referring to his peers' attitudes to HIV/AIDS he states, They not worried about it. Never happen to them. They know the women that they messin' with. They know that they not doin' nothin' and everything like that. You know, naïve. ...Just 'cause it feel good don't mean it ain't gon' kill you down the line.*

*Multiple Sex Partners.* Over 70% (11) of U.S.-born men reported that their friends and associates tend to have multiple sex partners. As one participant reported:

*All of them [friends] seem like, you know, I'm going to talk to this girl, I'm going to talk to that girl, and they are itching to hump, I mean, they do what they want to do.*

A 20-year-old participant articulated his beliefs about multiple partners among his peers.

*We could get as many [women] as we want. Some guys actually had bets to see how much girls they could sleep with in the night. And yes, African American males they do have multiple females. But really, it is the male, but sometimes you really put all the blame on the male, because sometimes the female open themselves up to the male.*

Several interviewees expressed their belief that men engaged in risky sexual behaviors as a means of occupying their spare time. When asked why he thought his peers had multiple sex partners, a 26-year-old man stated:

*I mean just to fit in, I guess. A lot of times they don't have anything to do with their time, you know, they need something to do.*

Another 29-year-old participant remarked that his peers often need a way to appease their boredom.

*They find it more interesting to have more than one partner, when it gets mundane being in a monogamous committed relationship so that, you know, most of them talk about how they get bored, you know, being in, you know just one relationship.*

Of middle socio-economic status and a college graduate, a 27-year-old man gave an account of the conceptualization of relationships and multiple sex partners from the perspective of his peers.

*So, it's just not a norm, unfortunately. Especially in the African American community, you know, it's just...Even men that I know that's in love with their significant other, you know, it's still...they don't have that whole...this is the person you're gonna be with, but they still fool around with other people and just say, you know, I'll worry about that once I'm married. It's almost like if you're not married, it's free will. Once you get married, you know, you know, that's the time to do that. And this is not just...I know...All these are my college buddies, you know, so they're all professionals now. This is from doctors, from lawyers, to like, you know, who knows what they're doing now. And none of them are married and all the not married ones, you know, like one of my friends is actually...He just became a lawyer in South Florida and he's actually thinking about bringing up his girlfriend so he can have that whole, "Now I'm making a hundred fifty grand a year, let me experience life a little and not be tied down by this girl who gives him nothin' since like, since we were Freshmen in college....I call it like...he wants to be a man whore....Unfortunately, that's our community and some women know, some women don't, some women are just very naïve and don't wanna believe it.*

When asked to explain his thoughts on why some men may have multiple sex partners he openly responded:

*Well, you ever heard the saying, "Show me one beautiful woman, and I'll show you a man who's tired of sleeping with them?" But like a lot of us are still young, you know...none of us...like...you*

*know...not even 30 yet. There not just...just not ready to be tied down and stuff. And they just so much more to explore, and then it's just...and I don't mean to be rude or vague but the always say, "There's no pussy like new pussy." I apologize for my-*

U.S.-born men between 45-60 years of age also reported the practice of concurrent sex partners among their peers.

*A lot of my friends think that women are put on earth just to please men. And some of 'em, yeah, they might love one woman, but if they find somebody else who gon' give it to them that night, they go with her. He further exclaims, but my friends, hey! Women are put on earth to please us. When I hit 'em with the Bible, they quote me back that, "God created Eve to please Adam". That true? That's their beliefs.*

A 51-year-old participant who reported to having monogamous relationships sees his peers as stupid and attributes their promiscuous behaviors to "*ignorance, lack of knowledge, and tryin' to be players*".

Normative peer sexual behaviors reflect risk-taking such as inconsistent condom use and multiple sex partners. Peer norms may have a significant influence on the adoption of risky and or preventive behaviors and must be considered within the context of HIV prevention.

#### *Hip-Hop Culture.*

Results of the inquiry show that 80% (12) U.S.-born men perceive that the media and hip-hop music have a negative influence on their sexual behaviors and communicate negative messages to the black community. The data show that hip-hop culture plays a significant role in black male identity and their conceptualization of sexual behaviors. In fact, study participants acknowledged that hip-hop often promotes profanity, promiscuity and the degradation of women. As a 20-year-old man stated:

*Oh, man. As far as hip hop, I for one don't think hip hop is really a good inspiration for anybody right now. Because all they do is, they do promote sex to the fullest. Now back in the days, it was ridiculous. But now, it kinda slowed down a little bit, but still, no matter how bad it slowed down, it's still promoting sex, period. Like, back in the days you didn't hear nothin' but, "Oh," you know..."Stick it in there, stick it in there. Drop it down low. Duh, duh, duh." But nowadays, you hear more of...I guess because of how strong the virus is gettin', most people are startin' to...well, more people are positive and more people are actually telling a story about it. But in my opinion...like myself, I hardly listen to rap. Like, if you ever hear me listen to hip hop, it's like once in a blue moon...because it promotes sex. One reason, because I have 4 sisters, and I refuse to let any guy call them, excuse my language, a bitch or a hoe. And that's what hip hop is all about.*

A 19-year-old father described the influence of hip-hop music and music videos.

*All them women, shaking their booties, that, that do affect people. Because that gives you the urge to just urge to just want to have intercourse and everything, you know.*

A 21-year-old father also commented on the negative impact of hip-hop music and especially music videos.

*Hip-hop culture maybe because of the videos and you know the video girls, and then you know you got to have THIS type of girl and such and such, and you know, it puts pressure on people to go out and grab the baddest chic, and the baddest chic be the one that got something, and other stuff like that. It's just, I don't know, I think kind of how hip-hop focuses on it[sex] like, it makes it seem like they, they're not really trying to send a message to you, but just their videos and their words, you know, puts in the kids' minds like its okay, yeah, like they think that's so cool because this person is rapping about it, this person made a video about it, such and such.*

A 26-year-old student voiced similar concerns.

*Um, I mean, hip-hop music videos, scantily clad women all the time dancing, half naked, it seems like you rarely see artists who come out with something other than that has a topic other than sex because, you know, obviously sex sells. So, with these, with this all in the media, you know, TV, radio, you're always hearing: "Sex, sex, sex...sex, sex, sex," so I think it affects your, um us as black*

*men to get involved, the sexual behaviors, and usually at an early age.*

Another 29-year-old participant partially attributed the spread of HIV to the media.

*The media. I think the media has been, um, assisted in the spread actually. I think the whole question of the, you know, you know, being, you know, I think a lot of kids are influenced to have sex to, you know, approve, to be cool, or whatever, and I think the media actually, um, has a part in that, and sex sells, and it's a big money maker, and so you know they are going to make sure they have a big hand in that. ...Hip-hop is a big, is a big influence for a lot of black males because it's one of the first avenues that gave a lot of black males voices and stuff like that. But then, the mainstream hip-hop is not really conscious of that, and it's pretty much about making the money and stuff like that, and then promoting, you know, promiscuous life with males, a lot of females and stuff like that, so, um, it definitely plays a role in you know, guys not using protection and stuff like that I believe.*

Men between the ages of 45-60 expressed concern for the influence of hip-hop on the younger black male population. One 53-year-old participant expressed his belief that the hip-hop also promotes drug use.

*You know with the rap songs, they always have the ladies dancing, you know, in suggestive outfits. And so, you know, that's part of the culture in the hip-hop. See, the hip-hop culture seems to promote drug use to a certain extent especially the weed smoking.*

Referring to hip-hop, a 54-year-old participant of low socio-economic status exclaimed that hip-hop “messes up everything”.

*It just messes up everything. Makes a young man...black men think its alright to have [sex] from behind, back, mouth, ear without protected. Not really thinkin' about the consequence of someone's life. Just out there for the money. Don't care what they say or how they say it on this music these days. And that's how the epidemic just went, “Boom!”*

A 45-year-old participant believes that hip-hop demeans women causing men to lack respect for them.

*Oh, hip hop culture influence sexual activity because, first of all, it parade a lot of women in half nude clothes and stuff like that. And lettin' them know that, you know, women who dance hip hop automatically wanna go...you know, because they like the music or anything like that...gonna automatically be sexually active after they leave a club or listen to some music or somethin' like that. You know, as far as me, you know, in the hip hop culture...and I actually DJ. So... Some of these people idolize these people so they wanna be like -these people on the video. Or they see a, 'xcuse my language, a big butt girl, they automatically think if this girl gon' dance like this, I would probably think that's what she gon' do for me in the bed. You know, not to say that most hip hoppers demean women, but they do. You know, they be like Oprah and Montell and all them, they put it on there how some of the hip hop rappers, you know, the word, the fema-....I don't use this word, I say female dog. They use that word a lot. Or they use the H-word a lot. And our persona of a young black man come up thinkin' women are nothin'. Just like I said. Just like some of my friends did the same thang. Women are here to please them. And they ain't nothin' but female dogs and H's. You know, but I tell'em, I was like, "You were actually born from a female dog or a H. What do you think of that?" "Hey, dog. Don't go there. That's different." "How is that different? That's still a woman."*

Research findings suggest that hip-hop culture may have a deleterious effect on sexual behavior, sexual identity and definitions of womanhood and manhood in the black community. U.S.-born men believe that of hip-hop culture conveys negative sexual images and messages that are especially impactful during the impressionable years of a young man's life. They perceive the messages communicated by hip-hop to be highly negative and have a significant influence on sexual behaviors and perceptions among black men.

#### *Attitudes and Beliefs about Homosexuality and Bisexuality.*

U.S.-born male study participants expressed negative attitudes toward homosexuality and bisexuality. Similar to the findings from previous studies (Stokes & Petersen, 1998; Brooks et al, 2005), homosexuality was perceived as taboo, "bizarre",

“confused”, irreligious, and insulting to black masculinity. A 20-year-old man expressed his homophobic beliefs:

*It's [homosexuality] a spirit. So if you can get that spirit of lesbianism, homosexualism out of you, then you won't have to have that problem. But most people, they don't say...I have a real strong problem with it, because most people know that it's bad. One thing that these people don't do is pray about that problem that they have about bein' lesbian, hetero...whatever. So, my problem is if you guys...if they just prayed more about the problem that they have, they would really see that that's not the way to go. And like I don't...I'm sorry to say, but I'm really homophobic. He describes a negative experience with a gay man. ...Because I'm not gon' lie, I do go to the gym a lot, I do work out, and I like to keep myself well-preserved, and guys tend to like that. I was in class, I had this white gay guy like me. And I'm playin' basketball and you know, when we box up on each other and get the ball and stuff and playin' ball with this guy and I didn't even know he was gay...he just, and I'm all up on him tryin' to get the ball and he's actually likin' it. And then some of'em, they'll just walk by and just slide their hand on your behind and I don't like that. And really that, that really gets me pissed off. I would literally knock somebody out if they ever touched me that way. Like, I don't care if I go to jail for it. But just through that experience, I just don't like it. I hate it.*

A 25-year-old participant attributed his negative attitude toward homosexuals to his family's religious values and beliefs.

*There was a kid in the school that was gay. Like I didn't even know the kid was gay, but they was picking on him, and he was getting in fights. He was beating them up. He was running home, and it was like, "man, he's gay." Like that just blows me. He likes dudes. He likes boys. Like, you know what I'm saying, and like because growing up, I never seen that, you know. And it was like, you know, like my dad, like you know, when he sees something like that, you know he will say something crazy, like you know what I'm saying. So me seeing him, how he looked at it, I looked at it that way, too, like you know. And then like, you know, me being in a spiritual household, like you know, my mother, she was a religious woman, so she always, you know, she always did things according to the Bible. You know what I'm saying? And we didn't have no gay friends coming to the house, you know what I'm saying, my mama wasn't with that, like you know my dad, even my dad, so you know what I'm saying?*

A 54-year-old father of three with a history of incarceration also expressed his homophobic attitudes.

*I don't even wanna have nothin' to do with them man. Period. I know some of them... Well to be honest with you, I have 3 daughters. When I got out, I found out that one of my daughters was gay. Real pretty. I wish I brought pictures of them. And it kinda blowed me a little bit. So what can I say. That's my daughter, so I just accept it.*

Expressing his feelings toward homosexuals, a 19-year-old father stated:

*I mean, I don't think, I don't think nothing wrong, I'm still be cool, it's just don't shake my hand. I don't want to be seen, I don't want to be seen with you!*

The study also found that within the sample, U.S-born men of all age groups had strong feelings against the “down low” behavior. In fact, some men expressed that the “down low” may be a causative factor in the spread of HIV in the black community.

*I think it's disgusting. I think it's just ungodly and just wrong, because...I don't know, in my opinion, it's like you're keeping secrets.*

Another participant shared his thoughts about the “down low”.

*I think it passes I [HIV]t, really, because I don't think it's right for you to lie to your partner or someone you're going to have sex with about your sexual orientations.*

Similarly, a 53-year-old HIV-positive participant described his observation of “down low” behavior while he was in jail.

*Another reason why HIV is so prevalent, especially with the women, because a lot of the guys mess with men and then they bring it to their women. I went to prison overnight and these guys were talkin' about their women and all these manly things. And then some gay guy came in and about all ten of them left the table and went to the gay guy and was doing this gay guy...but yet, they were talkin' about their girlfriends and all this.*



Describing his disgust for men who are on the “down low” or engage in homosexual situational sex a 27-year-old college graduate stated:

*[Down low is] someone who’s having sex with a male or doing homosexual actions but doesn’t believe that he’s gay. Like a lot of people in prison are like that. Like, “Yeah, I suck his dick, but I’m not a gay man”. I hate those faggots.*

### *Haitian-born Men*

#### *Family Attitudes and Communication about Sexual Behavior.*

Among Haitian-born men, family discussions and communication about HIV prevention and condom use was virtually non-existent as 79% of this subgroup reported little or no family communication about sexual issues. Younger men reported that their parents and family members were reluctant to discuss sexual issues within the family unit. Any discussion about sexual behavior centered on pregnancy prevention. Haitian fathers admitted to being embarrassed and afraid to discuss sex and STI prevention with their children. Many Haitian men in the sample indicated that conversations about HIV and AIDS were typically initiated when a relative or friend died of AIDS.

Referring to the lack of family communication about HIV and AIDS, a 20-year-old college student stated:

*They don’t really...they don’t really talk about it like that. I guess, like, since we don’t really have that conversation...I guess, like, we don’t even have a open conversation about that as in like, well...aside from occasional, there might be some testing on site on campus or at some, like, social community service events. Stuff like that. It never...barely to never comes up.*

He recalled one of the few times his family discussed HIV and AIDS was when his uncle died of AIDS. When asked to describe what his family has said about HIV/AIDS he replied:

*Well, what have they said about it? Well, nothin' really. Except that last year, I had a uncle and about 5 years ago that died. I was younger. Like, in '98 he passed out and then last year when I was like, just getting' started about like 2 years ago. I just started havin' girlfriends and stuff like that, whatever. And that's when my mom told us that he actually died of HIV.*

A 36-year-old Haitian-born entrepreneur recalled a similar experience while growing up.

*I don't think, you know we've ever really, I would say, really took time and really discussed...I think we had maybe one friend we knew who died of AIDs, but the conversation never really, you know, in terms of open conversation...there was no conversation on that.*

Similarly, a 20-year-old participant recalled having little to no family discussion about HIV and AIDS. Seemingly, the information communicated was inadequate and even incorrect.

*...we haven't had nothing, no conversation about sex or diseases. They like...they're like...they know it's out there. They taught us a little bit of stuff like, "people who have sex have HIV". They'll like, if a news come in, stuff like that, that's when they'll say something about it. But never something like, well we sat down one-on-one or as a family talk about it. That's why I'm hoping to change with my family growing up in the near future.*

External avenues of HIV prevention education was a common theme among research participants. As this 18-year-old indicated, his mother was reluctant to address the issue and tended to be somewhat vague in the messages she communicated, so most of his HIV knowledge came from his "physicist" (physician).

*My mother is the type that don't really talk about condom usage, but she always told me to...if you are, to use it in order to protect yourself from getting a child at the moment, and also there is STDs out there... The main person that talked to me about it was my physicist. Before I came here, she was like, "Oh yeah, there are girls out there. Yes, I know you guys are gonna get involved with them, so make sure you use protection and make sure you talk to them about it first.*

Participants also reported their perceptions of the barriers to sex communication among Haitian families: a) parents are in denial; b) parents are busy working and have less time to speak to their children; c) parents depend on schools to teach children about sex and STI protection and; d) parents are uncomfortable discussing the issue of sex and STI prevention. In fact, sex education within the family was stigmatized and viewed as taboo among Haitian families. The high prevalence of religious conservatism within the Haitian community further prevents open dialogue about sexual behaviors.

*My parents and I never had a sex talk at all...they don't wanna think that their kids are having sex. Also, they're always working. My parents will work from 3-11 every single day. So coming from middle school around 3:30, I was by myself...well, with my siblings, by ourselves 'til about 11 and stuff like that. So we were all alone almost all the time. So we never had the chance to talk about it, I guess. And growing up, as we grew up, I guess they thought school would teach us or somethin' like that. But my father and I, and my mom never had anything about sex. But my uncle, actually not my uncle, my dad's uncle...Actually, when I was 15, he sat me down at the table, and he told me that if you're gonna have sex, you should wear a condom because it's gonna protect you from this and this and that. So that's my uncle...that was only one time for about 30 minutes. It was a pretty good talk, long talk as far as guys. But my mom and I...never. My father...never.*

*That's (condom use) something you don't ask growing up. You know, I never heard my parent talked about that because I grew up in a Christian home. So my nature was church, church, church, church...education and then you get married, that's it. Job and marriage, but never heard about that. But I've come to be education on condom actually through school. And also through some friends who talked about it. And also education that they have out there through community outreach or television ads, as well. So, that's how I've come to know...*

Another participant shared his experience learning about sex and HIV prevention outside of the home environment.

*I can honestly say growing up in my household, we never had a conversation about sex. I learned about it once I...well actually I*

*learned by looking at TV. And also once I came to...here, to University. That's pretty much the way I learned about the different type of disease and things of that nature. ... I guess they automatically assume that you going to know what to do when that chance come. And also, it could also be like a comfort level. They really may not be comfortable talking to their kids about that particular issue. They figure that when that time comes, you'll know.*

Participants reported that Haitian families are more likely to emphasize abstinence than STI prevention. A 36-year-old respondent stated:

*Okay, now this is the other side as far as the culture. I think, like, sexual conversations like that, I don't think really...ever really take, you know, took place. In certain instance, "Okay, you should use it or don't use it." I think they only say, "Okay, well you don't have sex." And I think that's the only thing that he taught you. But other than that as far as what to use, don't use condoms. No...*

Due to the diverse age groups included in the study sample, the researcher had the opportunity to probe parents about sex communication with their children. Parents reported that while they understood the importance of sex education, they were uncomfortable and embarrassed to address the issue with their children. Moreover, they held strong religious beliefs about abstinence before marriage and did not think it necessary to educate their children beyond emphasizing the abstinence only message. A 50-year-old father of five exclaimed,

*In the Haitian culture, we embarrassed! Embarrassed to talk to the kids about that (condom use). But it's not because we don't know. We know what's best for them, but we don't do it. I don't know if maybe 1% or 2% of Haitian do it. But most Haitian don't.*

The lack of communication about sex and condom use is a generational phenomenon among Haitian families and a recurrent theme throughout the study. As a 58-year-old father reported, as a child he could not discuss sex in the presence of his

family while growing up. Likewise, he does not discuss sexual behavior or HIV/STI prevention beyond abstinence with his children.

*When you think about that (family discussion about condom use), in front of my family, stuff like that, they used to beat you up, because you not supposed to...*

A 54-year-old father echoed similar comments.

*I don't encourage them to use this condom, nothing. I always, because we always talk about how to be committed. You know that? I always, because in Haiti, Haitian families not easy to talk sex [with] their kids. When you live in a big country, your mind...you got a open mind on everything. That's why I always teach my kids how to preserve themselves, you know? I always tell them, if you want to get sex, it's better to married with someone first. Because Bible is against going to a woman without marriage. It say sin is a kind of fornication. You know? You know what fornication means? It's a poison on your body. I always tell them, it's better to get somebody to get married, clear your void, fornication, adultery, thing like that. I don't tell them to use any protection.*

*Peer norms.*

*Condom use.* Similar to the U.S.-born sample, Haitian-born men reported that their peers held negative attitudes toward condom use. The perception that condoms detract from sexual pleasure as a barrier to condom use was a recurring theme in this inquiry. Remarking about his peers' perceptions of condoms, a 28-year-old entrepreneur shared:

*The majority of them say naw, they don't like using it 'cause it doesn't feel right. Or I get they won't ejaculate fast enough per se.*

Another participant shared his peers' views on condoms.

*I think most definitely, you know, I'd say, [they] prefer not to use it. I think the other thing is that it doesn't feel the same and it gets in the way and so a lot of them [peers] really prefer not to use it.*

One participant who reported inconsistent condom use himself, explains that his friends also have negative attitudes toward condom use which may result from their beliefs that AIDS is “fake”.

*Some say, “Awe man, they just lie. There ain’t no certain thang ‘bout AIDS out there. They just tryin’ to make money.” Some of them don’t believe it’s true, though. Even though they heard about it, they know it’s killing people and all, but they think it’s fake. So that’s their believin’.*

*Multiple sex partners.* An exploration of the perceived peer norms around concurrent sex partners revealed that 64% (9) Haitian-born men believed and observed that their heterosexual male peers did not practice monogamy. A 20-year-old participant remarks that while his peers tend to be promiscuous, he tries not to succumb to peer pressure.

*In high school, all my friends were like going to parties and having girls every week. Stuff like that, but I never partake in those activities. First of all, my parents kept me straight. I couldn’t go out and stuff like that. But my friends definitely have multiple partners at a time. No commitment and stuff like that. But I don’t let that bother me or like get into me ‘cause I know...I stand strong in what I believe and what I do, so I don’t let that affect me. My friends definitely have multiple partners.*

Another 22-year-old Haitian man attributed his peers’ risky behaviors to hormonal activity.

*Their hormones kick but they don’t think. It’s when they done the mistake, they like “look what I did”. It’s like they don’t have no common sense that should prevent yourself from doing things.*

A 36-year-old entrepreneur who himself reported partner concurrency commented about his Haitian peers.

*I think most Haitian men want to have a steady sex partner. But it is not uncommon to see some Haitian men with multiple sex partners.*

Referring to the cultural influence on male sexual behavior, another 36-year-old participant echoed similar comments.

*Okay, I think part...aside from just being Haitian, I think, I think it is a man behavior, also. It's just, hey, the more people you can have, the more macho people look at you. And I think that's why. ...I think really for me, living in Haiti and also being...grow up here also, seeing the mentality. I think it boils down to if you're a man, the more women you can get, the more acceptable your friends will see you. Just like, "Wow, how you manage to have that?"*

A 28-year-old married Haitian man who reported being faithful to his wife provided possible reasons for the infidelity he observes among some of his peers.

*It could be many things. I say based on the satisfaction need that they may be seeking from a female. For me, my personal friend's female, so from a female perspective, they (male peers] may be looking at the breast size, the body gesture, the body type. So it could be many things that could influence them to, per se, go from one person to the other person.*

Referring to Haitian male sexual behavior, a recently married 32-year-old participant explained:

*It depends on the age group. If you talk about my father's age group that's in like 50's to 60, most likely that's not in their vocabulary to actually have one sex partner. As a matter of fact they are not even using condoms because they feel that it was their right to actually populate. You know? If you look at my age range which is 30 – 45, some of these guys have the same kind of mindset because they look up to their father and they see their father just like sleeping around. Some of them might use condoms, but a lot of them probably don't wanna use it because they just tell you they don't like the feel of it. And then they get sick. And it's almost like, "What can I do?" So it's kind of very tough because you have a person that decides like that 20 minutes to 2 hours was worth it and then they counting their days and say, "Hey, c'est la vie."*

A 50-year-old Haitian man who has been married for 19 years, recalled the reaction he frequently gets from his peers toward his marital fidelity.

*But some time I meet some Haitian who tell me the same I just explain to you. And some of them told me if I'm crazy! And I told them, "You crazy!" Me crazy? I don't forget that one of the Haitian and Spanish, both of them told me how I got married for one woman since 29 years I never go out with someone else? And I said to them, you know what, "I'm not crazy, you crazy."*

A 55-year-old Haitian-born participant who admits to having extramarital sexual relationships, explained that men in general tend to have multiple sex partners.

*A lot of them [Haitian men] they like to have different women. Well, really honestly, I'ma tell you it's a man thing. Most of the time, man always like different, it's like you eatin' a fruit, you want a different taste.*

Haitian men tended to report that monogamy is not a typical sexual pattern for their male friends and peers. While Haitian study participants reported monogamy as their personal sexual behavioral preference and practice, they reported that many of their peers and family members practice partner concurrency. Although mutual monogamy is an HIV risk reduction strategy, based on the feedback obtained from Haitian men in this study, it may not be a behavioral choice for some Haitian men.

#### *Hip-Hop Culture.*

Similar to U.S.-born men, Haitian men (93% or 13) reported that mainstream hip-hop culture and the media negatively influence sexual behavior primarily because they sexualize women and promote skewed, oversexed definitions of masculinity. A 20-year-old student described the effect of hip-hop on young men.

*But I think overall, it's like...as in like...it has a big effect on it, as in like, well, okay, we have to be the...if you don't have so many, so many chicks, you're not really a man, whatever.*



While indicating that hip-hop does not have a personal effect on him, an 18-year-old shared his perceptions of the effect of the hip-hop culture on early initiation of sexual activity.

*The hip-hop music may actually want to get people to have sexual intercourse from the way they talk about girls, from the way they elaborate certain stuff and certain songs. And though they put on there that it's explicit some kids still listen to it. And they may get them to get involved at a younger age than they were supposed to be.*

A 20-year-old student gave an account of the images portrayed in rap music videos and the messages sent by those images. Women are not only sexualized but social definitions of beauty are reinforced in these videos.

*Rappers in the rap videos, all you see is girl's booties shaking, titties bouncing, pretty girls. I never seen a big [fat] girl in a video. I haven't seen a ugly girl in a video. I mean, they always beautiful females that every guy wanna sleep with and stuff like that. So, I mean in the rap songs, the rap lyrics is like she do this, she lick me like a lollipop, all that stuff. You know what I mean? So the rappers and hip-hop are influencing a lot.*

Another young participant, a 22-year-old aspiring musician from low socio-economic status commented on not only the sexual content of rap music but also the violent lyrics and the personal effect it has on his mental state.

*All they talk about...sex and money. Say if you wanna have like, money, you gotta do somethin' for me. They talk sex, how I wanna do this, this and that. You don't have to be scared to do anything, you grown. ...You gotta have self-control to listen to it. I never knew nothing about hip-hop, 'cause I love jazz. I used to love that. Suddenly, somebody say, "well you gotta listen to hip-hop, hip-hop." I'm thinkin' hip-hop, rap. 'Cause I wasn't used to stuff like that. So I listened to it, then Cam'ron [a rapper] had me [when he sang about], "shoot somebody, gun, gun this and that." Yeah, it affect my mind. ...It affect me, I'm not gonna lie. It does affect me.*

A 36-year-old participant indicated that both men and women buy into the messages conveyed by the hip-hop world.

*I think it's still the same mentality as far as...okay hey, if you're African American, black male in general, or Haitian I think its just...hey, the more women you can get, the more credit you gonna have, not only with your boys, but all the women also flock to you, 'cause they know, "Hey, he quote-unquote "the man".*

A 28-year-old married man admitted to the temptations he feels based on sexual messages conveyed by rap music and the media.

*Oh, well I think that's one of the biggest things that really affect a lot of black...black men in general, because I know for me, being that I am married, I still feel see a instant influence on the temptation on the temptation of going out and doing different things based on what you see on TV, based on the type of way that they depict women, and also based on that particular male preference. And TV will definitely sell you off right off hand if you don't have a good, strong foundation of who you are, that could definitely destroy you to make you do a lot of things that for a fact you know you said that you shouldn't be doing. So it does play a big role, especially in the rap videos.*

Some men made a distinction between Haitian music and rap music which originated in the United States. Having been raised in Haiti, a 34-year-old participant relates that Haitian music emphasizes love while American music promotes sex. Moreover, rap music fails to promote safe sex.

*For instance, the way they make those videos for instance. When you start to watch it, it seems like it's encourage to go out there and do certain things. But some of them don't preach about you should take necessary steps to prevent certain things from happening...AIDS. ...As far as Haitian bands concerned, media, I would say our song is more likely, the musician I'm talking about it's more into...love! Yeah, it's more into love. It's not like, compared to the media here, it's like, "Hey, this lady here and there and..." And that's how we do it.*

A 50-year-old father voiced his concerns about the openness of the media and the dangerous influence of hip-hop music.

*For me, it's not a good thing for the kids, but it's best they know but for me, I always think about it, and I say, "The media inform too much. Inform too much." It's good for the know, but sometime too, you let them know too much.*

*That's one of the dangerous for me for the youth. Because when they don't know and they hear or see, now they want to know what it is. Now they want to go to see and now because they want to go to see and sometime they don't have opportunity to do it. They can go anyhow, they can make it, they don't care anyhow they can make it. And now they can get AIDS. Anybody for example, a girl, any man, whatever, the same age or not. Because I know some Haitian girl up in school and high school get pregnant for old men who got many kids. And that happen because, how you say about music. They hear that, the music or they say, like the television. And they want to know how they hear it, how it's going to feel. And now, anybody who they got chance talk to them, they don't care.*

Interviews among Haitian-born men indicate that the media and particularly hip-hop culture have a strong, negative influence on sexual behavior. Sexual images of women, the promotion of multiple sex partners, and oversexed masculine ideologies may have a direct impact on the risky sexual behaviors practiced by some U.S.-born and Haitian-born black men.

*Attitudes and Beliefs about Homosexuality and Bisexuality.*

Haitian men expressed even stronger feelings of homophobia and intolerance for homosexuals and bisexuals than their U.S.-born counterparts. In addition, they conveyed a culture of violence toward homosexuals, a behavior that is more extreme than that of U.S.-born men.

*It's [homophobia] more of a cultural thing. As in here, when I moved here, it's really like open. But in Haiti, nobody really dare come out saying that...well they're homosexual. It's more of a*

*under-the-table type of thing and stuff like that. So, I guess some day it could go as far as being beat up by people you don't even know just 'cause you're homosexual.*

An 18-year-old student explained his fear of homosexuals.

*I don't have any friends that are homosexual. It's not that I'm...I mean, I don't think I would feel comfortable around them in a way. ...I'm scared of certain actions that they may have...and actions they may have towards me especially...and stuff like that.*

Another 20-year-old participant explained that Haitian men who are homosexual are afraid to identify as such for fear of isolation and dismissal by friends and family members.

*Well, for Haitians, I know Haitians do not like the term, do not wanna see no homosexual people. They think it's the worse, so if a Haitian happened to be homosexual, it's gonna be on the down low for...maybe for life. They always say homo tendencies. I know pinky or whatever. Gettin' your nails done and stuff like that. So they gonna be on the down low for life because Haitians will not...past generations will never accept homosexuals. Maybe you are generous, you're 20 years down the road. We might let it end because we're gonna know a couple of people. But as far as down low, a lot of people are down low, because they're maybe just scared to come out the closet because they fear what people might say or might think of them differently.*

Blaming the United States for homosexuality, a 22-year-old participant recalled the treatment of homosexuals back in Haiti.

*That's what I love about Haiti. They never accept no gays. Now it's affected 'cause ain't nobody listen to nobody no more, 'cause back in the day they beat the crap out of you and put you on jail and learn you a lesson and teach you. Say God created man and female, you gotta stick to it. But since people come down here and have the mess around this country. Gays started in this country, that's how gays started.*

Older Haitian men between the ages of 45-60, viewed homosexuality as an ungodly act that contradicted the laws of creationism. Three men in this age group expressed the following views.

*That [homosexuality, bisexuality] don't go. That don't go. You don't even have to ask about it. That don't go. It's not fair, it's not admissible. It's not admissible. I cannot see a man with a man, a woman with a woman. It's not the way we were created. ...Back home when somebody is homosexual, you can't even pass the street that we live on....They gonna even throw rock at you.*

*I don't know nobody...well, I seen people out there, but I don't really know, and I don't wanna know nobody like that. That's weird. Most the time if I have seen somebody like that, what I do, I just stay away from them. I don't even wanna touch the people. See, I'm a Christian, I go to church. I don't, you know...in general, people is people, I respect that. But I don't know, for some reason, when it comes to this here, I just... ignorin' them. I like, I don't wanna know you. Just stay away from me.*

*I call it [homosexuality] sinners work because the Bible said it, not me. ...In my country. it's a shame to see that. ...In my country in Haiti, if you were homosexual, if you say that, you would be in trouble. ...People teasing you everywhere. Even beat you up.*

While some Haitian-born men had never heard the term “down low”, others thought the “down low” phenomenon may be a significant contributing factor to the high rates of HIV and AIDS among black women.

*I mean, that's the easiest way. If you have a wife or a girlfriend, and they thinking, "Okay, hey, my husband or my boyfriend...this is the only person." And they most likely, especially if it's a husband, a wife most likely will say, "Okay, well there's no need to use protection." Thinking okay, well partner's faithful. And even if it's a homosexual relationship, then also, I think going from one person to another person, so easy to just transmit it that way.*

*Oh, that affect it a lot. I mean, especially by looking at the different things people do and the different body gestures people use. I mean especially when, I mean a male to male, I mean, they pretty much have to pretty much have sex anal. You know what I'm sayin'? And with that, I mean that's one of the most sensitive parts*

*of the body. You know, and that part right there could cause for a different disease to come in through you and in different ways. Actually faster than doin' it, I mean vaginal, you know. So that definitely have a big effect. And people that are not really that educated about it will definitely be hurt more. Especially the African-American population, and they tend to, I guess, they tend to want to go that route mostly. And that have a very big effect. You never know who, you never know who's who and who's not. You know? So you definitely have to be on the lookout every single day.*

Others expressed the perception that black men may feel the need to be on the down low because homosexuality is stigmatized and “shunned” in the black community.

*Well, personally, I do not know anyone that's in that category, but I would say the reason that they do it it's probably...has to do with society. To do what society...the norm is to...if you're a man, you have to...should be married to a female. And vice versa. If you're a female you should be married to a man. But they may have...were born with a certain things in their heads or brain that triggered them to act certain...different from the norm. But my opinion on that is as I was raised, I always said that I believe in marriage between a man and a woman, but who am I to judge. I'm a individual, I'm a sinner just like anyone else. But only God can judge a person's behavior.*

*And a lot of times when I go to lunch for instance, very often the subject will go from a donkey to gay. I don't know how, but let's say I have lunch with a few of my colleagues that are African-Americans. And they would actually just like always come back to this. Who's gay on campus, who's not. You know? And it's something that there's...there's that prejudice with them that they feel it is something that is so unnatural, etcetera, etcetera. And that can stem from a lot of things such as religion. Because African-Americans typically are very religious. So when you have the down low, it's because it's a behavior that is shunned that that's something that they do not like at all.*

The study revealed that both U.S.-born and Haitian-born black men hold strong feelings of homophobia and stigmatization toward homosexuals. Haitian men, especially those over the age of 45 years, were more likely to attribute their negative attitudes to

religiosity. Haitian-born men were also more likely to identify a culture of violence against homosexuals as practiced in their native country.

*Question 4: How do gender norms influence sexual behavior among black men who identify as heterosexual?*

This study explored the gender norms that influence sexual behavior within black heterosexual relationships. Reports from male study participants indicate that black women demonstrate financial independence and are not dependent on their male partners for monetary support. Findings also indicate that within gendered relationships, men tend to make decisions about condom use.

#### *U.S.-born Men*

##### *Financial Decision-making.*

A recurrent theme within the exploration of gendered relationships was female financial independence. Most U.S.-born men reported that their female partners were financially independent and did not depend on their male partners for financial support. Both married and single men tended to report that their female partners were employed for wages and were fairly independent. A 20-year-old participant shared his views about financial independence.

*One thing I make sure, if I be with somebody, in order for me to take care of them, I gotta make sure that they take care of themselves, also. 'Cause my role, I like to be the big shot. Like, you know, I don't like to say I'm a control freak, nothin' like that. 'Cause I don't do nothin' like that. It's always a fifty-fifty thing with me. If she could do it and she needs help with it, I'll help her. But as far as payin' her bills and stuff, I'm her man, I'm not her baby daddy or nothin' like that. I am not her husband, I am just her man, her boyfriend, okay?*

Another participant with a history of incarceration indicated that because of his unemployed status, his sexual partners cannot depend on him financially. *They can't be*

*financially dependent on me 'cause I ain't got no income.* A 53-year-old participant also shared that financial responsibility is “*about equal*” in his relationship.

The theme of financial independence recurred throughout the inquiry as U.S. born men reported that their female partners were not dependent on them for financial resources.

#### *Condom-use Decision-making.*

A major finding regarding gender roles around condom use was mutual decision-making and male decision-making. Most U.S.-born men in the study sample reported that condom use decision-making was either equally shared with female partners or solely the decision of the male partner. Describing condom use decision-making in his relationship, a 27-year-old participant reported:

*I think in any kind of relationship you have to be 50/50. You can't just say well I am going to use this brand and this is all I'm going to use. Sex is between two people, not one person. So if your partner likes a certain brand of condoms, talk about it. Maybe that's better for her, even if it doesn't do anything for you. Sometimes it's best to give in a little.*

Men who reported inconsistent condom use reported that their female partners supported decisions against using condoms during sexual intercourse.

*A high percentage of women don't tell us anything. 'Cause I...there'd be times I have sex and if I don't bring out the condom, she don't say a word.*

*Well, when we started off it [condom use] was automatic. But I think the first time that we, we stopped using condoms was the, it was a “heat of the moment” kind of thing. I actually went into you know, it's while I was looking for a condom, I didn't have it, and kind of didn't and so we kind of, you know, came to a mutual agreement to let things go anyway.*

*Well, she feels that...she's okay with that [condom use]. Now from an oral [sex] perspective, she's not...she's willing to take the risk. Yeah, she's willing to take the risk.*



Some men reported that their female partners held negative attitudes toward condom use and encouraged their male partners not to use condoms during sexual intercourse.

*You know I take that [condom use] seriously because there was a time, you know, we didn't have no condoms and she was like—it was like she was giving me oral sex, right? And so I said I was looking for the condoms, you know I thought she hid them or something, and she said they ran out. And then she was like, you know, showing me her pussy and I was like, "I'm sorry, you've got the wrong person!" I say that because you know I take that [condom use] very seriously and she was like, you know, she took several tests and said okay, that's nice, but I was never, you know, that's not my thing, you know, and uh, and so, that was just... Her, she, I don't know about her.*

*No, she don't, well she don't mind not using condoms. Usually it, it's me, for things that most of the stuff like birth control and stuff like that she have, she's a little, I have to say it in that she really is against that. But when it comes to condoms and stuff like that, you know, most of the time it's me, you know, to make sure that I have one, or state different rules like that. I don't think, actually in my whole life I don't think I ever met a female that would stop, "hey, you have a condom?" you know, I never really met a female that even said that before, you know, so.*

Themes such as the need for female empowerment, better knowledge and awareness of male partners, and honesty about STD and HIV status emerged when U.S.-born men were asked to describe the role they thought black women played in the HIV epidemic. Men held women responsible for not insisting on condom use and believed that women should be more aware of the sexual history of their sex partners. Some men also voiced concerns that women were irresponsible in not knowing their own HIV status or not honestly sharing their sexual history with male sex partners. These themes are evident in the following quotes:

*But somethin' that most people don't realize is that even though women tryin' to put the word out, but there's women that's allowin' it. Women are just, I don't know...like I said, they just don't know the value that they have. And because they don't know, they just let*

*anything get through. So, I mean, I give the women most props. And most women like to say that men are dogs, I agree with them a hundred percent. And we are dogs, but a dog can be tamed. And even in the Bible, God says a woman is a man's foot. A woman can tell a guy anywhere to go. If you really want it...if you really want that sex that bad, all a women gotta do...a women could get a guy to do anything if a guy wants that sex. Most women don't know they have a hundred percent control of a man. If you tell a man, "If you want to have sex, you have to do this, you have to do that." And I guarantee a hundred percent, a man would do it. But most women don't see that because they don't see how strong and how powerful they are to a man.*

*What women can do differently. In general, they make women condoms, so I mean, you can use those as well. And if your partner, the male, tells you he doesn't have a condom, be like "No glove, no love." If you don't have one, we're definitely not doing anything. Don't fall into peer pressure or anything*

*Because a lot of women do just, you know, for that one night, they've got a one night stand, and that's the wrong thing to do. You know, try to, if women stop serving basically they aren't the ones to understand that you know disease is out there and just be okay, I'll find out about this person before I actually have sex with this person, then I think that's really the best way for them to prevent actually catching something or getting HIV.*

One 27-year-old participant pointed to the role of self-esteem in sexual relationships and its importance in empowering women to make safer sex decisions.

*Women play a larger role now because of the fact that the statistics are higher. So, I hate to put everything on African American women because it takes two people, but for some reason they are not being careful enough. Whether it's they are not talking to their partners, they are not getting their partners tested, or they are just choosing to have risky sex. So, something has to happen. But they need to either take it more seriously, or they need to be more proactive and don't let a man talk them into having unprotected sex, no matter WHAT they say. Some women have—it's a lot of different issues. I mean, you can have a woman that has issues with men. Say if she's self-confident, she doesn't have enough confidence in herself, or she's never heard the fact that she's beautiful before. Or, or have, have, have an older male figure hug her, or tell her that, you know, she is important, you know, who she is as a person is important. So if you have a woman that self-*

*esteem is not that high, she will do whatever it takes to keep the man that she's with, thinking that he is giving her the love that she has never gotten.*

One participant who was a strong proponent of the argument that incarcerated men who re-enter the general population are the major routes by which black women acquire HIV infection, implored women to be aware of the sexual and incarceration histories of their sex partners.

*Well, what they are doing to put them at risk, my personal belief is that it is coming out of the prison system. Guys go get in the prison system, and you know they are incarcerated for an extended amount of time, and actually I spoke to some guys that disclosed, you know, that sometimes they may do things in prison, you know, in your gang type thing, or like an induction type thing, you know, that they probably wouldn't do if they were out in the outside, and so I think more black women need to especially evaluate who you are dating, who you are with, and understand, you know, that background—that more communication about you know some of their past experiences and different things like that, before you get, you know, before they would engage into sexual, you know activity with, you know, with their partner.*

A 27-year-old college graduate related the story of his best female friend who continuously practices high risk sexual behaviors. He was perplexed as to why she puts herself at risk and believes that black women in general should be aware of their HIV status.

*....And then she is intelligent...You know, college grad...Doin' well...I mean supporting herself. And like I just can't think what was goin' on through her head when you just meet this guy...probably knowin' for a week, and you're havin' unprotected sex....So I believe black women has a major, major role in it. You know, and I think as a...I think black women should get themselves tested all the time. I think they should really, really, really get themselves tested.*

Likewise, other men reported that HIV testing and partner notification are critical to curbing the HIV epidemic in the black population. Some felt women can do more to be

aware of their own status and inform their partners of such. One 54-year-old participant shared the story two of his friends who are addicted to crack and neglect to get tested for HIV.

*Like it's a girl, two girls, they're friends, and I mess around with both of 'em. They like hot lil' mamas, you know, they out there. And I be tellin' them to get tested. And they keep satin' they went, I don't think they went. ...That's where the drug thing come in, 'cause they be tryin' to get crack, cocaine. And they will do anything to get that. So that would cause somebody else to get infected.*

Another 51-year-old participant emphasized the role of fear as a barrier to black women getting tested and discussing HIV with their partners.

*I would say [women play] a major role because some of them transmit it. Then they don't wanna discuss it. A lot of them not open, as open as men. And they'll pass it on. Don't wanna get the tests. Don't wanna know the outcome. Afraid.*

An HIV-positive man who is currently involved in a sexual relationship identifies substance addiction, promiscuity and physical abuse as risk factors for HIV among black women. In reference to gendered relationships, he believes that women need to be empowered to “be strong” and independent.

*Well, you have to be wary especially of the women who are caught up in the disease of addiction. Because there's ladies who'll do anything for the next round. ...And those are the type women you will see at the bars, at the discos, and they're very promiscuous. And you have to be careful about the Internet, too. Because the Internet has a lot of...is another area where people meet people and get involved in all kinds of situations. I've been approached on the Internet, and I'm just amazed about the approaches you can get on the Internet. ...I saw recently where felt...was saying that she was being abused by her partner, you know, physically abused. But she felt like, "But he's the breadwinner and he's making the money, so I'm puttin' up with this because he's paying the bills. And if I do put my foot down and he leaves me and I don't have a job, what am I gonna do?" ...So you tryin' to hope things get better. So yeah, I could see where the same thing could be HIV.*

*The woman say, "Well, he'll just go somewhere else." Then I'll be left to do things on my own. So it's up to the woman I guess, to be a strong woman, the woman needs to try to understand or not depend on someone else for their livelihood...bottom line.*

#### *Haitian-born Men*

##### *Financial Decision-making.*

Similar to U.S.-born men, Haitian-born men (86% or 12) reported that their female partners were financially independent, contributed equally to the finances of the household and played a key role in making financial decisions. Within most Haitian households, both partners were employed for wages. Even men who were the primary breadwinners reported that they include their wives or partners in financial decisions. As one 55-year-old participant stated:

*Well, I always invited her; you know what I'm sayin'...'cause the thing is that because I work, makin' money right now, but I'm thinkin' she's my partner so we supposed to help one another. While I'm makin' a decision, it might be wrong decision, I always invite her. If I'm gon' do something, I tell her.*

Another newly married 32-year-old participant reported that within his household, he compromises with his wife on financial decisions.

*We both work. However, because I'm usually the more savvy one, she trusts a lot of my decisions. And at the same time, from times...let's say when it comes to investment. If it's for investment, she knows that I've done investment before, so she would say, "Okay, you do the analysis and then break it down for me in layman's terms." And then I'll say yes or no. And sometimes I'll make a case on the stuff, but basically the preliminary stuff I do. But when it comes to financial decision, we always come to a compromise, because of the fact that me personally, I don't want 5 years from now that somebody to tell me that I could have been in a better place, it's because of you.*

A 50-year-old participant who has been married for 19 years reported equal financial decision-making within his relationship.

*We did together. I got no control about it because...and she know I don't get any girlfriend. I don't get any kids out [of the marriage].. And the only thing, I got family on my country, she got family on her country, and we each other can send a little bit money there when we can. But we work almost equal-*

Therefore, findings indicate that Haitian-born men engage their female partners in financial decisions within their relationships. Haitian men commonly reported that their female partners were employed and therefore contributed equally to the household. Thus, mutually financial decision-making was a typical behavior among the Haitian-born sample in this inquiry.

#### *Condom-use Decision-making.*

Among Haitian-born men, male decision-making emerged as the primary theme regarding condom use decisions. Most men reported that they made the decisions about whether or not to use condoms during a sexual encounter. An 18-year-old participant noted:

*It's usually me that says I want to use one. And most of the time, they are okay with it because they know what's out there and stuff like that and what may happen. So they were okay with it.*

A 22-year-old insisted on condom use because many of his female partners have a desire to become pregnant.

*Well, mostly me 'cause they too active. Too this, "I wanna have a baby, I wanna-." I'm like, "Man, we not even close to...we just met each other and you talkin' about this and that, like nah, it ain't gonna happen." I say, "You gotta understand me to understand you. 'Cause if we don't have understanding, we never will work." 'Cause Yeah, they too active.*

Likewise, a 36-year-old participant claimed that he does not negotiate condom use with his female partners.

*Well, I don't think I give them an opportunity to make that decision, you know? I make, you know...better be safe than sorry.*

This inquiry explored Haitian men's perceptions about the role Haitian women play in HIV transmission within the black community. Similar to the findings in the U.S.-born sample, the need for female empowerment emerged as a recurrent theme when condom-use decision-making was discussed. Some men asserted that within gendered relationships, women need to realize the power they have to negotiate condom use to better protect themselves from HIV and other STI infection. Moreover, discussions of the female condom recurred throughout the discussion of women's roles as Haitian men argued that if it seemed impossible to negotiate the use of the male condom, women should utilize a female controlled method such as the female condom.

*Well, they always say women have all the power. They always say...and they do. They do have all the power. If a woman say I'm not having sex with you unless we use a condom, I bet she's gonna wear a condom. Now they might try to sweet talk her, but if she's strong...if she stand by her morals and tell him, "I'm not having sex unless you have a condom." he's definitely gonna wear a condom. Or he ain't gonna get none. So women definitely play the star role. The woman have all the power like they say. So women, I don't wanna say it's their...it's not their fault, but if every woman would be like, "We're not having sex unless we have a condom," there would be a lot less HIV cases out there. So, they definitely have all the power, they should definitely tell their partners to use condoms. Or actually, there's also a female condom, so they too can wear a condom. So if he don't...if he really, really don't wanna wear it, she can wear one and then be safe in that situation.*

Describing how he thinks women can better protect themselves, a 20-year-old participant stated:

*Well, I don't know, just saying they won't have sex without a condom. Or, I don't know, if they use the women condom.*

A 55-year-old, married participant, who admits to infidelity and dislikes the “unnatural” feeling of male condoms, believes that women should take responsibility for using condoms.

*I think they can do the same thing a man do, 'cause they have a woman condom. They can use them too. Probably better for them to use theirs, 'cause I don't use nothin'. That way I feel more reality.*

Using a biblical anecdote, a 22-year-old Haitian man implores women to be strong even though it is sometimes difficult not to succumb to men's persuasions.

*Well, females. Most females, even though they probably think...you know about HIV, but sometimes they like, "No, there is nothing. That ain't gonna happen." Giving them little soft words, you know guys. It's not far from females, but them little soft words like, "Yes, honey yes everything." They just do it like, yeah. For example, in the beginning Adam and Eve. Eve say "Try it." Adam says "Okay." That's it. Soft little words. It's so tempting. You just gotta like, you gotta be strong. Even though you have self-control, you just gotta learn to say no is no. It's hard. It's hard.*

Having admitted to inconsistent condom use, a 36-year-old Haitian participant fears that women may be voiceless within sexual relationships.

*In terms of using protection, they [women] play a very big role. I think they are at the forefront of this. If there's going to be any sexual transmission, sexual transmitted diseases, then, and if a condom is going to stop that or whatever else is available to stop that, then, you know, they are at the forefront to voice that. But I'm not sure if their voice may be heard. But hey, you have to put your foot down to be heard, you know? That's what I think. In the heat of the moment, you know, you might never know what's going to happen.*

The theme of women's empowerment and the need for women to exercise more power within sexual relationships continued to surface throughout the exploration of women's role in the HIV epidemic.



*I don't know if it's so much just black women or women in general definitely have, I guess, the power to make sure that the partners use protection. And so as much as the guy makes it, "Well, it doesn't feel the same. It doesn't this." But I think if black women would say, especially...I mean, even when you are married there are certain precautions you still have to take, but especially for those who are not married...I think regardless how good the relationship, make sure that the guy uses protection.*

Another emergent theme was women's promiscuity and self-degradation as factors that contribute to high HIV rates among black women.

*Well, I think women play a big role, but, I mean...Even with the black population, I mean, that's one thing I really want to do is to go out and talk to kids. Mostly young male, but even with the black population with females, I see a lot of females nowadays degrading themselves to a lower standard. And they're pretty much allow themselves to interact with people, just for nothing really, honestly. And especially with a lot of black females, they're looking for something, but they're looking for it in the wrong direction. So it's easy for a black female coming from not the norm now, just I'm basing what I've seen based on what I've observed coming from a single family home without a father figure at home. And they more so tend to have more than one partner and sleep with so and so, and do this and do that. And, I mean honestly, if the child doesn't have that type of foundation, education...aye, say don't be havin' sex with so-and-so. Aye, I mean, it's there, I mean, guys ain't gon' say no to it. And they gon' go in and take it especially if you don't say "use condoms." Aye, easier for them. So that's why it's a lot of the black females are getting those transmitted disease more, because of just a lack of information.*

Another participant stated,

*The same ways for the man, the same thing for the woman. If I go back to explaining the same thing I'm going to said. You met a man. You don't know who that man is, you cannot the same day you meet that man you already go in relation with that man. You don't know that man. You got little bit information about that man. At this time, depend you can go into relationship, but even too, you don't know that much, you use your protection. And tell him, okay, you have to!*

Some men believed that women who dress provocatively attract unwanted sexual attention to themselves. *The way they dress can lead the man to wanna have sexual intercourse with them.* A father of two daughters attributes high rates of HIV to the behavior and appearance of young women.

*First, I'm not gonna ask you to wear long dress, but at least wear decent clothes. Stay in school. Stay in school and listen to your parents!*

Relationship scripts from U.S.-born and Haitian-born men produced themes such as female financial independence and stability. However, within sexual relationships, women seem less likely to make condom-use decisions. Themes such as male control and female submissiveness emerged within discussions concerning condom use decision-making. Female endorsement of unprotected vaginal sex was also a common theme throughout the inquiry suggesting that while women may be financially independent, sexual decisions are largely made by their male partners. Men in this study also ascribe responsibility for condom use and safer sex behaviors to their female partners. Themes of female insecurity, lack of self-esteem, and low levels of female assertiveness and empowerment emerged as men described their perceptions of women's role in the HIV epidemic within the black community. Moreover, Haitian men identified the need for Haitian women to use female controlled protective methods.

*Phase II Results: Focus Groups among U.S.-born and Haitian-born Women*

Phase II of this inquiry was designed to explore black women's attitudes and perceptions about black men's sexual behaviors. Using focus group methods, the following objective was addressed: 1) to discover how black women conceptualize and perceive the socio-cultural, intrapersonal and behavioral factors that influence black

men's HIV-risk behaviors. This section presents of the demographic profile of the study population. While the original objective was to include a sample of Haitian women over the age of 30 years, the researcher experienced challenges recruiting this age group primarily because community contacts were engaged with the Haiti earthquake relief efforts. After making multiple attempts to organize a focus group with Haitian-born women over the age of 30, several women cancelled due to unexpected travel plans to Haiti, a result of the massive, catastrophic earthquake that hit the island of Haiti on January 12, 2010. However, 2 focus groups were conducted among younger Haitian women between the ages of 20 and 27 years. In the section below, the results of the content analysis of the qualitative data obtained from focus groups are presented by research question. As quotes are reported, they will be labeled with the age group and the ethnicity of the participant who offered the quote. The term *young* is used to refer to women ages 20-27 years and the term *older* refers to women ages 43-65 years.

#### *Demographic Information: Phase II*

A total of 23 black women who identified as heterosexual between the ages of 20 and 65 years of age ( $M = 35.3$ ,  $SD = 14.1$ ) participated in the study. All women who participated in the study identified as black or African American, 65% were U.S.-born and 35% were Haitian-born. Of the female study participants, 65.2% were never married, 43.5% had some college education, 60.9% reported a household income of under \$15,000 per year, and 52.2% were employed for wages. Detailed demographic data on educational, level, marital status, household income, race and ethnicity are presented in table 9 below.

Table 9: Demographic Characteristics of Female Sample (N=23)

| Demographic Characteristics                         | N  | Percent |
|-----------------------------------------------------|----|---------|
| Age (range 20-65 years)                             |    |         |
| 18-24 years                                         | 9  | 39.1%   |
| 25-44 years                                         | 6  | 35.9%   |
| 45-60 years                                         | 8  | 34.6%   |
| Marital Status                                      |    |         |
| Married                                             | 1  | 4.3%    |
| Divorced                                            | 1  | 4.3%    |
| Widowed                                             | 1  | 4.3%    |
| Separated                                           | 1  | 4.3%    |
| Never married                                       | 15 | 65.2%   |
| Member of unmarried couple                          | 4  | 17.4%   |
| Ethnicity                                           |    |         |
| Hispanic or Latino                                  | 0  | 0%      |
| Not Hispanic or Latino                              | 22 | 95.7%   |
| Missing                                             | 1  | 4.3%    |
| Race                                                |    |         |
| American Indian or Alaska Native                    | 0  | 0%      |
| Asian                                               | 0  | 0%      |
| Black or African American                           | 23 | 100%    |
| Native Hawaiian or other Pacific Islander           | 0  | 0%      |
| White                                               | 0  | 0%      |
| Educational Level                                   |    |         |
| Never attended school or only attended kindergarten | 0  | 0%      |
| 8 <sup>th</sup> grade or less                       | 0  | 0%      |
| 9 <sup>th</sup> to 11 <sup>th</sup> grade           | 3  | 13.0%   |
| High school graduate or GED                         | 4  | 17.4%   |
| Some college or technical school                    | 10 | 43.5%   |
| College graduate or higher degree                   | 6  | 26.1%   |
| Household Income                                    |    |         |
| Under \$15,000 per year                             | 14 | 60.9%   |
| \$15,000 - \$24,999 per year                        | 4  | 17.4%   |
| \$25,000 - \$34,999 per year                        | 4  | 17.4%   |
| \$35,000 - \$44,999 per year                        | 0  | 0%      |
| \$45,000 - \$59,999 per year                        | 1  | 4.3%    |
| \$60,000 - \$75,000 per year                        | 0  | 0%      |
| \$75,000 or more per year                           | 0  | 0%      |
| Employment Status                                   |    |         |
| Employed for wages                                  | 12 | 52.2%   |
| Self-employed                                       | 0  | 0%      |
| Out of work for more than 1 year                    | 0  | 0%      |
| Out of work for less than 1 year                    | 1  | 4.3%    |
| A homemaker                                         | 0  | 0%      |
| Student                                             | 3  | 13.1%   |
| Retired                                             | 1  | 4.3%    |
| Unable to work                                      | 6  | 26.1%   |
| Sexual Orientation                                  |    |         |

|                   |    |       |
|-------------------|----|-------|
| Heterosexual      | 21 | 91.3% |
| Bisexual          | 1  | 4.3%  |
| Homosexual or gay | 0  | 0%    |
| Other             | 1  | 4.3%  |
| Country of Birth  |    |       |
| United States     | 15 | 65.2  |
| Haiti             | 8  | 34.5  |

In phase II of the study, several themes emerged around HIV risk behaviors as well as cultural norms and gender norms that influence these behaviors. Table 10 below outlines the themes that emerged within focus group discussions with black heterosexual women.

Table 10: Emergent Themes: Phase II

| Domain of Inquiry: Intrapersonal Factors                           | Subgroups |              | Age (years) |
|--------------------------------------------------------------------|-----------|--------------|-------------|
|                                                                    | U.S.-born | Haitian-born |             |
| <b>Themes:</b>                                                     |           |              |             |
| <b>Sexual abuse histories among women</b>                          | Yes       | No           | 43-65       |
| <b>Depression in women</b>                                         | Yes       | No           | 18-65       |
| <b>Women's negative attitudes to condom use</b>                    | Yes       | Yes          | 18-65       |
| <b>Women desire pregnancy</b>                                      | Yes       | No           | 18-30       |
| <i>Domain of Inquiry: HIV Risk Behaviors</i>                       |           |              |             |
| <b>Themes:</b>                                                     |           |              |             |
| <b>Inconsistent condom use</b>                                     | Yes       | Yes          | 18-65       |
| <b>Level of trust determines condom use</b>                        | No        | Yes          | 18-30       |
| <b>Primary concern for contraception versus disease prevention</b> | No        | Yes          | 18-30       |
| <b>Discomfort with condoms</b>                                     | Yes       | No           | 43-65       |
| <b>Non-condom use equates to heightened emotional connection</b>   | No        | Yes          | 18-30       |
| <b>Condoms decrease sexual stimulation</b>                         | Yes       | Yes          | 18-65       |
| <i>Domain of Inquiry: Cultural Norms</i>                           |           |              |             |
| <b>Themes:</b>                                                     |           |              |             |
| <b>Sex-ratio imbalance</b>                                         | Yes       | No           | 18-65       |
| <b>Absence of father figure</b>                                    | Yes       | No           | 43-65       |
| <b>Lack of family communication</b>                                | Yes       | Yes          | 18-65       |
| <b>Parental emphasis on contraception</b>                          | Yes       | Yes          | 18-65       |
| <b>Negative influence of hip-hop</b>                               | Yes       | No           | 18-65       |
| <b>Role of voodoo</b>                                              | No        | Yes          | 18-30       |
| <i>Domain of Inquiry: Gender Norms</i>                             |           |              |             |
| <b>Themes:</b>                                                     |           |              |             |
| <b>Masculine ideologies</b>                                        | Yes       | No           | 18-65       |
| <b>Socialization of women</b>                                      | Yes       | No           | 43-65       |
| <b>Differential socialization of boys and girls</b>                | No        | Yes          | 18-30       |

*Question 5: What are black women's perceptions of the risk behaviors practiced by black men who identify as heterosexual?*

Findings of the inquiry reveal that U.S.-born and Haitian-born women perceive that black men practice unsafe sexual behaviors. Women confirmed that black men often reject condom use and practice partner concurrency. Women also identified their personal HIV risk behaviors, their aversion to condom use, and the influence of drugs and alcohol in their sexual decision-making.

*U.S.-born Women*

Women born in the United States identified lack of condom use and multiple sex partners as prevalent HIV-risk behaviors practiced by black men. Moreover, women confirmed men's assertions that black women often neglect to suggest condom use during sexual encounters. Themes around women's self esteem, self-confidence, and mental health issues emerged as barriers to condom use negotiation among black women.

*Condom Use.*

Confirming the findings from phase I of the study, U.S.-born women identified lack of condom use as one of the primary HIV-risk behaviors practiced by black men. In their discussions, women stated the most common explanations black male partners often provide for their negative attitudes toward condom use such as: 1) small condom size, 2) lack of sexual stimulation and; 3) the unnatural feeling derived from condoms. U.S.-born women shared the following comments as they discussed men's attitudes toward condoms.

*I mean I do hear that a lot in black men where they do say no I don't like the way it feels or it don't feel the same or it hurts, it's too tight and you're like yeah right but you know and yeah I mean my opinion about it I don't feel the same way. I agree that you should definitely protect yourself.*

(Young, U.S.-born woman)

*They [black men] don't like to use condoms. They really don't.*

(Older, U.S.-born woman)

*Well some say, they have so many stories. Some say the condom might not fit right or it don't feel they rather be natural. And they have some kind of issue.*

(Older, U.S.-born woman)

*I think some of this is mind over matter. So guys most of them they always say they are too small and it has to be a magnum or nothing.*

(Older, U.S.-born woman)

#### *Women and Condom Use.*

U.S.-born women voiced concerns about women's attitudes toward condom use and eagerly shared their own personal perceptions and hesitation to use condoms within their sexual experiences. An interesting finding in this inquiry is that while men have been identified as having negative condom use attitudes and behaviors, women also hold similar attitudes toward condom use. However, some of the reasons for non-endorsement of condom use among women are vastly different from those identified by the male study participants. While some women may not encourage their male partners to use condoms because they also desire the natural feeling derived from unprotected vaginal sex, others report feelings of low self-esteem, desire to "trap" a male partner through pregnancy, trusting a male partner, and vaginal discomfort associated with condom use. Commenting on women's desire to "feel the meat" or the natural penis, one participant noted:

*Well with some experiences I have been through, the woman will tell the man that she don't want him to use a condom. So he be um*



*surprised or skeptic about that because of the feeling they wanna feel the meat or whatever they call it.*

(Older, U.S.-born woman)

Other participants discussed the social, emotional, and mental processes that may inhibit women's motivation to negotiate condom use with their male sex partners.

*I think sometimes some women actually be going into the sexual act wantin' to get pregnant.*

(Older, U.S.-born woman)

*With my experience I know with a past relationship I had in which I felt like I didn't want to use a condom because I wanted to trap him in. I kinda wanted to trap him, I kinda wanted to get pregnant, I didn't want him to go anywhere. My self esteem was down, I was depressed and I was like OK if we don't use a condom I'll get pregnant or something like that and I wasn't thinking of the sexual partners or anything like that so I really didn't have a problem with it. He gave me the whole "Oh I don't like to use a condom and I was like no problem 'cause I didn't want to be that girl that said no to him and then he was going to leave me or something like that. And I was really depressed back then.*

(Young, U.S.-born woman)

*I have heard men say that a female did not want to use a condom and usually it's because of a situation like what 5 star stated about wanting to trap somebody or wanting to get pregnant whatever making sure that they have the connection with the guy for a long time so usually that's in the back of the female's mind one of the main reasons why they will tell the guy that it's ok to not use a condom.*

(Young, U.S.-born woman)

Similar to findings from the male interviews, condom use is less likely and deemed unnecessary if a woman trusts her male partner.

*Yes, I had an experience where I didn't use a condom with a guy but we was together for like 5 years. And we did take the time out and went to the clinic and got tested. It wasn't like I wanted to be pregnant 'cause I don't want any kids but you know 'pull out' method [laughter]. You know we did that and thank God I'm safe now and I don't know about him but I'm safe.*

(Young, U.S.-born woman)

Vaginal discomfort emerged as a concern especially among women between the ages of 45 and 60 years. Many asserted that condom use resulted in physiological discomfort that makes condoms less appealing.

*Well, you can tell the difference like when they use condoms and when they don't use them, your vagina feels kinda sore or like raw like. When they use the condom you get like dry is what I'm trying to say.*

(Older U.S.-born women)

*With the condoms with me it's very discomforting because it does dry out my vagina. But I use it for protection purposes and a lot of times I have no problem with the male partner using the condom being that its either the condom or nothing at all so I don't have a problem with it but yes it does affect my body and gives my body a dryness. It really does and sometimes it is uncomfortable.*

(Older, U.S-born woman)

Attitudes toward the female condom were explored and revealed negative attitudes and experiences with the female condom as well as misconceptions about its use. Women agreed that it is very difficult to insert the female condom.

*If you don't insert it correctly, you will feel a lot of discomfort. If you do not put them in correctly, it will be very uncomfortable for the female. If they are applied correctly no problem. But you have to almost get all the way down and put your leg all the way up to make sure it over that cervix to not have an irritated effect. I am speaking about my body. The female condom, that's out! And that part about you can use it for 8 hours, that's another thing. With this its just me speaking but there is no way in the world I'ma walk around with the same thing I have used for no 8 hours!*

(Older, U.S.-born woman)

*No it says you can wear it up to 8 hours before you have sex.*

(Older U.S.-born woman)

*It is obvious I misunderstood. I turned my brow I mean I had pure union on my face behind that foolishness. I'm like Oh no!*

(Older, U.S.-born woman)

Study findings reveal that U.S.-born women confirm that U.S.-born black men hold negative attitudes toward condom use and are therefore unlikely to use them during sexual intercourse. Factors that contribute to these attitudes include men's perceptions that condoms are too small and tight for their physique and condoms create an unnatural feeling during sexual intercourse. Findings also reveal that black women also hold negative attitudes toward condoms and identified important physiological, psychological and social factors that contribute to these attitudes.

*Multiple Sex Partners.*

U.S.-born women identified multiple sex partners as an HIV-risk behavior practiced by black men. Many women reported personal experiences whereby their male partners engaged in concurrent sexual relationships with multiple women.

*The guys that I have dated or been with, it wasn't just me so I may not have known that right then and there but it wasn't just me so thankfully I was smart enough to protect myself and use a condom.*  
(Young, U.S.-born woman)

*Yeah I agree too as far as, I mean at the beginning I don't think you are the only one as far as how I think men think. I feel they say let me just keep this one on the side and see how it go and play a little longer and see where it go and eventually once the relationship progresses then at that point then they may stop their ways or you once they see its real or serious or whatever, but I do think that at the beginning all black men are just like tagging you along, hanging you along, pulling your collar until they I guess see or learn about you I guess.*

(Young, U.S.-born woman)

*I feel the same way as well. All the relationships I have been in you really don't know at that moment if you the only one or not until alter on down the line. You might hear from somebody "I've seen him in town with somebody else". You might actually have caught him up with a girl number or somethin'. Not till recently did I actually find somebody that I know isn't with anybody else. Well I can't say for sure but in my mind for sure [laughter] I know who he come home to. And until myself this the first boyfriend I am*

*actually living with and we are around each other 24-7 I know that where he go I am there with him and I don't have a doubt in my mind there's nobody else. All of the prior relationships though I know it wasn't just me sometimes there was 3 or 4 but you know they are promiscuous at times.*

(Young, U.S.-born woman)

*Yeah. I had went with a man, had more than more one woman at a time. He safe with me and not safe with himself. I'm like "no baby I can't do you no more". I mean two three women. I come over there, women leaving out the door. Oh they just friends. Yeah right. Um hmm. Where do they get that?*

(Older, U.S.-born woman)

Women understood and recognized that their male partners have multiple sex partners, a phenomenon that was expressed by many of the female U.S.-born study participants. Results from question B below will address the important question of how women respond to male sex partner concurrency and the cultural and gender-related factors that may contribute to this risky behavior.

#### *Behavioral Health – Alcohol and Substance Use.*

U.S.-born women did not confirm their male counterparts' beliefs that alcohol and/or substance use prior to sexual intercourse does not inhibit their condom use decision-making. In fact, U.S.-born women reported that if intoxicated or high, their male partners are unlikely to think about safe sex behaviors such as condom use. Women also expressed their experiences with alcohol and drug use expressing that substance use impairs their personal judgment and negotiation skills.

*I have had sex intoxicated as well as my partner and to me it was..... great! Yeah you know it gives you more courage and you a little more bold and wanna try new things when you intoxicated. From a man's standpoint I can say that them being intoxicated they wanna lay back and see what you gon' do. I mean they have they liquid sex going on, their drink, and then they have you and you willing to try, well myself personally, but to me they don't be thinking otherwise but let me see what she's about to do, let me go*

*ahead and lay back so well I guess you lead the way with how you feelin' at the moment. When you intoxicated they run with it.*  
(Young, U.S.-born woman)

*I don't think it's a healthy decision. A lot of unplanned pregnancies occur through drugs and alcohol sex. In my personal experience being with someone who was intoxicated did not help the situation but being sober did not help the situation either...so I don't know if that's saying a lot. I don't support it. They might forget that condom when they drunk.*  
(Young, U.S.-born woman)

*It impairs your train of thought. Like driving a car, you ain't supposed to do it.*  
(Young, U.S.-born woman)

*You don't make good choices because you are not in control.*  
(Young, U.S.-born woman)

*And sometimes a woman may want it right then, not saying you in a rush but.....you in the motion and your head not level with the alcohol, you may try to jump into it so that's why I usually try to keep my condoms close so [inaudible]. But you know sometimes you with your loved one and sometime it's just like right there bam! Somebody jump out the shower, well hello, let me shut on up. Y'all know what I'm trying to say.*  
(Young, U.S.-born woman)

One participant shared her experience with alcohol, drug abuse and prostitution and her impaired abilities to negotiate safe sex.

*Well not only men but any human being it will compromise your decision making if you use alcohol or drugs before any type of activity whether its sexual or whatever because there is no rational thinking when you are under the influence. So yes it is a compromised state no matter what your gender. In my experience I been under the influence of alcohol and drugs making money it didn't matter to me what they did or how they did it except for I didn't do nothing in the butt. They told me no they didn't want to use no condom then no condom it was, but I was under the influence of drugs and alcohol and that makes a difference of course it does.*

Substance abuse is a major risk factor for the transmission of HIV and other STIs. Results of this inquiry show that unlike U.S.-born male participants, female participants, some with substance abuse histories, understand that substance use impairs judgment and increases the risk of having unprotected sex and multiple sex partners.

### *Haitian-born Women*

Confirming Haitian men's reports of negative attitudes toward condom use, Haitian women identified lack of condom use as a prevalent HIV-risk behavior among Haitian men. Contrary to the reports of Haitian men, Haitian women identified multiple sex partners as a behavioral choice of Haitian men. An interesting dynamic in this discussion, however, were female reports that infidelity among Haitian men is relatively common and while Haitian wives may be aware of their husbands' infidelity, they tend to tolerate the behavior in order to protect the integrity of their families. Similar to their U.S.-born female counterparts, Haitian-born women confirmed men's assertions that Haitian women often neglect to negotiate condom use during sexual encounters. Another factor that affects condom use among Haitian women is the focus on pregnancy prevention rather than disease prevention, a theme that also emerged in the U.S.-born scripts.

### *Condom Use.*

Most Haitian women expressed that within Haitian heterosexual relationships, condom use is often determined by the level of trust perceived by the partners involved. Once a certain level of trust is obtained, condoms are deemed unnecessary.

*...Once they get comfortable with the particular sex partner them they will stop using condoms.*

(Young Haitian woman)

Other women stated that men are suspicious of women who negotiate condom use, believing that women who suggest condom use are unfaithful.

*It's a trust thing with some of them. If you are in a monogamous relationship supposedly, then if you ask them to use a condom its kind like, "Why? Who you seeing on the side?" But a lot of times it's trust.*

(Young Haitian woman)

Confirming Haitian men's perceptions that condoms are unnatural, Haitian women indicated that they often hear from their male Haitian partners that condoms "don't feel right".

*I hear it doesn't feel right a lot.*

(Young Haitian woman)

#### *Women and Condom Use.*

Women's negative attitudes toward condom use emerged as a theme during discussions with young Haitian women (18-30 years). Similar to findings among U.S.-born women, Haitian women report that among women, condoms are sometimes perceived as a barrier to sexual spontaneity and decrease the pleasurable feeling during sexual intercourse. A new theme that emerged from Haitian scripts was that not using a condom signifies a strengthened bond in a sexual relationship. A young woman who continues to use condoms in her long-term relationship shared the reaction she gets from her female friends.

*I have heard from women, "Doesn't that take away from sex since you guys are together and there are no outside people, doesn't it take away from the spontaneity of when things happen?"*

(Young Haitian woman)

The concept of sex "feeling better" without condoms continued to emerge throughout the focus group discussions.

*It just feels better without one. Sometimes you don't want you're like in a monogamous relationship or you're seeing someone for a very long time once you actually do it once or twice without a condom it's really hard to want to go back to using condoms because it just feels so much better without one.*

(Young Haitian woman)

Haitian women also indicated that not using a condom solidifies the bond between sex partners and signifies a heightened level of trust and intimacy within a relationship.

*I think for most women it's a form of a bond like an intimate bond. For the women I know it's like you with this dude and you stop using a condom so it's not like you're gonna be seeing Bob and John and them, it's just strictly him so its kinda like a bond now and that's why most women probably don't want to use condoms because they feel more closer to their partner.*

(Young Haitian woman)

*It's like the trust has come into a relationship and now I trust you to be only with me and I am allowing us to have sex without a condom because I know that you are not going to do it with anybody else.*

(Young Haitian woman)

Haitian women are less concerned about disease prevention and more concerned about pregnancy prevention, a phenomenon that is based in cultural values and socialization. Pregnancy prior to marriage within the Haitian culture is seen as immoral, disgraceful, and reprehensible and is often punished by family rejection. Therefore, emphasis is placed on oral contraceptives rather than condom use.

*I think with Haitian women it's not so much getting a disease its getting pregnant and getting pregnant is like the worse of the worse. When dealing with Haitian men, they put the responsibility of birth control on the women so are you on the pill. Even in Haitian movies they will be like "mwenn menm ki sou an grenn" [I'm on the pill]. As long as a person is on the pill then they are fine they don't have to use a condom because getting pregnant is like the worst thing that you can do.*

(Young Haitian woman)



*I'm 24 and that's my biggest fear. I mean. Every day at 9 o'clock I take those birth control pills. I can't afford to get pregnant. I'm like if I get pregnant the first thing I think about is my father just saying "get out my house". And I'm his only child and I can picture my father just not talking to me and just saying "get out my face". And that is harder for me to imagine than the doctor saying "oh you have gonorrhoea". I don't care. For us [Haitians] it's shame.*

(Young Haitian woman)

Therefore, negative condom use behaviors exist among Haitian men and women. Condom use themes included concerns about the aesthetic feel of condoms, relationship trust as a barrier to condom use, abandonment of condoms signifies heightened intimacy, and concerns for pregnancy prevention such that oral contraceptives are emphasized rather than condom use.

#### *Multiple Sex Partners.*

Haitian-born women reported multiple sex partners as a common behavior among Haitian men. However, if married, Haitian men tend to remain with their families while engaging in extramarital affairs. Haitian wives often are aware of their husband's infidelity but tolerate their marriages for the sake of their families and to maintain their status in the Haitian community.

*Haitian men cheat too but I think the difference is when it comes to black Americans and Haitian men, Haitian men they won't ever throw it back in their wife's face. Haitian men will keep it more discrete. A woman knows, a woman is always going to know, but with Haitian men, they will still take care of home and that's the thing, as long as you take care of home you can have 6 baby mamas around my house, I don't care. Long as my family and I are taken care of.*

(Young Haitian woman)

*In the Haitian culture if you're married and you are with your Haitian guy or whatever I think somehow it is more accepted for the guy to cheat. It's not like, as long as everything is discrete, I mean I come from a product of a household in which both parties*

*cheated but remained together for 23 years as long as my father was taking care of home my mom did not have a problem with it. And my mom knew the lady and everybody else knew the lady. Haitians, what you see is not often what you get. 'Cause we were the perfect nuclear family, husband, wife, kids but behind closed doors it was something totally different. We always put on that front that we had everything together.*

(Young Haitian woman)

Demonstrating promiscuity among Haitian men, a young woman recalled the behavior of her uncle and exclaimed that she will not personally tolerate a partner who is unfaithful.

*I have an uncle he run around Haiti talkin' bout I can give you twins because he had an affair with one woman and gave her twins, had an affair with another woman gave her twins, gave my aunt two sets of twins so he's telling everybody he can give them twins. Why are you advertising that and you are married? He's been married to my aunt for 40 years now and they have 10 kids together and he has I think 16 kids altogether. And for me growing up I was just like I can never be one of those women. And when it comes to cheating I tell people all the time I despise cheaters, I cannot stand cheaters and even with me and my fear of commitment it's because if I'm with you I'm with you. If you cheat I have no problem leaving you. And I don't wanna go through that. I can't be another stigma.*

#### *Behavioral Health – Alcohol and Substance Use.*

Haitian-born and U.S.-born women held similar views about the influence of alcohol on men's sexual behavior. Haitian women reported that alcohol impairs their personal judgment and that of their male Haitian partners disabling them from even thinking about condom use.

*When you're drunk, not to the point where you pass out. When you're drunk to your limit, it does affect it. 'Cause you can't just say "oh, let me go ahead and get a condom". I myself have been in that situation where it does affect it. You don't think about the condom. It's like unless you on birth control, you've popped that pill that's about the only thing you'll be responsible for but as far as the condom it's like the last thing.*

(Young Haitian woman)

*'Cause you can be...even if you are tipsy. I mean I don't know about anybody else but when you are tipsy, drunk or buzzed, you are kinda in a mellow state. You are just chill; you relaxed, you not trying to do anything out of the ordinary. You just wanna be you. That's it, you just wanna chill. For a man to say yeah I can out on a condom maybe you are thinkin' about it subconsciously but I don't believe that. Because something as simple as walking in a straight line you can't do. Something as simple as talking right or um knowing where you parked your car or where your friends at, you can't focus on that but you can focus on taking a condom, open it up, put it on the right way.. no.*

(Young Haitian woman)

In sum, Haitian women identified several factors that increase risk for HIV transmission within the Haitian community: 1) negative attitudes toward condoms resulting in lack of condom use; 2) lack of concern and perceived susceptibility to HIV/STI transmission; 3) multiple sex partners and; 4) alcohol use. Negative condom use attitudes are held by both Haitian men and women as condoms are seen as aesthetically unappealing. Moreover, non-condom use signifies trust and monogamy in a sexual relationship. Women who negotiate condom use may be perceived to be disloyal thus discouraging women from discussing condom use. Of particular note is the finding that pregnancy prevention is the primary concern for most Haitian women thus negating concerns about HIV/STI prevention. These factors combine within the context of the socio-ecological environment to impact HIV risk within the Haitian community.

*Question 6: What are black women's perceptions of the gender and cultural norms that influence sexual behavior among black men who identify as heterosexual?*

The findings of this inquiry reveal that gender and cultural norms are important factors that influence sexual behaviors among black heterosexual couples. Several themes emerged that address women's perceptions of the gendered and cultural aspects of sexual behavior within black relationships. Specifically, U.S.-born women identified social,

cultural, and gender-related factors that contribute to risky sexual behaviors in black men and women: 1) masculine ideologies, 2) sex-ratio imbalance and lack of female empowerment, 3) socialization of women and girls, 4) sexual abuse and trauma histories; 5) lack of a male father figure in the lives of black girls and young women; 6) lack of family communication and dialogue about sexual issues and; 7) the negative influence of mainstream hip-hop culture. Haitian women-born identified: 1) lack of family communication, 2) differential socialization of girls and boys and; 3) the voodoo culture as important cultural and gender-related factors influence risk behaviors among Haitian men.

#### *U.S.-born Women*

##### *Masculine Ideologies.*

Themes of black masculine ideology emerged as a factor that influences partner concurrency in black men. Culturally driven definitions of masculinity influence male behaviors within gendered sexual relationships. As discussed by some women, men equate masculinity with having a high number of female sex partners.

*I don't think it has anything necessarily to do with the sex per se. Men from what I hear they enjoy having it but I think it's just to be able to say yeah man I hit this girl, I hit that girl whatever. It's just like a game for them. It's like they don't have anything else better to do.*

(Young, U.S.-born woman)

##### *Sex Ratio Imbalance/Lack of Female Empowerment.*

Women expressed feelings of helplessness to address their men's practice of having multiple partners because they feared losing their male companions. This fear is exacerbated by feelings that it is difficult to find a suitable black mate because of the sex

ratio imbalance that exists within the African American community which renders women powerless to negotiate safe behaviors within their relationships.

*I think because we outnumber men and men figures they can have as many women as they can.*

(Older, U.S.-born woman)

*Like I see it too, any woman that got a booty call from a man, they going at it. They ain't gon' let it pass by. They ain't gon' just gon' write that down, I'll do that tomorrow. They going right at it and talk to him.*

(Older, U.S.-born woman)

*You have some women that know they man doing it and let them do it so that's why they keep doing it.*

(Older, U.S.-born woman)

*We are [responsible]. 'Cause most of us say well if he gon' do it, let him do it. A lot of women know that their men have multiple sex partners but because they decide to have that man they just go on and settle for what they can get.*

(Older, U.S.-born woman)

#### *Socialization of Women and Girls.*

Women discussed the socialization of women and girls as a factor that contributes to women's inability to negotiate safe sex behaviors thus allowing men to continue to practice risky behaviors. The socialization of girls to be submissive and the "perfect woman or wife" is a socio-cultural norm that inhibits women's ability to address sexual behaviors with their male partners.

*I agree with her that because women are who we are, we settle for the man coming and going and we know they have other partners.*

(Older, U.S.-born woman)

*It has a lot to do with self esteem.*

(Older, U.S.-born woman)

*One time for me, I was with this guy for 13 years. He had multiple sex partners. But it was just something about him. It didn't matter to me. I just wanted to be with him. I was in love. It didn't matter*

*to me that he had someone else he was sleeping around with but you know I just wanted to be with him. It didn't matter. Yes, I really thought that I needed a man. I really thought that I needed a man to be me.*

(Older, U.S.-born woman)

*It is taught to us at a young age. As African American female human beings we are gonna be home. We are gonna be the perfect woman or wife or whatever, however you wanna voice it. And this is a taught behavior to us as females. And then once we get our own way of thinking or get our own bad experiences to where we have actually had enough and we actually are willing to change. 'Cause a lot of time we endure with it and we might not appreciate or like it. But until we get the strength or the wisdom or the will to change we continue on with it. But it is a behavior that is taught.*

(Older, U.S.-born woman)

#### *Sexual Abuse and Trauma Histories.*

Women with histories of childhood sexual abuse reported the impact of such abuse on their ability to successfully negotiate safe sex behaviors with their male partners. One participant who reported that she was unable to address her partner's risky sexual behaviors attributes her impaired negotiation skills to her history of childhood sexual abuse.

*Where mine comes from I feel like is because I was raped at 12 by my stepfather and I believe that where it [inability to negotiate safe sex behaviors] come from for me. I can't speak for no one else but I believe that's where it come from for me. Because after that I hated men. I hated just the thought of a man but um after years went by he was like the second guy I had been with so um... 'cause I was scared for a long time in my young days but I'm past that now. I think that's where mine comes from.*

(Older, U.S.-born woman)

She talks about her experiences of men always wanting to be in control within relationships.

*For me, men want to be the dominant one. They wanna be in control and if they're not in control, oh man, ain't nothing right.*

Another participant shared her experience growing up in a household with domestic violence. The abuse she observed had a crippling effect on her relationships in adulthood.

*For instance as I was growing up like you know [inaudible]. My father, he used to drink like on weekends and he used to work over at the hospital. My mother was not no drinking lady. She would go to work, come back home. But when my father come in and we were kids, he would like come home and argue at my mother and that would get me so upset and I would get into a little shake and nervousness. To bring down the commotion, that used to hurt me so bad but there was nothing I could do to my father because I was a child and he was overruling my mother and cussing and this that and the other. That really took a toll as I was growing up.*

(Older, U.S.-born woman)

#### *Lack of Male Father Figure.*

Other women reported the lack of a male father figure as an important factor in determining their levels of empowerment to address sexual issues with their male partners. Some women argued that the absence of a father led them to remain in relationships that put them at risk for HIV infection.

*I think that with Afro Americans that we come from homes that it's not both parents and we didn't have a father figure, someone that you can look up to and know that you are safe. We come from broken homes. It's just a cycle that goes on and on and you pass it to your children. It's just a curse that needs to be broken.*

(Older, U.S.-born woman)

One woman described the hurt she experienced by not knowing her father and her failed attempts to meet the man who helped create her. She admitted that she compensates for this lost relationship with her father by establishing sexual relationships with different men.

*I was, I'm like I didn't have a father, didn't know him. I knew his name, you know, I knew my grandparents' name. Never seen him. He never came in my life and my mama she was a strong woman but it's just I was missing my dad. You know, nothing could take that place of my dad. And I told her, when I came home I said*

*mama I said look I said there's one thing I wanna do before I leave this earth I need to see my dad. I got home, I said mama I want to see my dad and she said well we'll look for him. I seen his aunt, she was married to his uncle, and she said "girl I ain't seen you in a long time" and I said, "my mama got me traveling all over the United States". She said "you know your dad passed". I was like oh man no. Here I come home to look for my dad to find out now he's gone. I can't tell him the things I wanna tell him. I can't see his face. My mama always tell me "look in the mirror you'll see his face". I said "when I look in the mirror I see you, I don't see my dad. I don't know what he look like so I can't say that." I say "all I see is you". And she like "you still see your daddy". And I'm like "mom, you might see my dad but I don't 'cause you know what he look like. I don't.*

#### *Lack of Family Communication about Sexual Health.*

Similar to the findings from U.S.-born male interviews, focus group findings reveal that U.S.-born women in the study were denied sex education within the family structure. Due to high levels of religiosity and taboos against sexual activity, the primary messages women received from their families and mothers pertained to abstinence and "you better not get pregnant".

*...When I was younger my mother really really sheltered me a lot. She kept me away from everything. She said "no sex period". So of course there was no sex, but when that time comes nobody taught me, nobody informed me on what to do. Nobody told me what a condom was until actually high school is really when I um, junior or senior year. I didn't lose my virginity until actually I went off to college. So that whole time I was just like ok, just no sex. But I wish I was informed at an earlier age by being a female period even though my mother is very into the Lord you know what reality is and what's going on in civilization you know in public schools as well to especially what's going on down here in the South.*

*(Young, U.S.-born woman)*

*A discussion not so much. I can recall the whole birds and the bees talk when I was 9. It really wasn't a talk. My mom just gave me a book and was like here [laughter all]. As far as a discussion as I got older it was more like you better not get pregnant because my mother was a teenage mother and sex was the last thing on my mind as a child of a teenage mother. When I was 14 she took me to*



*the clinic to get birth control and I didn't even know, I don't even think I really fully understood what a penis was and where it went at the age of 14 because I was just a little girl, a kid at 14 years old. So it wasn't something that we sat down and talked about...*

(Young, U.S.-born woman)

*I was more afraid of my mom finding out that I had sex versus because she thinks the guy I was with for 5 years took my virginity, it was one before so I didn't never tell her that. I lost it at 16 but at age 14-15 my friends was telling me about it, "oh it's good" "oh it's that". But my mom always told me "your boyfriends is your books" so I was always afraid of my mom you know to go to her and tell her I wanna have sex, I'm thinking about having sex. And I didn't want to disappoint my dad.*

(Young, U.S.-born woman)

Older U.S.-born women (43-65 years) echoed similar views about the lack sex education within their families. When asked about the level and types of sex education they received within their homes they responded as shown below:

- *I had zero*
- *When I was in high school, through my health classes. That's how I really got my schooling, through my health classes*
- *I wasn't taught. My mom didn't teach us stuff like that. My mom was too religious.*
- *I was born in the 50's and then, they didn't talk about sex. We didn't talk about sex because you would get slapped in the mouth. That was a nasty word.*
- *My mother was always the religious type. We didn't know nothing about no sex or none of that. I learned that when I got older. The only reason I got on birth control was because of my cycle to regulate it. I don't like those pills at all because they made me sick anyway. The worst thing I coulda did was when I went to my mother and told her I might be pregnant. I should have never have said nothing. It was like I was the worstest child ever since. So I went to that rebellious state and started acting all out of control and everything you wanna call it in school. That's how you do though, if you can't talk to your own family, who can you talk to?*

*Influence of Hip-Hop Culture.*

Within the societal level of the socio-ecological context, women identified hip-hop as a cultural phenomenon that has a significant effect on male and female sexual behaviors. Women's perceptions about rap and hip-hop confirm the responses received in phase I of the study from male study participants. Similar to the men's accounts of the effect of mainstream hip-hop music and media, U.S.-born women perceive hip-hop to have a negative effect on the conceptualization of sexual behavior, definitions of masculinity, sexual expectations of women, and actual sexual behavior.

*It gives men a lot of ideas both men and women a lot of ideas to start makin' them do all kind of crazy stuff.*

(Older, U.S.-born woman)

Women expressed that they too were influenced by sexually demeaning and derogatory songs. The younger group of U.S.-born women made reference to popular hip-hop songs such as "Becky" that explicitly addresses women's role in oral sex.

*At first they promotin' oral sex and this and that but after a while it's repetitive and you start singing "that becky". I don't know if it's the beat but you know just like having all the repetitive...always playing, always on the radio, they got the video. But having it always out there at first you don't connect with until you constantly hear it and then you connect on kind of level.*

(Young, U.S.-born woman)

*I'm telling you 'cause when you hear it over and over it gets stuck in your head. If they hearing it they'll be living it like they do everything else.*

(Young, U.S.-born woman)

*I swore up and down that I hated that song "Girls around the world" and all of a sudden I was like [singing], "I'm a open up and something that....." and I'm singing along and I'm like oh my God am I really blasting this. Is somebody thinking like...I can't believe I'm singing it.*

(Young, U.S.-born woman)

U.S.-born women identified family, relational and community factors that influence sexual behavior within the U.S.-born black community. Factors such as masculine ideologies, male-to-female ratio imbalance, sexual abuse histories, socialization, absence of male father figures, deficiencies in family communications, and negative influence of the mainstream hip-hop music emerged as primary themes within the exploration of cultural and gender norms that influence sexual behavior.

### *Haitian-born Women*

Within focus groups with Haitian women, three major themes emerged in reference to gender and culture norms that influence male and female sexual behaviors: 1) lack of family communication about sexual health and risk behaviors; 2) cultural association of HIV/AIDS with voodoo and; 3) differential socialization of girls and boys.

#### *Lack of Family Communication about Sexual Health.*

Most Haitian women described Haitian culture as traditional and conservative. Therefore, Haitian parents do not discuss sexual health or behavior with their children. Issues such as condom use and HIV risk and protective behaviors are seldom discussed within the family environment.

*Haitians this is their mentality when their daughter get their first period it's "ok you have your period, you get pregnant, you get kicked out" End of the discussion. Now as far as the men go for my male cousins they didn't get talked to about sex ever.*

(Young, Haitian woman)

Noting that parents even opposed sex education in schools one participant took measures into her own hands to participate in sex education classes.

*I remember in middle school we had signed a consent form [for sex education] and I forged it because my mom was like no and my dad didn't want me to hear anything about it and I forged my mom's signature.*

(Young, Haitian woman)

*Like sex was taboo pretty much. If you ask about it [parent would ask, “why, are you having sex?” Tampons, you couldn’t use ‘cause you would be seen as not a virgin.*

Attempts to shelter children and especially Haitian girls from exposure to sexual activity prevented women from taking their daughters for gynecological care.

*You couldn’t go to the GYN because...and that’s another thing I had a lot of friends who were having sex and they needed to go to the gynecologist but you can’t. You can’t tell your mom I have to go to the gynecologist. [She would ask] “Why? You havin’ sex?”*

(Young Haitian woman)

Haitian women indicated that their male counterparts also did not receive sex education from their parents. Instead, they learned from siblings and peers.

*The Haitian males that I have dealt with... Not even their own fathers. Nothing. They didn’t learn about condoms unless they heard it from their big brothers, older cousins, or in school.*

(Young Haitian woman)

#### *The Role of Voudou.*

The role of voodoo in the conceptualization of HIV/AIDS emerged as a primary theme in the Haitian focus groups. Haitian-born women explained that Haitians held non-sexual, non-biomedical concepts of HIV transmission, often believing that HIV is caused by “someone putting voodoo on you”.

*...In the African American culture, HIV is associated with the down low brothers. With Haitians, HIV and AIDS are associated with voodoo. Somebody did something to you.*

(Young, Haitian woman)

*It’s not necessarily you’re having unprotected sex or you’re having sex with this person, that person. If you have what we call SIDA or AIDS you messed with somebody and someone is getting you back or someone put voodoo on you. They put something on you, it has nothing to do with sex it has something to do with voodoo.*

(Young, Haitian woman)

*You don't really have it [HIV], it's because of the voodoo. I can't tell you how many times I have heard the story especially for the Haitian women it a defense mechanism especially knowing that my husband has cheated on me, had unprotected sex with some woman and she burned him. I'd rather think that the lady got jealous and then gave him voodoo and just put the AIDS on him. And that's what they say, its voodoo. They don't even talk about that, they won't even talk about AIDS or anything in the church because, for what, it's not something that you get, it's someone sent it to you.*

(Young, Haitian woman)

*They openly talk about voodoo. Like for instance, my aunt, my mom's sister died a year ago and she died of AIDS and my mom knew it was AIDS. Like my immediate family knew it was of AIDS but the rest of people jus 'cause she was involved with a lot with different guys, 'cause she was the one of the five that wasn't really married or with anybody and she was just one of those free spirits supposedly, that's what they call it, and it was of AIDS. Like through the doctor and everything it was confirmed it was AIDS but everybody else just covered it up, "oh you know she was involved with too many people, it was something on her". And my mom knew it was AIDS but she continued to say, "oh they put something on her, she was involved too much with too many people" and stuff like that. They didn't acknowledge the fact that it was HIV.*

(Young, Haitian woman)

#### *Differential Socialization of Girls and Boys.*

A phenomenon that may not be entirely unique to the Haitian culture, differential socialization of girls and boys, emerged as a recurrent theme throughout discussions with young Haitian women. The women expressed cultural and gender-based attitudes whereby boys are expected to be sexually experienced while girls are expected to abstain until marriage. As such, male early sexual initiation is accepted and even expected within Haitian culture. As women explained, a sexually inexperienced man may be viewed being homosexual, a sexual behavior that is not accepted within the Haitian culture.

Women believe that these cultural attitudes influence risky sexual behaviors among Haitian men.

*If a girl doesn't have sex she is a good girl but if a man does not have sex oh he's gay. And I think a lot of cultures it's like that.*  
(Young, Haitian woman)

*They [men] are allowed to do whatever they want and so that mentality with sex when you think about it, it's like I do what I want, I can have sex at 14, 15. There's really no consequence of a mother finding out. 'Cause if a mother finds out her son is having sex...OK. A lot of my male cousins were having sex at 14, 15, 16 years old in the house. The mother will cuss the girl out and call her a whore instead of calling the son a whore and I'm like "what?" In my experience they are free to do what they want.*  
(Young, Haitian woman)

*My male cousins what can I say. I remember one day I walked into my cousin's house and he had condoms on public display just sitting right there and I'm sure his mom walks in and out of his room do laundry and his condoms were on public display and I think it was more for her, he is having sex and I really don't care as long as he doesn't get somebody pregnant.*  
(Young, Haitian woman)

Study results show that Haitian women believe that cultural and gender norms within the Haitian community influence sexual behaviors among heterosexual Haitian men. Of particular note are the issues identified by female Haitian study participants such as: 1) lack of family communication about sexual health and risk behaviors; 2) cultural association of HIV/AIDS with voodoo and; 3) differential socialization of girls and boys. These factors are engrained within the fabric of the Haitian culture and continue to persist even as HIV/AIDS becomes more prevalent within the Haitian community.

*Question 7: What are black women's perceptions of the ways in which black men's sexual behaviors affect their own health?*

Both Haitian-born and U.S.-born women demonstrated an understanding their health is directly affected by the sexual behaviors of their male sex partners. As discussed in previous sections, women identified several risk behaviors practiced by their partners such as multiple sex partners and lack of condom use. Women discussed the idea that these risk behaviors may have significant implications for their own health.

*I would say with Haitian men, not all but the majority or the one with the true Haitian mentality is again they don't, a lot of people don't know about condoms and so it's like I have this woman, this wife whatever and I'm not using protection with her but then I have this side piece and I'm not using protection with her and so forth and they don't think about that. Because the same thing goes back to us saying pregnancy, that's all they care about is not getting the mistress pregnant or if they do get the mistress pregnant having to pay for her baby and then for his family. But they don't even think about these other things because the mistress who is she sleeping with? You know, who is she having her own affair with and so forth? And I think that's where the problem lies because I think a lot of Haitian men are not aware of the diseases that are out there or they only know of HIV. That's all they know of. It's either pregnancy or HIV. But many of them and I think it's that whole stigma of women where we are supposed to be quiet and nonsexual beings so if you're having sex with a woman, she is not having sex with another man. And she is "clean", compared to the reality is she could be sleeping with three other guys and sleeping with you. So that's how I see it.*

(Young, Haitian woman)

Demonstrating the possible effects of risky sexual behavior, a young Haitian woman shared the experience of some of her friends.

*I know a lot of girls who get burned literally when they are in the monogamous relationship with their boyfriend and they go for their pap or whatever... "oh you have gonorrhea". "How did I get that?" And a lot of them feel like betrayed yet some women still will go back to that same partner and not use a condom so I would say some women just don't like using it period.*

U.S.-born women also identified some of the potential consequences of having a male partner who practices HIV-risk behaviors.

*There could be a lot of consequences. I mean STDs, HIV, pregnancy.*

(Young U.S.-born woman)

*Drama with the pregnancy. It's the grass is always greener until you get on that side.*

(Young U.S.-born woman)

Findings reveal that women have a good understanding of the manner in which men's sexual behaviors affect their own health. They perceive risk for HIV, STDs, and pregnancy as the major health and reproductive consequences for women.



## CHAPTER FIVE: DISCUSSION AND CONCLUSIONS

Chapter five is divided into four sections. Section I discusses the summary of the study results. Section II analyses findings within a theoretical context. Section III provides a synthesis of the research findings for the two phases of the study, and outlines the strengths and weaknesses of the inquiry. Section IV describes the implications of the research findings for public health education, practice and research and concludes with final comments.

### *Section I: Summary of Study Results*

In sum, study results reveal that intrapersonal, socio-ecological and behavioral health factors are critical within the holistic context of HIV-risk and protective behaviors among heterosexually identified U.S.-born and Haitian-born men and women. Comprised of in-depth interviews among U.S.-born and Haitian-born men, Phase I of the study explored knowledge, attitudes and beliefs about HIV, actual risk behaviors practiced by black men, and cultural and gender norms that influence sexual behavior. The findings of this inquiry show that while high levels of HIV knowledge, perceived severity, and perceived seriousness exist within U.S.-born and Haitian-born populations, they do not translate into safer sex behaviors. Theories of HIV conspiracy also play a key role in the conceptualization of HIV among U.S.-born and Haitian-born men.

Among U.S.-born men, findings reveal high-risk behaviors such multiple sex partners, lack of condom use, and substance use prior to sexual activity. U.S.-born men identified the following barriers to condom use: a) trust in a sexual partner; b) use of

alternate forms of birth control; c) perceived decrease in sexual pleasure; d) desire for sexual spontaneity and; e) unavailability of condoms during a sexual encounter.

Moreover, U.S.-born men did not perceive alcohol use prior to sexual intercourse to be inhibitive of their ability to think about and use condoms.

Among Haitian men, multiple sex partners and substance use were not commonly reported, however, lack of condom use was consistently reported as a preferred sexual behavior. Factors that presented barriers to condom use for Haitian men were: a) trust in a sexual partner; b) perceived faithfulness within a relationship; c) decreased sexual pleasure and; d) the “natural” feeling obtained without condoms. Moreover, both U.S.-born and Haitian-born men were less likely to use condoms if their female partners held negative attitudes to condom use.

Cultural and gender norms play a significant role in the adaptation of HIV protective behaviors. The results of this inquiry reveal that exosystem factors such as family and peer norms, and macrosystem factors such as hip-hop culture and cultural attitudes toward bisexuality and homosexuality present challenges to HIV prevention within the black community. Pertaining to gender roles, while women seem to be increasingly financially independent and share financial decision-making roles with their male partners, they are not likely to make condom use decisions or negotiate condom use within their sexual relationships. Both sub-groups reported low levels of family communication about sexual behavior often related to embarrassment and religious beliefs; a highly negative influence of hip-hop culture; and negative attitudes toward homosexuality and bisexuality which may lead black men to secretly engage in high-risk same-gender behaviors.

Conducted among U.S.-born and Haitian-born women, Phase II of the inquiry explored black women's, a) perceptions of the black men's HIV risk behaviors; b) perceptions of the gender and cultural norms that influence black men's sexual behaviors and; c) perceptions of the ways in which black men's sexual behaviors affect their own health. Focus group discussions among women confirmed the HIV risk behaviors reported by black men including multiple sex partners, lack of condom use, and substance use prior to sexual intercourse. Interestingly, women also described their personal aversion to condom use stating that condoms produced discomfort and were sexually unappealing. Some women reported a desire to "trap" their male partners by deliberately attempting to conceive.

Within focus groups with Haitian women, the emergent themes regarding gender and cultural norms that influence sexual behaviors were, lack of family communication about sexual health and risk behaviors; cultural association of HIV/AIDS with voodoo and; differential socialization of girls and boys. U.S.-born women identified family, relational and community factors that influence sexual behavior within the U.S.-born black community. Factors such as masculine ideologies, male-to-female ratio imbalance, sexual abuse histories, socialization, absence of male father figures, deficiencies in family communications, and the negative influence of hip-hop culture recurred as primary themes around cultural and gender norms. Finally, both U.S.-born and Haitian-born women perceived that black men's risky sexual behaviors may have detrimental effects on their physical and mental well-being.

## *Section II: Theoretical Analysis*

### *Analysis of the Study Results within the Context of the Socio-ecological Model of STD Risk and Protective Factors*

Results suggest that multiple factors interact to produce a context of HIV risk among black men and women. The socio-ecological model of STD risk and protective factors (illustrated in Chapter 2) offers a comprehensive framework within which the multisystem risk factors that contribute to the HIV epidemic in the African American and Haitian communities can be assessed. As this inquiry revealed, it is insufficient to analyze HIV risk behaviors within the context of intrapersonal factors alone, as social, ecological, cultural, gender and behavioral health factors are also key to understanding HIV risk behaviors.

#### *“I” or Microsystem Level.*

Within the innermost *I* sphere (microsystem) of the model, individual and psychological factors operate to influence behavior (DiClemente et al., 2005). To more closely assess intrapersonal level factors, tenets of the Health Belief Model were used. Study findings indicate that U.S.-born and Haitian-born men possess high levels of knowledge, perceived severity, and perceived seriousness about HIV and AIDS. In addition, both subgroups hold conspiracy beliefs about HIV and AIDS that might impact their receptivity to prevention messages and implementation of safer habits. Findings indicate that intrapersonal factors may not translate into safer sex behaviors as U.S.-born and Haitian-born men with high HIV/AIDS knowledge levels did not automatically demonstrate safer sex practices.

Further, some men in this study held negative attitudes to condom use which they attributed to: 1) the aesthetic feeling of condoms; 2) trust and faithfulness in a female

partner and; 3) lack of perceived susceptibility and heightened concerns for contraception. Very importantly, these findings emphasize the need to consider socio-ecological influences on sexual behavior. Among U.S.-born women, individual level experiences and personal factors such as childhood sexual abuse, trauma, and depression increased engagement in risky sexual behaviors. This finding highlights the need for specific strategies to address and alleviate the effects of these stressors in the lives of black women.

*Family and Relational or Mesosystem Level.*

The *family* sphere (mesosystem) refers to the familial influences on behaviors. Study findings show that family dynamics, structure, and support have important influences on sexual behavior. U.S.-born and Haitian-born men identified several familial factors that influence their sexual behaviors such as: 1) lack of family communication about sexual issues; 2) family pressure toward early sex initiation among men and; 3) failed relationships or bonding between fathers and sons. Female study participants reported similar family influences: 1) dearth of family dialogue about sexual behavior and; 2) lack of a male father figure. Similarly, the *relational* sphere (mesosystem) exerts influence on HIV and other STI risk. According to DiClemente et al. (2005), the relational sphere refers to partner communication about sexual issues. Findings reveal that men and women often find it difficult to discuss sexual history and disease status with their intimate partners. Voicing her inability to discuss sexual history with her male partners, one U.S.-born woman shared:

*As responsible as I claim to be and as I would like to think I am with my body I have never asked that question [sexual history and disease status]. I have wanted to because I get tested every year so...but it is such an uncomfortable question. But if I can be bold*

*enough to be having sex with somebody, I know that I have the right to ask them you know “who have you slept with?” But that is a difficult question to ask somebody.*

Combined with other risk factors such as inconsistent condom use, the lack of communication about sexual history introduces an additional level of potential risk among black heterosexual couples.

*Community/Peers or Exosystem Level.*

The next sphere of influence is the *community/peers* level and is synonymous with Bronfenbrenner’s (1979) exosystem. Within this level, factors such as the drug culture, condom availability, peers norms, high rates of STIs and social capital interact to influence sexual behavior. Study findings reveal that among U.S.-born and Haitian born men, peer norms and the drug and alcohol culture exert influences on their sexual behaviors.

*Societal or Macrosystem Level.*

The societal level includes the broader social and cultural values and beliefs that interact with the other spheres of influence. Based on the results of this inquiry, several societal factors affect sexual behaviors among the study participants. As reported by male study participants, critical influencing factors include: 1) media and hip-hop culture and; 2) cultural attitudes toward homosexuals and bisexuals such as homophobia. Among women, important macro-level factors include: 1) gender roles; 2) cultural differential socialization of girls and boys; 3) sex ratio imbalance in the black community; 4) hip-hop culture; 5) cultural defined masculine ideologies; 6) cultural association of HIV/AIDS and voodoo [reported by Haitian-born women].

### *Analysis of Study Results within the Context of the Theory of Gender and Power*

Used to examine the gendered relationships of black heterosexual couples, the theory of gender and power guided the assessment of gender roles within intimate relationships. Findings reveal that while women share in financial decision-making, they are unlikely to make decisions about condom use. Women's inability or hesitation to negotiate condom use may be grounded in social constructions of gender roles that socialize girls to be passive and boys to be sexually aggressive. Women are often taught to defer to men in the sexual decision-making process (El-Bassel et al., 2009). Moreover, the sex-ratio imbalance in the black community exacerbates power inequities between black men and women. Fearing neglect and abandonment by scarce black men, women may decide against condom negotiation and safer sex practices. In addition, knowing their high demand, black men may engage in high-risk behaviors such as multiple sex partners, exercising their power and control over black women's lack of partner options. These social constructions and gendered dynamics impact women's abilities to protect themselves from HIV.

In sum, the findings of this inquiry demonstrate the importance of socio-ecological influences on sexual behaviors. While intrapersonal factors are relevant, increased efforts must be made to continue to assess and address the multisystem context of risk that contributes to the HIV/AIDS epidemic in the black community. The socio-ecological framework provides a comprehensive approach within which HIV risk can be addressed. As shown by the study findings, multiple factors interact to produce an environment of risk. HIV prevention science and practice must therefore utilize multilevel approaches to address the HIV epidemic in the black community.

## *Section II: Synthesis of Research Findings*

Phase I of the study was designed to address the following research objectives: 1) To understand the intrapersonal factors (knowledge, attitudes and beliefs) that influence HIV-risk behaviors in subgroups of black men (U.S.-born and Haitian-born) who identify as heterosexual and; 2) To understand the socio-cultural and behavioral health factors that influence HIV risk behaviors in subgroups of black men (U.S.-born and Haitian-born) who identify as heterosexual.

Phase II of the study was designed to explore black women's attitudes and perceptions about black men's sexual behaviors. Using focus group methods, the following objective was assessed: To discover how black women conceptualize and perceive the socio-cultural, intrapersonal, and behavioral factors that influence black men's HIV-risk behaviors. Research findings are synthesized with the juxtaposition of the findings from Phases I and II relative to each topic assessed.

### *Knowledge, Attitudes and Beliefs about HIV/AIDS*

Study findings reveal that U.S.-born and Haitian-born men possess high levels of knowledge about HIV/AIDS. Overall, they are aware of the risk and protective factors associated with HIV transmission and are cognizant of the outcomes of HIV infection. Men identified HIV risk factors such as unprotected sex, injection drug use, multiple sex partners, lack of education, and homosexuality. Protective behaviors such as abstinence, condom use, open communication, monogamy and abstaining from injection drug use emerged in male-focused discussions. Tenets of the Health Belief Model (HBM) emerged in the sexual scripts of the male study participants as both U.S.-born and Haitian-born black men perceive HIV/AIDS to be a serious and severe disease that is ultimately fatal.



While this study did not assess all the constructs of the HBM, findings reveal that high levels of knowledge, perceived seriousness, and perceived severity did not translate into safer sex behaviors for black heterosexual men. In fact, findings show that male study participants practice risky sexual behaviors such as multiple sex partners and inconsistent or lack of condom use with 47% of U.S.-born men reporting multiple sex partners, 53% of U.S.-born men reporting inconsistent or no condom use and 86% of Haitian-born men reporting inconsistent or no condom use. While the high levels of HIV knowledge among the study population is not a surprising finding, it is discouraging to note that more 25 years after the HIV virus was first identified, high levels of risk behaviors are being practiced within the study population.

Male study participants also did not emphasize the importance of HIV testing. While HIV testing initiatives have been disseminated widely by the CDC and other national organizations, study participants may not perceive their susceptibility to HIV or may fear receiving a positive HIV status. As HIV prevention models move towards routine HIV testing in health care, these gaps in HIV testing awareness need to be addressed.

Study findings suggest that the HIV epidemic cannot be viewed as an individual-level phenomenon that can be addressed solely with individual-level interventions and programs. Rather, an ecological approach must be used to adequately address the multiple factors that interact to create an environment of risk.

### *Conspiracy Beliefs*

An exploration of men's beliefs about HIV/AIDS revealed high levels of conspiracy beliefs among the study population. These beliefs ranged along a continuum ranging from beliefs that HIV was created to control and ultimately destroy the black population, to beliefs that the federal government has developed a cure for HIV that is accessible only by the wealthy and is deliberately withheld from the poor black community. An important finding related to conspiracy beliefs is that these beliefs were not confined to men with low educational or literacy levels. Many of the participants who endorsed conspiracy beliefs had higher educational levels including college degrees. Interestingly, discussions with black women did not confirm these beliefs of conspiracy. In fact, black women rejected conspiracy beliefs indicating their surprise that black men believed these theories. This finding is consistent with previous studies that men exhibit stronger HIV conspiracy beliefs than women (Klonoff & Landrine 1999; Bogart & Thorburn, 2005). Further, men's conspiracy beliefs may be linked to more frequent experiences with racial discrimination and more recent experiences of racism (Klonoff & Landrine, 1999).

Black men's feelings of conspiracy are embedded within structural processes such as racism, discrimination, racial/ethnic oppression, and social control. HIV conspiracy beliefs may present unique challenges for HIV prevention efforts. Rooted in mistrust of the medical system, conspiracy beliefs may further manifest into distrust of HIV prevention and treatment information disseminated by the health care system. Further, individuals who endorse conspiracy beliefs may be suspicious of HIV prevention recommendations such as condom use (Bogart & Thorburn, 2005). HIV education and

prevention efforts must therefore consider these macrosystem factors that directly impact attitudes and beliefs about HIV. Gender-specific HIV prevention programs that discuss conspiracy beliefs are needed for heterosexual black men. These programs should be conducted by culturally competent black men and women to provide an open forum for the discussion of experiences of racial discrimination, distrust of the government, AIDS conspiracy and HIV prevention. Interventions such as “Nia”, a video-based, small group level intervention to educate African American men about HIV/AIDS can be utilized to address beliefs about AIDS conspiracy and the importance of safer sex within a culturally competent framework (Kalichman, Cherry & Browne-Sperling, 1999).

The inquiry found that among Haitian men, the historic labeling of Haitians as carriers of HIV is offensive. Haitian men expressed their discontent with the discrimination and stereotyping they have experienced over time. These attitudes must be considered within the context of HIV prevention targeted to the Haitian community, as feelings of recrimination may create barriers to acceptance of HIV prevention messages. Efforts must be made to bridge the divide between historic discrimination, mistrust of the health care system among Haitians, and current HIV prevention efforts. Interventions such as “Nia” (Kalichman et al., 1999) should be adapted and tested for cultural relevance for the Haitian male population. Therefore, gender-specific, culturally appropriate HIV prevention programs are needed within black subgroup communities to appropriately disseminate prevention messages.

#### *HIV Risk Behaviors among Black Men*

As previously noted, although male study participants portrayed high HIV/AIDS knowledge levels, perceived severity, and perceived seriousness of the disease, their

sexual behaviors were not reflective of knowledge levels. U.S.-born men reported risk taking behaviors such as multiple sex partners, lack of condom use or inconsistent condom use, and alcohol and substance use and abuse. Among Haitian men, lack of condom use or inconsistent condom use emerged as the primary risk taking behavior.

#### *Multiple Sex Partners.*

Sexual scripts of U.S.-born men revealed that intrapersonal and socio-psychological factors contribute to the practice of partner concurrency. Needing a sense of personal validation of manhood, men seek to engage in intimate relationships with multiple women. Multiple sex partners may also be a direct result of the sex-ratio imbalance in the black community as heterosexual men may take advantage of their high demand (Ferguson et al., 2006). U.S.-born and Haitian-born women confirmed that their personal experiences reflect partner concurrency within their sexual relationships. Haitian-born women also indicated that within the Haitian community, having multiple sex partners is a common behavior even within marital relationships. This behavior speaks to deeper cultural and societal influences that dictate definitions of manhood.

Traditional notions of masculinity may fuel partner concurrency as male behavior is traditionally defined by sexual assertiveness and multiple sex partners (Bowleg, 2004). The findings of this inquiry reveal that traditional masculine ideologies continue to dictate the sexual behaviors of black men. Men in this study, particularly U.S.-born men, validate their masculinity through risky sexual behaviors such as partner concurrency. Societal and cultural concepts of masculinity are macrosystem level factors that must be addressed within a structural context. To address definitions of masculinity, a shift in the thinking of acceptable male behavior versus female behavior is necessary. This

deconstruction of the definition of masculinity begins with the socialization of boys and girls by reinforcing the idea that sexual prowess is not a defining masculine quality.

These beliefs are rooted within the social fabric of our society and addressing these deep rooted beliefs will require a multifaceted approach that considers the ecological factors that play a role in the current ideologies of masculinity and femininity.

Interventions at the community level can begin to address these traditional notions of masculinity. Community-based implementation of interventions such as “Nia” described above (Kalichman et al., 1999) that target black heterosexual men are important. Adaptation of these programs should include key elements that address male perceptions and definitions of manhood. These interventions can begin to deconstruct current notions of masculinity by presenting alternative approaches to how sexual relationships are conceptualized by black men. Interventions must educate men to de-emphasize male sexual prowess and multiple sex partners. Deconstruction of traditional masculine ideologies must also occur within the family unit. Parents and guardians of black children and youth should be engaged in interventions that teach them how to educate their children and especially boys to devalue multiple sex partners and extensive sexual experience. Public health researchers and practitioners should build on interventions such as ImPACT (Informed Parents and Children Together) by focusing on parental education and activities that enhance parents’ abilities to discuss appropriate male and female sexual behaviors within the context of HIV prevention (Stanton et al., 2004).

### *Condom use.*

While consistent condom use continues to be the most effective HIV prevention method besides abstinence, the study found that inconsistent or no condom use is normative sexual behavior among some U.S.-born and Haitian-born black men who participated in the study. When condoms are used, pregnancy and disease prevention are the primary motivating factors. These findings are consistent with those of other studies that show low levels of condom use among heterosexual men (e.g. Bowleg, 2004; Flood, 2003; Harawa et al., 2006). Male study participants identified eight main themes in describing their non-use of condoms: 1) condoms are not immediately available at a sexual encounter; 2) perceived trust in a sexual partner deters condom use; 3) condoms make sexual intercourse less pleasurable; 4) use of alternate forms of birth control overrides condom use; 5) lack of sexual spontaneity with condoms; 6) women have negative attitudes to condom use; 7) condoms create an unnatural feeling during sexual intercourse and; 8) condoms are not endorsed by religious beliefs (Catholic religion).

Men reported that they are less likely to use condoms if they are not immediately available during a sexual encounter. While understanding the risk of having unprotected sex, men and their female partners are unable to postpone sexual intercourse if condoms are not readily available. While condoms were found to be affordable for the male study sample, men reported that they forget to carry condoms with them or do not think about condoms prior to sexual activity. These findings indicate that condom use may not be important within men's conceptualization of sexual intercourse. Seemingly, condoms are not considered until the point of vaginal penetration. HIV education efforts must continue to emphasize the importance of condom use as a key component of everyday life and

address the significance of men and women carrying condoms and strategically placing them in areas where sexual activity is likely.

Men reported that they are less likely to use condoms if they have developed a certain level of trust within their relationships. Study results reveal that men discontinue condom use with a regular or steady partner when they perceive that trust has been developed. Condom use is even equated to lack of trust and casual sex. Therefore, using condoms with a steady sex partner denotes infidelity and distrust, making condom use a negative practice within a perceived monogamous relationship. In addition, condom use is deterred by the use of alternate forms of birth control. Male study partners frequently referred to “the pill” indicating that if their partners used other forms of birth control, condoms are less likely to be used. An overarching theme was the emphasis placed on birth control rather than HIV and other STI prevention. While birth control is important, it seems to be the primary sexual concern for many black heterosexual couples, overriding concerns for HIV and other STI prevention.

Younger male study participants expressed concerns of fatherhood and the financial stress of procreation. However, the responsibility for birth control is placed on the female partner with expectations that she will take some form of contraception. Men expressed that if their partners took oral contraceptives or other forms of birth control such as the *Nuva Ring*, they were less likely to use condoms. HIV education and prevention efforts must address condom use within the context of contraception. Men and boys must be educated on the importance of male controlled forms of birth control to diminish dependence on female controlled methods. Just as female controlled methods of HIV and other STI protection are needed, male controlled methods of birth control such

as the male condom must be emphasized. The male condom is often marketed as primarily an HIV/STI prevention method and while this information is critical, condoms must be presented within the context of birth control among populations that emphasize contraception over HIV/STI prevention. The dialogue around condom use should emphasize not only its protective properties but also its contraceptive properties especially when used with other forms of birth control.

The theme of the aesthetic feeling of condoms emerged as an important barrier to condom use. Male participants expressed their perceptions that condoms detracted from the pleasurable feeling of vaginal sexual intercourse. Commenting on their preference to “go raw”, men indicated that condoms decrease penile sensitivity during sexual intercourse. This emphasis on penile pleasure is rooted within a larger social and cultural context whereby sexual intercourse is characterized by intense sexual pleasure for the male partner through vaginal penetration. Within the broader societal framework, female sexual pleasure is deemphasized, while male pleasure is the optimal goal of sexual intercourse. HIV prevention and education efforts must emphasize the importance of men appreciating less intense physical pleasure through vaginal intercourse and highlight the benefits of less penetrative sexual activities such as mutual protected masturbation and protected oral sex.

Haitian men echoed condom use concerns such as the unnatural feeling of condoms. Viewed as an artificial, foreign object, older (45-58 years) Haitian men especially were averse to condom use. In addition, older Haitian men did not advocate for condom use since their religious Catholic affiliation does not endorse the use of condoms. These findings indicate that culturally tailored approaches are needed to address Haitian



beliefs about condoms and sexual intercourse. Consideration must also be given to the religious beliefs among Haitians that may deter positive thinking about condoms.

Study findings demonstrate that men's condom use behaviors are largely determined by their female partner's attitudes toward condom use. An emerging theme throughout discussions of male condom use behavior was women's negative attitudes toward condom use. Men frequently reported that their female partners objected to condom use thus creating an additional barrier to protected sexual intercourse. According to male study participants, women fail to negotiate condom use and even encourage their partners not to use condoms. Men perceive that these condom use attitudes in female partners are rooted in desires for pregnancy, an event that may create a more permanent bond with their male partners. Men also asserted that women did not support condom use and often complained that "*It don't give you the same feelin*".

Focus groups among Haitian-born and U.S.-born women confirmed men's scripts regarding women's attitudes toward condoms. Themes regarding women's negative attitudes to condom use included: 1) condoms created physiological or vaginal discomfort; 2) low self-esteem and depression resulting in women's inability to negotiate condom use; 3) desires for pregnancy and; 4) trust in a male partner. Findings reveal that women's attitudes toward condom use must be addressed within an ecological framework that considers the social, psychological, structural and biomedical factors that might produce these negative attitudes. HIV education efforts among women must highlight methods of making condom use less discomfoting. Emphasis must be placed on the use of water-based lubricants to minimize vaginal discomfort during sexual intercourse. HIV prevention models must also consider macrosystem factors such as unemployment,

discrimination and other chronic stressors that may lead to depression and low self-esteem among women. Interventions such as “Sister to Sister” and “The Sista Project” that teach negotiation and refusal skills, enhance self-worth, and build communication and sexual assertiveness skills among African American women are important to address the HIV risk behaviors practiced within black heterosexual relationships (DiClemente & Wingood, 1995; Jemmott, Jemmott & O’Leary, 2007). Adaptation and implementation of similar interventions for Haitian women are necessary to address attitudes to condom use that inhibit safer sex behaviors.

In addition, condom negotiation and safer sex must be taught within the context of the male-female relationship dynamic. Historically, the onus has been placed on women to negotiate the use of a male controlled prevention method. This approach must be revisited and couples-based HIV prevention must be emphasized with men and women being held responsible for safer sex behaviors. Interventions such as RAPP (Real AIDS Prevention Project) that target heterosexual women and their partners should be adapted more broadly in black communities to increase consistent use of condoms. Key elements of RAPP include community engagement, peer outreach, one-on-one safer sex discussions, safer sex gatherings, HIV prevention presentations, and role model stories (Lauby, Smith, Stark, Person, & Adams, 2000). These approaches should be adopted to engage men, women and communities in taking responsibility for safer sex behaviors.

The study also revealed that black women are threatened by the gender sex-ratio imbalance within the black population and feelings that it is necessary to “trap” a man or attempt to solidify a sexual relationship through pregnancy. Women therefore often oppose condom use because of their desire to conceive. Considering this gender

imbalance, women are more likely to adhere to men's sexual preferences and less likely to negotiate condom use fearing rejection by their male partner. As one study participant stated, she did not want to be "*that girl that said no to him and then he was going to leave*".

Within stable or long-term relationships, condoms are viewed as a symbol of infidelity or sexual activity outside the relationship. Men who attempt to use condoms are questioned about their fidelity. Likewise, women who suggest condom use are seen as distrusting or are suspected of sexual promiscuity. This link between condom use and fidelity creates a major barrier to condom use within heterosexual relationships. Couples-based interventions such as CONNECT, a couple-level intervention for heterosexual couples (El-Bassel et al., 2003) are needed to unravel the misconception that condoms equal distrust. Like CONNECT, interventions must teach couples the skills to enhance communication, condom negotiation, solve problems, identify risk behaviors and commit to change behaviors to enhance safer sex. HIV prevention efforts must also emphasize the need to continue to use condoms even within perceived long-term relationships. Since men in this inquiry report partner concurrency and low condom use, persistent condom use must be encouraged within casual as well as regular or steady sexual relationships. In addition, instead of focusing primarily on women, men who have sex with men, or gay populations, prevention efforts must also target heterosexual men as a group and hold them accountable for safer sex practices.

### *Behavioral Health*

This study explored the influence of alcohol and substance use and abuse on HIV risk behaviors in U.S.-born and Haitian-born heterosexual relationships. Findings reveal

that younger black men especially, do not perceive mental or physical impairments caused by intoxication and substance use. Male study participants younger than 45 years of age perceived that their cognitive and behavioral skills relative to condom use are unaffected by alcohol and/or substance use prior to sexual intercourse. These perceptions contradict the findings of research reports and studies that have found that alcohol and drugs inhibit cognitive and behavioral skills related to safer sex (Cederbaum et al., 2006; Meade, 2006; National Institute on Drug Abuse (NIDA), 2006; U.S. Department of Health and Human Services, 2008). However, more mature U.S.-born men between the ages of 45-60 years related experiences whereby alcohol and drug use significantly altered their judgment, inhibition, and behavioral skills, and in some instances resulted in negative outcomes such as HIV infection. Additionally, Haitian-born and U.S.-born women acknowledge that alcohol and substance use impairs their own safe sex abilities and that of their male partners. Women reported that their partners are unable to think about condoms let alone properly use a condom while intoxicated or high. These findings reveal the need for continued and enhanced education on the relationship between substance use and high risk sexual behaviors especially targeted to younger black heterosexual men.

### *Cultural Norms*

From a cultural perspective, several themes emerged as male study participants discussed macrosystem factors that influence their sexual behaviors: 1) family attitudes toward sexual health communication; 2) peer norms; 3) hip-hop culture and; 4) cultural attitudes toward homosexuality and bisexuality.

*Family Attitudes toward Sexual Health Communication.*

A critical finding was the dearth of sexual health communication within the family structure. Overwhelmingly, U.S.-born and Haitian-born men and women expressed that their families failed to discuss sexual behavior, condom use, or sexual health. For most study participants, sex education was largely acquired through venues external to the family such as schools, the media, and peers. Any family or parental sex communication centered on abstinence and warnings against pregnancy. Parents who participated in the study were asked to discuss the extent to which they addressed sexual behaviors with their children. These discussions confirmed that there are several barriers to parental communication about sexual issues. Parents admitted to being embarrassed to discuss sex with their children and therefore relied on schools and teachers to teach their children about sex. In addition, highly conservative and religious beliefs prevented parents from providing comprehensive sex education. Children are therefore open to receiving sex education from sources that may or may not be reliable. Interestingly however, despite religious and conservative beliefs, this study found that family members encourage their male adolescents to be sexually experienced. This advice seems to counter conservative religious beliefs that prohibit sex outside of the marriage. These gaps and inconsistencies in family communication have significant implications for HIV prevention and education efforts. Approaches are needed to build parental skills and enhance their confidence and self-efficacy to discuss sexual behavior. Interventions should also teach parents the importance of communicating consistent messages to their children rather than endorsing conservative behaviors while also encouraging sexual experience in male adolescents. As discussed above, interventions such as ImPACT that

emphasize building parental skills such as parental monitoring and effective communication can be helpful in addressing the lack of family dialogue about sexual health (Stanton, 2004). As one Haitian-born male study participant suggested, an open forum with children and parents may initiate the dialogue within families.

*I think some kind of forum or some kind of training that needs to really take place where parents and their kids can actually come to. I think the same thing with the health fair that takes place, so something I would say almost similar where you could have, depending on the amount of people who register, well you have this group, you have ten parents and yeah, with their kids in one session and so forth where they can really sit. 'Cause then it will make the parents who are uncomfortable to discuss it have someone else discuss it then ask some questions and then have the kids ask questions. And so it kinda make the pathway much easier for them.*

The importance of family communication on sexual health is even more critical with the existence of abstinence-only or abstinence until marriage education in schools and other entities that interface with children, teenagers and young adults. Abstinence is effective in preventing HIV and other STIs and should be taught as a component of comprehensive sex education. While abstinence is a healthy sexual option for teens and young adults, in reality, abstinence is not largely practiced within the American society (Santelli et al., 2006). Therefore, abstinence-only programs are deficient because they do not offer safer sex alternatives for individuals who choose to be sexually active. In their study among 7<sup>th</sup> and 8<sup>th</sup> graders, Sather & Zinn (2002) found that abstinence-only education did not significantly change adolescents' values and attitudes about premarital sex or their intentions to engage in premarital sexual activity. In its position paper on abstinence-only education policies and programs, the Society for Adolescent Medicine supports comprehensive sex education that includes abstinence, correct and consistent

condom use, and contraception among adolescents who are sexually active (Santelli, Ott, Lyon, Rogers & Summers, 2006).

Comprehensive education on sexual health should be provided within the family unit as well as in schools. Public health professionals must continue to work with policymakers and advocate for legislative changes that repeal abstinence-only education laws and requirements. Strategic approaches and community advocacy as adopted by The California Wellness Foundation will be key to effecting policy changes. In California, the passage of the Comprehensive Sexual Health and HIV/AIDS Prevention Education Act was made possible by building capacity with community based organizations to advocate for effective teen pregnancy prevention policies (Brindis, Geierstanger & Faxio, 2009). In Florida, similar approaches are necessary to initiate long-term changes in abstinence-only education legislation.

#### *Hip-Hop Culture.*

Operating within the macrosystem, study findings reveal that mainstream hip-hop music negatively influences men's sexual behaviors and their perceptions of women. The study indicates that black masculine ideologies are directly influenced by the media and especially by hip-hop culture. The negative images and stereotypes portrayed within this musical genre often promote promiscuity, profanity, and objectification of women. Female study participants also acknowledged that hip-hop lyrics and graphical images affect their personal self images and concepts of womanhood. Often, women aspire to emulate the images of women who are portrayed within rap videos as "video vixens" and are seen as the ultimate woman who is able to keep and sustain relationships with men.

HIV education and prevention efforts must consider the strong influence of hip-hop and make better attempts to collaborate with the music industry to communicate HIV prevention messages. Efforts such as the “wrap-it-up” campaign on Black Entertainment Television (BET) have fueled some awareness, however, broader, collaborative HIV education and awareness efforts are needed. Male and female study participants suggested that public health practitioners work directly with hip-hop moguls and artists such as Jay-Z, Trey Songz, and Lil’ Wayne to enhance HIV awareness. Since hip-hop artists are viewed as role models especially among the adolescent and younger populations, the public health community must engage musicians and rappers in serious dialogue about the images and lifestyles portrayed by the lyrics and music videos that influence sexual behaviors, ideologies, and self-concepts among black men and women. Hip-hop is an underutilized vehicle for widespread HIV education and awareness. The public health community must take the first step to bridge the divide between HIV prevention messages and the negative sexual influence of the hip-hop culture.

*Cultural Attitudes toward Homosexuality and Bisexuality.*

Findings of this inquiry demonstrate that homophobic attitudes persist within the U.S.-born and Haitian-born black communities. Rooted within black culture and history are definitions of manhood that dictate heterosexuality. Findings from this inquiry show that within the study population, homosexuality is stigmatized and viewed as sinful and unnatural. In addition, homosexuality is seen as contrary to Black masculine ideologies as homosexuals are seen as effeminate and weak. These perceptions of homosexuality may result in fear and reluctance of Black gay or bisexual men to identify as homosexual and secretly engage in risky sexual behaviors with men.



As confirmed by the findings of this study, homosexuals and bisexuals are blamed for the HIV epidemic. Therefore, it is not surprising to learn that men expressed homophobia and a culture of violence toward homosexual and bisexual men. These attitudes are exacerbated by high levels of religiosity within the black community whereby homosexuality and bisexuality are not tolerated and viewed as sinful. These negative and sometimes violent attitudes deter African American and Haitian men who have sex with men (MSM) and men who have sex with men and women (MSM/W) from disclosing their sexuality, encourage secretive same-sex encounters, and prevent them from seeking HIV prevention services and care. Although the researcher probed male participants about their experiences with bisexuality or the “down low” participants tended to share their disgust towards the behavior but did not identify with or connect with bisexuality. This distancing of self from bisexuality may result from stigmatizing and negative attitudes to bisexuality and homosexuality within the black community.

Therefore, effective HIV prevention strategies will require understanding the experiences of black MSM and MSM/W within the context of African American and Haitian history and culture that ascribe specific definitions of manhood. Interventions need to address structural and socio-cultural factors that create barriers to HIV prevention including an emphasis on the violent attitudes portrayed toward MSM and MSM/W. First, community-based interventions such as RAPP (Real AIDS Prevention Project) are needed on a broader level to address community attitudes to homosexuality and bisexuality (Lauby et al., 2000). A key element of RAPP is community engagement to change community norms that may facilitate risky sexual behaviors. Using similar approaches, interventions should target community individuals with educational

messages that discourage violent and stigmatizing attitudes toward homosexual and bisexual men. Second, interventions that target heterosexual men such as “Nia” described above (Kalichman et al., 1999) should address their feelings toward homosexuality and bisexuality and discuss the implications of negative community attitudes for increased sexual secrecy and HIV transmission within the black community. In addition, these interventions should be adapted for the Haitian community as Haitian men in the study portrayed feelings of violence toward homosexuals and bisexuals.

### *Peer Norms*

Peer norms also play a significant role in men’s conceptualization of HIV risk and protective behaviors. Operating within the exosystem or the community/peers sphere of the socio-ecological model of STD risk and protective factors, peers can exert important influences on sexual behavior (DiClemente et al., 2005). Themes regarding peer norms involved risky sexual behaviors such as multiple sex partners and inconsistent condom use. These peer norms may place black men and women at risk for HIV/AIDS and make it challenging for them to implement protective sexual behaviors. Studies have found that individuals who are not constrained by social and peers norms are likely to engage in HIV protective behaviors (Dancy & Berbaum, 2005). Therefore, HIV prevention efforts should not focus primarily on individual-level factors to promote behavior change. For optimal effectiveness, interventions must also focus on the social and peer norms that influence sexual behaviors within the black community.

### *Gender Norms and HIV Risk*

Study findings indicate that gender norms shape the environment of HIV risk and protective behaviors within heterosexual relationships. As shown in previous applications

of the theory of gender and power to safer sex behaviors (Wingood and DiClemente, 1998), power imbalances and gender inequalities often black women's decisions regarding condom use negotiation. As shown in this inquiry, women are largely financially independent and are mutual partners in making financial decisions, but take minimal control over sexual decision-making. While financial independence among women has been linked to increased likelihood to effectively negotiate condom use (Pulerwitz et al., 2002; Whyte, 2005; El-Bassel, Caldeira, Ruglass & Gilbert, 2009), the results of this inquiry contradicts this link. In fact, men who reported having financially independent female partners also reported inconsistent condom use and mutual agreement against using condoms. Condom-use decisions are driven by male partners who may have negative attitudes to condom use. Results suggest that gender norms such as female submissiveness and a desire to cater to their partners' preferences may contribute to risky sexual behaviors within black heterosexual relationships. Likewise, women's hesitation to negotiate condom use may also be driven by their own negative condom use attitudes which give men even less motivation to use condoms. Women's attitudes to condom use must be viewed within a broader socio-cultural and structural context that ascribe women to inferior roles and affect female self-protective behaviors. One such structural phenomenon is the gender ratio imbalance in the black community.

### *Sex Ratio Imbalance*

Among focus group discussions with U.S.-born women, themes regarding sex ratio imbalances emerged as a factor that diminishes women's power and abilities to negotiate safer sex practices. As shown in previous studies (Ferguson et al., 2006; El-Bassel et al., 2009), the consequences of this sex ratio imbalance is men having

concurrent female sex partners and women adhering to men's condom use preferences. This inquiry found that women who perceived a shortage of eligible mates were more likely to tolerate male promiscuity and more likely to report attempts to conceive in order to "trap" their mate. In addition, women are less likely to insist on condom use fearing rejection and abandonment by a male sexual partner. The sex ratio imbalance creates a complex environment within which to address safer sex behaviors. HIV prevention approaches must address the link between this imbalance and women's often unspoken fear of losing their sexual partners. HIV prevention and intervention programs must incorporate counseling that discusses healthy relationship-seeking and self-esteem building. Interventions such as "The Sista Project" and "Sister to Sister" that emphasize pride, self-worth, negotiation skills and assertive communication skills need to be utilized on a broader level (DiClemente & Wingood, 1995; Jemmott et al., 2007). These interventions must also be adapted and tested within the Haitian community. To address gender imbalances, open dialogue must also be initiated about this topic in which the community (men and women) is engaged in developing solutions to this growing problem.

#### *Childhood Sexual Abuse and Trauma Histories*

Sexual abuse and trauma histories emerged as primary themes in discussions of cultural and gender-related factors that influence sexual behaviors. U.S.-born women revealed histories of childhood sexual abuse, childhood exposure to parental domestic violence, and sexual coercion. Women also noted that the absence of a positive male role model and father figure in their lives contributed to their limited abilities to communicate effectively with their male partners. These experiences often diminish women's abilities

to negotiate safer sex because of fear of victimization and male-perpetrated abuse. These findings have significant implications for behavioral health care and mental health counseling. Health care providers should be aware of the prevalence of childhood sexual abuse among female patients and offer referrals for mental health counseling and treatment.

HIV prevention programs must also consider women's sexual abuse histories and facilitate linkages to mental health resources. Research findings indicate that intrapersonal approaches to HIV prevention are inadequate. HIV prevention must be conducted in consideration of social ecological models that incorporate structural, cultural and gender-related factors. Conceptual models such as the Sexual Health Model (Wyatt, 2009) can be used to inform the development of interventions that incorporate cultural and historic aspects of the African American culture. As Wyatt proposes, interventions should consider key concepts such as interconnectedness, sexual ownership, and body awareness. Likewise, interventions such as the Enhanced Sexual Health Intervention (Wyatt et al, 2004) that focus on the impact of sexual histories on current cognitive and behavioral patterns within a culturally competent framework are necessary to address childhood sexual abuse and trauma histories in black women.

#### *Influence of Religion*

A significant finding is the effect of voodoo on the conceptualization of HIV transmission within the Haitian community. While Haitian men portrayed relatively high levels of knowledge about HIV transmission, Haitian women revealed that voodoo continues to influence beliefs and practices around HIV communication, prevention and care. According to Haitian-born female study participants, Haitians hold non-sexual, non-

biomedical concepts of HIV transmission that are rooted in beliefs that HIV is a product of witchcraft which is assigned as a curse on the infected individual. Addressing these culturally embedded beliefs presents unique challenges to the public health community. However, efforts must be made to address mythical beliefs within the context of Haitian culture. These approaches will require the use of culturally competent models and gaining trust within the Haitian community. With younger generations that have been implanted in the United States, educational efforts must begin early in an attempt to supersede the misconceptions that may be taught within the family structure.

Likewise, older Haitian men (45-58 years) described the condom inhibitive effect of their Catholic beliefs. In a 2009 speech in Cameroon, Pope Benedict XVI was quoted as saying “condoms are not the answer to Africa’s fight against HIV” (MSNBC, 2009). Ascribing to similar beliefs, Haitian male study participants expressed their beliefs that condoms should not be used during sexual intercourse. Despite these religious beliefs, public health educational efforts must continue to target Haitian men with HIV prevention and condom use messages. Community-based approaches may be most efficient in reaching this community. Collaboration with churches, local social events, sporting events, and community venues frequented by Haitian men is key to effectively reaching this population with HIV education programs.

### *Structural Factors*

Coupled with the factors discussed above are the structural factors that influence HIV transmission in the black community. Many of the factors previously discussed such as the sex ratio imbalance, sexual abuse and even the hip-hop culture are the direct result of structural factors such as the disproportionate incarceration of black men, residential

segregation, gang subculture, lack of access to adequate health care services, urban deprivation, economic disadvantage, harsh drug possession laws that target black men for imprisonment, racism and discrimination (Lane et al., 2004; Rhodes, Singer, Bourgois, Friedman & Strathdee, 2005). These risk factors do not exist on the intrapersonal level but rather create an environment of risk that requires structural and political interventions. State and national policies such as the Affordable Care Act which became law on March 23, 2010 are needed to provide better access to health care services in poor, underserved communities (U.S. Dept. of Health and Human Services, 2010). In addition, the criminal justice and public health systems must work together to develop solutions to the disproportionate incarceration rates of black men and the resultant effects on the HIV epidemic.

In addition to policy changes, structural interventions that incorporate community-based approaches to reducing HIV disparities will be necessary to curb the HIV epidemic in the black community. Interventions that build social capital and emphasize interconnectedness, family cohesiveness and social networks may offer a structural approach to rebuild minority communities. Fullilove, Green & Fullilove (2000) propose structural interventions such as the “Family to Family” program that strengthen family functioning, encourage neighborhood building, and connect children to adults in their community through weekly family gatherings where family members pray, dine together, play games and focus on the children in the community. This approach may offer a feasible model to alter the social environment of communities that have been destroyed by epidemics of violence, drugs and HIV/AIDS.

## *Strengths and Limitations of the Study*

### *Study Limitations*

First, the findings of this inquiry are based on self-reported data from study participants. Results are based on participants' perceptions, recall and interpretation of their lived experiences. Although this is a potential weakness of the study, qualitative methods assume subjectivity as a part of the understanding of the human reality. Within the naturalistic paradigm, subjectivity is a major characteristic whereby meanings are constructed based on personal realities (Lincoln and Guba, 1985). To minimize the limitations of self-reported data, the researcher developed rapport with each participant to enhance levels of trust.

Second, nonprobability sampling techniques such as convenience and snowball sampling were utilized during the recruitment phase of this study. While random sampling methods are appropriate for quantitative studies, nonrandom samples are most appropriate for qualitative inquiry as sampled cases are selected based on their relevance to the research topic and ability to provide rich information rather than their representativeness (Neuman, 2003). In addition, while the researcher attempted to recruit a diverse age group of Haitian women, all female Haitian participants were between the ages of 18-27 years. As older women may have different experiences and views of male behaviors, future research studies should attempt to include older Haitian women within the exploration of HIV risk behaviors practiced by Haitian-born men.

The third limitation is social desirability bias among study participants. According to Neuman (2003), social desirability bias occurs when a participant alters his/her responses to make their reports conform to social norms. Sexual behavior is a highly



sensitive issue that carries elements of stigma and judgment. Interview participants may have reported socially desirable responses to prevent stigmatization or negative appraisal by the researcher. To control for this bias, the researcher maintained a neutral posture and was careful not to appear judgmental within interviews and focus group discussions.

The gender effect is a fourth limitation of the study. As the researcher was female, male research participants may have responded in a manner they perceive to be desirable for a female listener thereby altering their self-presentations. For example, male participants may have over reported conservative behaviors and underreported risky sexual behaviors. To control for this limitation, the researcher remained neutral and nonjudgmental during discourses with male study participants.

Finally, this study is subject to researcher bias. While several strategies were employed to minimize researcher bias as detailed in chapter three, it should be noted that researcher bias was of concern during the conduct of this inquiry. Neuman (2003) outlines six categories of bias that interviewers should be aware of: 1) errors by the respondent which involves forgetting, lying or misunderstanding because of the presence of others; 2) unintentional errors or researcher sloppiness; 3) intentional subversion by the interviewer such as purposefully omitting questions or altering answers; 4) interviewer's expectations based on appearance or other qualities of the participant; 5) interviewer failure to probe certain responses and; 6) influence on participants' answers based on the appearance or attitude of the researcher. The researcher addressed these biases by ensuring that she was properly trained and possessed appropriate skills to conduct interviews and focus groups. Chapter three further discusses in detail how researcher bias was controlled in this study.

### *Study Strengths*

Inherent in this study are many strengths that enhance the body of knowledge on socio-cultural, structural, and intrapersonal factors that interact to influence HIV risk and protective behaviors among U.S.-born and Haitian-born populations. First, the triangulation of data collection techniques adds to the strength of this inquiry by utilizing novel methodological approaches to explore HIV risk. During phase I, in-depth, semi-structured interviews were applied to derive sexual scripts of the experiences, knowledge and attitudes of heterosexual men. Because of the sensitivity of the topic and the researcher's goal of eliciting personal sexual information from male participants, the interview format was most appropriate. Phase II incorporated focus group methods to elicit black women's perceptions of the sexual behaviors practiced by black men. The use of focus groups in the second phase of the study was intended to promote self-disclosure within a group setting that would allow group discussants to influence each other by reacting to the ideas and experiences of others in the group (Krueger, 2000).

Second, this study fills a significant gap in the literature by exploring the intrapersonal, socio-cultural and structural factors that influence sexual behavior in subgroups of black heterosexual men. There are limited research studies that focus on subgroup analyses of sexual behavior. Two recent studies have assessed ethnic differences in HIV risk behaviors. Conducted in New York City, Hoffman and colleagues (2008) compared black West Indians' and U.S.-born blacks' sexual and drug use risk behaviors. They found that West Indian women had lower confidence levels to discuss STI testing or condom use with their sex partners. In this study, Haitians were not studied as a separate and distinct ethnic group. Villanueva et al. (2010) compared risk

perceptions and sexual experiences between African American, Caribbean Islanders and Haitians. They found that Creole-speaking Haitians had lower HIV risk perceptions, were less likely to use condoms, and less likely to have ever been tested for HIV. However, Villanueva et al. (2010) limited the age range of their study sample to 18-39 year olds. Therefore, this study adds to the body of knowledge relative to prevention science research by qualitatively assessing HIV risk perceptions and behaviors, including a wide range of ages, and focusing on distinct ethnic groups (Haitian and African American).

Third, this study revealed cultural factors related to HIV risk and protective behaviors that must be further explored. Relative to the Haitian community, there are unique cultural practices that must be addressed within the context of HIV prevention. One such finding is the belief that HIV infection is related to voodoo or non-biomedical, mythical, concepts of illness. As these beliefs are embedded within the cultural fabric of the Haitian community, prevention efforts must not gloss over these beliefs but rather incorporate them within HIV education and prevention efforts.

Finally, this study provided a holistic approach to sexual behaviors. Both men and women were included in this exploratory study giving a holistic perspective to the study findings. Moreover, the findings derived from phase II of the study confirmed many of the responses from the male individual interviews. In some instances, men and women provided divergent perceptions and experiences: 1) men ascribed to HIV conspiracy beliefs but women did not; 2) men did not perceive impaired skills after alcohol/substance use while women did; 3) men perceived that women hold most of the power to make sexual decisions in relationships while women did not seem to use or perceive the same level of power. Often, studies may not provide analyses through the

lens of both men and women. This study attempted to provide a comprehensive examination of the status of sexual behaviors among U.S.-born and Haitian-born men and women.

### *Section III: Implications for Public Health Education, Practice, and Research*

#### *Public Health Education and Practice*

The findings of this study have several implications for public health education. HIV prevention education should continue to focus on increasing knowledge about HIV transmission and safer sex methods. Findings show that HIV education has been successful in creating high levels of HIV knowledge among the populations studied. Prevention science however has not been effective in motivating individuals to translate their HIV/AIDS knowledge into safer sex behaviors. HIV education models have historically emphasized individual-level approaches that enhance intrapersonal knowledge and attitudes. However, this study shows the need to move beyond psychological HIV education and intervention approaches to ecological approaches that consider structural, socio-cultural and behavioral health factors that impact sexual behaviors.

Critical to this inquiry is the finding that HIV conspiracy beliefs were pervasive within the male study population. As these theories may create barriers to positive reception of HIV prevention messages, treatment and care, HIV education must begin to address the conspiracy beliefs held by U.S.-born and Haitian-born black men.

Consideration must also be given to the historical and cultural context of discrimination, racism and distrust within which these beliefs are embedded. For optimal effectiveness, HIV prevention messages must be sensitive to the cultural and historical intricacies that

dictate conspiracy beliefs. As noted above, gender-specific HIV programs and interventions that address conspiracy beliefs are needed for heterosexual black men. Implementation of interventions such as “Nia”, a video-based, small group level intervention to educate black men about HIV/AIDS can be utilized to address HIV conspiracy beliefs (Kalichman, Cherry & Browne-Sperling, 1999).

High risk sexual behaviors such as partner concurrency and inconsistent condom use must be addressed within the context of socio-ecological factors that influence risk. Masculine ideologies and social constructions of manhood and woman must be considered in the assessment of high-risk behaviors such as multiple sex partners. Cultural emphasis on heterosexism and male sexual experience may endorse promiscuous sexual behavior among men and boys. HIV education efforts must address these constructions and attempt to deconstruct the concepts of black male sexual prowess and machismo. HIV education efforts must also address the multiple social and contextual factors that influence condom use decision-making. Educational approaches should include couples-based counseling that reinforces mutual responsibility for safer sex, condom carrying and condom use skills-building, emphasize the importance of condom use within long-term relationships, construct the link between condoms and contraception, teach women effective ways of minimizing condom use discomfort, and explore novel ways of incorporating less penetrative sexual activities within the sexual experience. Couples-based programs such as “CONNECT” that emphasizes personal, relational, and societal influences on behavior can be implemented to teach couples skills to enhance sexual safety within their relationships (El-Bassel et al., 2003).

Study findings also have significant implications for behavioral health particularly mental health and substance abuse counseling and services. HIV education and prevention efforts must consider the childhood sexual abuse and trauma experiences of black women as these experiences may have a detrimental effect on women's abilities to protect themselves from HIV and other STIs. Study findings reveal that women with sexual abuse histories have diminished capacities to negotiate safer sex with male sex partners. Previous studies have found that trauma-based interventions are efficacious in reducing HIV risk behaviors among women who had experienced childhood sexual abuse and adult partner violence (Wyatt et al., 2004; Sikkema et al., 2007). The realities of trauma and abuse histories must be considered as HIV education and intervention programs are implemented, and mental health counseling services should be provided for women with these traumatic histories. In addition, based on the alcohol and substance use and abuse behaviors reported by study participants, substance abuse counseling and rehabilitation should be incorporated within HIV prevention programs. Education efforts must also emphasize the link between substance abuse and high risk sexual behaviors as younger men tended to deny any cognitive or behavioral impairment as a result of intoxication or substance use.

Within the context of community-based HIV education and awareness, public health practitioners and educators must address the underlying issues of sex ratio imbalance, women's self-esteem, gender roles, and women's abilities to seek healthy sexual relationships. HIV prevention efforts must address black women's fear of losing a male partner and its link to the gender imbalances in the black community. Likewise, traditional gender roles that hinder women's abilities to make condom-use decisions need

to be deconstructed within the minds of black women. While companionship is important, women must also consider the detrimental consequences of remaining in unhealthy relationships. The underlying factors such as depression, low self-esteem, and the need for male partner validation that contribute to women's negative attitudes to condom use must be addressed. These messages and socio-ecological influences should be incorporated in HIV prevention and intervention approaches that target black women. Interventions referenced above such as "Sister to Sister" (Jemmott et al., (2007), "The Sista Project" (DiClemente & Wingood, 1995) and "Sihle" (DiClemente & Wingood, 1995 that build self-efficacy and teach women personal and cultural pride and assertiveness skills within a culturally competent context should be adapted in black communities and tailored for other ethnic groups such as Haitians.

In addition, HIV prevention programs must address homophobia and the culture of violence toward homosexuals and bisexuals. Effective HIV prevention strategies will require understanding the experiences of black MSM and MSM/W within the context of African American and Haitian history and culture that ascribe specific definitions of manhood. Gender-specific interventions that target heterosexual black men such as "Nia" (Kalichman et al., 1999) need to address structural and socio-cultural factors that create barriers to HIV prevention including an emphasis on the violent attitudes portrayed toward MSM and MSM/W.

Study findings reveal that parental communication about sexual behavior is virtually non-existent in the African American and Haitian communities. HIV education efforts must therefore target parents and well as the youth within the African American and Haitian communities. Communication skills-buildings and self-efficacy enhancing

techniques would be helpful in teaching parents effective methods of communicating sex-based information to their children.

Finally, HIV education should utilize community-based approaches for the development and implementation of HIV prevention programs. Study participants indicated that HIV prevention messages are not widely disseminated within effective community-based channels. Study participants suggested that public health practitioners and educators utilize community-based venues such as sporting events, music festivals, dance and social events such as *Kompa* in the Haitian community, schools, and universities to disseminate HIV information. In addition, the media and hip-hop culture should be utilized as dissemination vehicles for HIV prevention messages.

#### *Public Health Research*

Future research endeavors should continue to focus on the social and ecological determinants of sexual behavior among black heterosexual men. Much of the research literature focuses on gay-identified men, MSMs and MSM/Ws. Little research focuses on the risk behaviors practiced by men who self-identify as heterosexual or who have sex with women (Bowleg, 2004). As one study participant noted, “...as far as research studies and stuff like that, there’s relatively none that really focus directly with heterosexual black males. That’s why I was surprised when I heard about this one. I was like *WHAT?*” This study deconstructs beliefs within the research community that black heterosexual men are opposed to participating in research. If approached in a culturally appropriate and trusting manner, men are open and even eager to participate in HIV prevention research. This study suggests that more holistic approaches to assessing HIV risk behaviors are needed within the black male heterosexual population.



Further, additional research studies are needed to further explore subgroup differences in the HIV/AIDS knowledge, attitudes, beliefs, and risk behaviors. This study represents a formative step in the development of socio-ecological subgroup analyses. Further research is needed to more fully explore this critical area of inquiry. Additional black subgroups living in the United States such as Africans and individuals from other Caribbean islands should be included in future studies. Subgroup analyses in relation ecological influences on sexual behaviors should also be conducted among Hispanic communities as subgroup differences may play a key role in the development and implementation of future HIV education and prevention programs as the U.S.-born population becomes more diverse.

Future research should more fully investigate the behavioral health factors that influence HIV risk. Factors not addressed in this study such as the relationship between specific levels of alcohol and drug use, sexual risk behaviors and perceptions of impairment should be more closely studied. In addition, the relationship between childhood sexual abuse, trauma histories, and depressive symptoms within these subgroups should be more extensively explored.

Factors related to family communication about sexual issues must be addressed within public health research. Larger impact studies are needed to more fully explore the factors that create barriers to family and parental communication within U.S.-born and Haitian-born black cultures. Intervention research is needed to develop effective approaches to address barriers in sexual health communication.

Socio-ecological influences on HIV risk is a growing area of inquiry that requires additional studies that fully explore social and ecological factors such as:

- black masculine ideologies and social constructions of manhood and womanhood;
- media influences such as hip-hop culture;
- sex ratio imbalances within the black community;
- culturally embedded social and peers norms and beliefs that influence sexual behavior;
- gender norms that may render women incapable of making healthy sexual decisions.
- Concepts and dynamics of trust and how trust influences condom use and safer sex behaviors

Finally, future studies should develop quantitative methods and instruments to more broadly assess socio-ecological factors such as cultural norms, media, parental communication and gender norms that influence sexual behavior in subgroups of black heterosexual men thus allowing for generalizability of findings.

#### *Dissemination of Findings*

Immediate next steps will include dissemination of research findings to academic and lay audiences. Research findings will be disseminated through manuscripts submitted to peer-reviewed journals, as well as national, statewide (e.g. Florida Public Health Association) and local conferences. In addition, articles will be submitted to local media outlets such as the *Florida Sentinel*, a local black newspaper. Findings will also be shared with research participants who indicated an interest in receiving follow-up information on the study results.

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## APPENDICES

Appendix A: Epidemiological Data

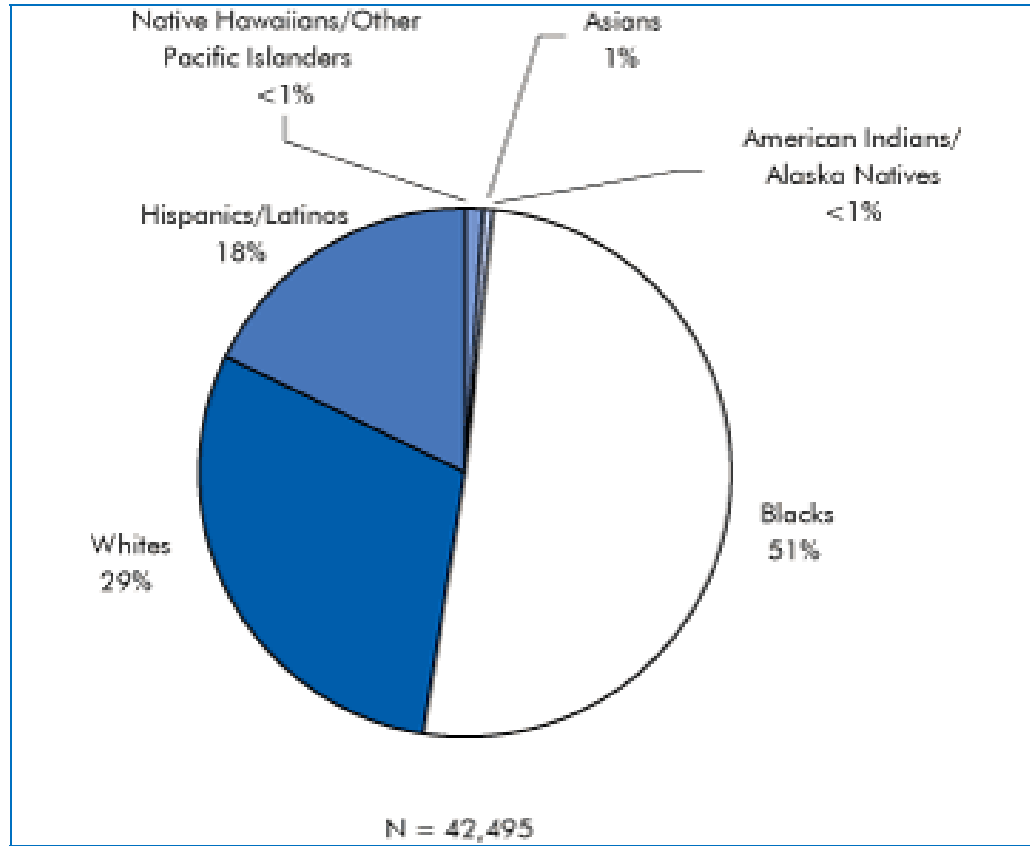


Figure 1: Race/ethnicity of persons (including children) with HIV/AIDS diagnosed during 2007 .

**Note:** Based on data from 34 states with long-term, confidential, name-based HIV reporting. **Source:** CDC Website.

<http://www.cdc.gov/hiv/topics/aa/resources/factsheets/aa.htm>



Appendix A (continued)

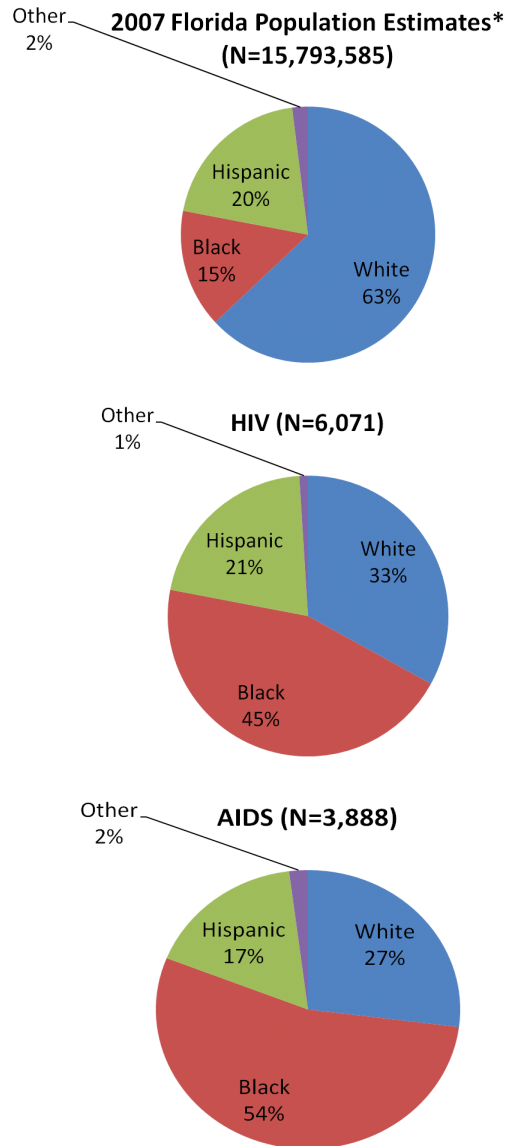


Figure 2. Percentage of adult AIDS cases by race/ethnicity, Florida, compared with percentage of adult HIV cases by race/ethnicity, Florida, 2007.

\*Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and mixed races. \*2007 Florida Population Estimates, Adults (Ages 13+), DOH, Office of Planning, Evaluation and Data Analysis.

**Source:** Florida HIV/AIDS Annual Report 2007 (mini version).

[http://www.doh.state.fl.us/disease\\_ctrl/aids/trends/epiprof/mini\\_aids07c.pdf](http://www.doh.state.fl.us/disease_ctrl/aids/trends/epiprof/mini_aids07c.pdf)

Appendix A (continued)

Table 1: Cumulative HIV cases through 9/30/06 in Hillsborough County

| Race/Ethnicity |                               | Adult/Adolescent |             | Pediatric |             | Total       |             |
|----------------|-------------------------------|------------------|-------------|-----------|-------------|-------------|-------------|
|                |                               | Cases            | %           | Cases     | %           | Cases       | %           |
| Hispanic       | All races                     | 324              | 15%         | 5         | 17%         | 329         | 15%         |
| Non-Hispanic   | Am. Indian/Alaska Native      | 5                | 0%          | 0         | 0%          | 5           | 0%          |
|                | Asian                         | 1                | 0%          | 0         | 0%          | 1           | 0%          |
|                | <b>Black/African American</b> | <b>1003</b>      | <b>48%</b>  | <b>21</b> | <b>69%</b>  | <b>1024</b> | <b>49%</b>  |
|                | Asian/Pacific Islander        | 3                | 0%          | 0         | 0%          | 3           | 0%          |
|                | White                         | 744              | 35%         | 5         | 14%         | 749         | 35%         |
|                | Multi-race                    | 17               | 1%          | 0         | 0%          | 17          | 1%          |
| <b>Total</b>   |                               | <b>2097</b>      | <b>100%</b> | <b>31</b> | <b>100%</b> | <b>2128</b> | <b>100%</b> |

**Source:** Hillsborough County Health Department  
[http://www.hillscountyhealth.org/hiv\\_aids/newsletter/JUL-SEP2006.pdf](http://www.hillscountyhealth.org/hiv_aids/newsletter/JUL-SEP2006.pdf)

*Appendix A (continued)*

Table 2. HIV/AIDS cases among Caribbean born reported through 2008  
(N=24,069)

| <b>Caribbean Country of Birth</b> | <b>Frequency of HIV/AIDS Cases</b> |
|-----------------------------------|------------------------------------|
| Aruba                             | 9                                  |
| Anguilla                          | 1                                  |
| Netherland Antilles               | 5                                  |
| Antigua and Barbuda               | 25                                 |
| Bahamas                           | 589                                |
| Bermuda                           | 9                                  |
| Barbados                          | 70                                 |
| Cuba                              | 6294                               |
| Cayman Islands                    | 10                                 |
| Dominica                          | 15                                 |
| Dominican Republic                | 439                                |
| Guadeloupe                        | 2                                  |
| Grenada                           | 26                                 |
| Haiti                             | 10956                              |
| Jamaica                           | 1427                               |
| St. Lucia                         | 28                                 |
| Montserrat                        | 1                                  |
| Martinique                        | 2                                  |
| Puerto Rico                       | 3678                               |
| Turks and Caicos Islands          | 65                                 |
| Trinidad and Tobago               | 206                                |
| St. Vincent and the Grenadines    | 12                                 |
| British Virgin Islands            | 15                                 |
| U.S. Virgin Islands               | 185                                |

**Comment:** Of the 24,069 HIV/AIDS cases born in the Caribbean, 24,047 were adults (13 years and older) and 22 were pediatric cases.

**Source:** Florida Department of Health Bureau of HIV/AIDS.

[http://www.doh.state.fl.us/Disease\\_ctrl/aids/trends/slides/2008\\_slides/Caribbean08.pdf](http://www.doh.state.fl.us/Disease_ctrl/aids/trends/slides/2008_slides/Caribbean08.pdf)

*Appendix B: Population Data*

Table 1: U.S. foreign-born black population by country of birth

| Country of Birth | Number living in the U.S. |
|------------------|---------------------------|
| Africa           | 512,628                   |
| Caribbean        | 1,250,611                 |
| Central America  | 136,535                   |
| South America    | 113,347                   |
| Others           | 867,717                   |
| Total            | 2,099,865                 |

Source: U.S. Census Bureau. [www.census.gov](http://www.census.gov)

Table 2: Estimates of U.S.-born and foreign-born black population in Florida by selected County and region of origin

|                                      | Hillsborough County |
|--------------------------------------|---------------------|
| <b>Black Population</b>              | 147,966             |
| U.S.-born blacks (African American)  | 137,925             |
| Foreign-born blacks                  | 10,041              |
|                                      |                     |
| <b>Foreign-born blacks by region</b> |                     |
| Barbados                             | 167                 |
| Haiti                                | 2,370               |
| Jamaica                              | 3,571               |
| Trinidad & Tobago                    | 1,343               |
| Other Caribbean                      | 1,692               |
| East & West Africa                   | 1,012               |

Source: U.S. Census Bureau. [www.census.gov](http://www.census.gov)

UNIVERSITY OF SOUTH FLORIDA

**WE NEED YOUR OPINION!**

**Nou vle fè yon ti pale avè-w**

We need your opinion on sexual health, and relationships in the Black/African American and Haitian community

We are looking for *men* who are:

❖ Black or African American and born in the United States

or

❖ Born in Haiti

❖ Are 18 years and older

❖ Live in Hillsborough County

**If you are selected, you will be paid for your time**

(Interviews will be conducted in English)

If you would like to participate please call 813-230-xxxx

*Appendix C (continued)*

UNIVERSITY OF SOUTH FLORIDA

**WE NEED YOUR OPINION!**

**Nou vle fè yon ti pale avè-w**

We need your opinion on sexual health, and relationships in the Black/African American and Haitian community

We are looking for *women* who are:

❖ Black or African American and born in the United States

or

❖ Born in Haiti

❖ Are 18 years and older

❖ Live in Hillsborough County

**If you are selected, you will be paid for your time**

(Interviews will be conducted in English)

If you would like to participate please call 813-230-xxxx

Appendix D: Eligibility Checklists

Eligibility Checklist: Men

**The criteria below will be used to determine the inclusion or exclusion of *men* from the study.**

Do you consider yourself to be black? \_\_\_\_\_ (Yes)

Were you born in the United States? \_\_\_\_\_ (Yes)

OR

Were you born in Haiti? \_\_\_\_\_ (Yes)

Do you consider yourself to be heterosexual? \_\_\_\_\_ (Yes)

How long have you lived in the U.S.?  
(at least 3 years) \_\_\_\_\_

How old are you?  
(18 years or older) \_\_\_\_\_

Do you reside in Hillsborough County? \_\_\_\_\_ (Yes)

Are you able to understand/speak English? \_\_\_\_\_ (Yes)

Have you ever had sexual intercourse? \_\_\_\_\_ (Yes)

If respondents answer according to the responses indicated in brackets, they qualify for the study.

If qualify, ask the person to provide a first name that they would like to be referred as at the time of the interview. \_\_\_\_\_

Schedule a date, time, and location for the interview.

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If their responses do not correspond to the answers in brackets they do not qualify for the interview. Thank the caller for their time and inform them that they do not qualify for the study.

Appendix D (continued)

Eligibility Checklist: Women

**The criteria below will be used to determine the inclusion or exclusion of women from the study.**

Do you consider yourself to be black ? \_\_\_\_\_ (Yes)

Were you born in the United States? \_\_\_\_\_ (Yes)

OR

Were you born in Haiti? \_\_\_\_\_ (Yes)

Do you consider yourself to be heterosexual? \_\_\_\_\_ (Yes)

How long have you lived in the U.S.?  
(at least 3 years) \_\_\_\_\_

How old are you?  
(18 years or older) \_\_\_\_\_

Do you reside in Hillsborough County? \_\_\_\_\_ (Yes)

Are you able to understand/speak English? \_\_\_\_\_ (Yes)

Have you had at least one African American/Haitian  
sex partner? \_\_\_\_\_ (Yes)

If respondents answer according to the responses indicated in brackets, they qualify for the study.

If qualify, ask the person to provide a first name that they would like to be referred as at the time of the interview. \_\_\_\_\_

Schedule a date, time, and location for the interview.

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If their responses do not correspond to the answers in brackets they do not qualify for the interview. Thank the caller for their time and inform them that they do not qualify for the study.



*Appendix E: Demographic Survey*

**Demographic Survey**

We would like to know more about you by asking you a few questions. We do not need your name and all the information you share with us will be kept confidential.

1. What is your age? \_\_\_\_\_
2. Tell me about your marital status. Are you:
  1. Married
  2. Divorced
  3. Widowed
  4. Separated
  5. Never married
  6. Member of an unmarried couple
3. How would you describe your ethnicity?
  1. Hispanic or Latino
  2. Not Hispanic or Latino
4. How would you describe your race?
  1. American Indian or Alaska Native
  2. Asian
  3. Black or African American
  4. Native Hawaiian or Other Pacific Islander
  5. White
5. What is the highest grade or year of school you finished?
  1. Never attended school or only attended kindergarten
  2. 8<sup>th</sup> grade or less
  3. 9<sup>th</sup> to 11<sup>th</sup> grade
  4. High school graduate or GED
  5. Some college or technical school (1-3 years)
  6. College graduate or higher degree (college 4 years or more)
6. What is your household income level?
  1. Under \$15,000 per year
  2. \$15,000-\$24,999 per year
  3. \$25,000-\$34,999 per year
  4. \$35,000-\$44,999 per year
  5. \$45,000-\$59,999 per year
  6. \$60,000-\$75,000 per year
  7. \$75,000 or more per year

7. Tell me about your employment status
- 1. Employed for wages
  - 2. Self-employed
  - 3. Out of work for more than 1 year
  - 4. Out of work for less than 1 year
  - 5. A homemaker
  - 6. Student
  - 7. Retired
  - 8. Unable to work
8. How would you describe your sexual orientation?(please pick one)
- 1. Heterosexual
  - 2. Bisexual
  - 3. Homosexual or gay
  - 4. Other (please specify)
- 
9. How did you find out about this study?
- 1. Flyer
  - 2. Newspaper
  - 3. Friend
  - 4. Other (please describe)
- 

***Thank you for completing this demographic survey!***



## **Informed Consent**

### **Information to Consider Before Taking Part in This Research Study IRB Study # 107697 I**

The following information is being presented to you to help you decide whether or not you want to be involved in this research study. Please read this carefully. If there is anything you do not understand, please ask the person in charge of the study.

**Title of the Study:** An Exploratory Study of the Intrapersonal, Socio-Cultural, and Behavioral Factors that influence HIV Risk Behaviors among Ethnic Subgroups of Black Heterosexual Men: The Intersection of the Beliefs and Perceptions of Black Women

*This consent is for individual interviews with male participants.*

**Person in charge of this research study:** Shalewa Noel-Thomas.  
Where the study will be done: various public sites in Hillsborough County.

### **Should you take part in this study?**

This form tells you about this research study. After reading through this form and having the research explained to you by someone conducting this research, you can decide if you want to take part in it. If, at any time, you have any questions, feel free to ask the person explaining this study to you.

#### **This form explains:**

- Why this study is being done.
- What will happen during this study and what you will need to do.
- Whether there is any chance you might experience potential benefits from being in this study.
- The risks of having problems because you are in this study.

**It's up to you. If you choose to be in the study, then you can sign the form. If you do not want to take part in this study, you should not sign the form.**

### **Why is this research being done?**

You are invited to participate in a research study about sexual health, behaviors of Black men, and HIV risk and transmission in the Black community. The purpose of the study is to learn about the HIV risk behaviors among black men including their attitudes, beliefs, values, and experiences as well as the beliefs of Black women.

### **What are the study procedures?**

If you agree to be in the study, you will sit down for an interview with a trained interviewer who will ask you questions about your life experiences, sexual experiences, beliefs, attitudes, and perceptions. The interview will be audio taped. You will also be asked to complete a short survey that asks general questions about you.

### **How long will you be asked to stay in the study?**

The interview will take 1 – 2 hours to complete. The general demographic survey will take 10 -15 minutes.

### **Will you be paid for taking part in this study?**

You will be paid \$25 for your participation in this study. You will also be paid for any applicable travel costs (bus fare, mileage) to the interview site. You will be paid in cash immediately after you complete your participation.

### **What will it cost you to take part in this study?**

You will need to provide your own transportation to take part in the study.

### **What are the potential benefits if you take part in this study?**

- The information you provide will be used to help researchers, health professionals and other agencies understand the knowledge, attitudes, beliefs and life experiences of blacks with regard to sexual behaviors and HIV transmission. Findings may be used to develop prevention messages and intervention programs with the black community.
- You will receive written materials on HIV prevention.

### **What are the risks if you take part in this study?**

We do not anticipate any risks to you as you participate in this study. However, some of the interview questions about sexual experiences, beliefs and perceptions may make you uncomfortable. Please remember that your participation is voluntary and you are free to decline to answer any questions or to stop your participation in the study at any time. Should you experience any mental distress during the interview, you will be referred to mental health resources in your community.

### **Who will see the information that you give?**

In our research, we use and share information about people and their health. We know that this information is private. Federal law protects health information.

The law lets us use and share health information for research if you agree to let us do this. If you let us use and share information about you, we will protect it as required by law.

If you sign this form, it means you are letting us use and share this information for research.

Your information will be stored on a password protected computer. When we write up the study, your information will be combined with that of other participants and shared with research participants, other researchers, and community members. Your name or other identifying information will be kept confidential.

Authorized research personnel, the USF Institutional Review Board and its staff and other USF personnel may inspect the records from this study. The results of this study may be published. However, the published results will not include your name or any other personal information that could identify you in any way.

**Your Rights:**

You can refuse to sign this form. If you do not sign this form:

- **You will not be able to take part in this research study**

You will be given a copy of this consent form. PARTICIPATION IN THIS STUDY IS VOLUNTARY. You may withdraw from the study at any time.

**What if you join the study and decide you want to stop later on?**

You can decide after signing this informed consent document that you no longer want to take part in this study. If you decide you want to stop taking part in the study, tell the study staff as soon as you can.

**You can get the answers to your questions.**

- If you have questions about the study, please call Shalewa Noel-Thomas at (813) 230-0210.
- If you have questions about your rights as a person who is taking part in a research study, you may contact the Division of Research Compliance at the University of South Florida at (813) 974-5638.

**Signatures for Consent for this Research Study**

It is up to you to decide whether you want to take part in this study. If you want to take part, please read the statements below and sign the form if the statements are true.

**I freely give my consent to take part in this study.** I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

---

Signature of Person Taking Part in Study

Date

---

Printed Name of Person Taking Part in Study

## **Statement of Person Obtaining Informed Consent / Research Authorization**

I have carefully explained to the person taking part in the study what he or she can expect.

I hereby certify that when this person signs this form, to the best of my knowledge, he or she understands:

- What the study is about.
- What procedures/interventions/investigational drugs or devices will be used.
- What the potential benefits might be.
- What the known risks might be.

I also certify that he or she does not have any problems that could make it hard to understand what it means to take part in this research. This person speaks the language that was used to explain this research.

This person reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her.

---

Signature of Person Obtaining Informed Consent

---

Date

---

Printed Name of Person Obtaining Informed Consent



## **Informed Consent**

### **Information to Consider Before Taking Part in This Research Study IRB Study # 107697 I**

The following information is being presented to you to help you decide whether or not you want to be involved in this research study. Please read this carefully. If there is anything you do not understand, please ask the person in charge of the study.

**Title of the Study:** An Exploratory Study of the Intrapersonal, Socio-Cultural, and Behavioral Factors that influence HIV Risk Behaviors among Ethnic Subgroups of Black Heterosexual Men: The Intersection of the Beliefs and Perceptions of Black Women

*This consent is for focus groups with female participants.*

**Person in charge of this research study:** Shalewa Noel-Thomas.  
Where the study will be done: various public sites in Hillsborough County.

### **Should you take part in this study?**

This form tells you about this research study. After reading through this form and having the research explained to you by someone conducting this research, you can decide if you want to take part in it. If, at any time, you have any questions, feel free to ask the person explaining this study to you.

#### **This form explains:**

- Why this study is being done.
- What will happen during this study and what you will need to do.
- Whether there is any chance you might experience potential benefits from being in this study.
- The risks of having problems because you are in this study.

**It's up to you. If you choose to be in the study, then you can sign the form.** If you **do not** want to take part in this study, you should **not** sign the form.

### **Why is this research being done?**

You are invited to participate in a research study about sexual health, behaviors of Black men, and HIV risk and transmission in the Black community. The purpose of the study is to learn about the HIV risk behaviors among black men including their attitudes, values, beliefs, and experiences as well as the beliefs of Black women.

### **What are the study procedures?**

If you agree to be in the study, you will sit down for a focus group with a trained interviewer who will ask you questions about your life experiences, sexual experiences, beliefs, attitudes, and perceptions. The entire focus group discussion will be audio taped. You will also be asked to complete a short survey that asks general questions about you.

### **How long will you be asked to stay in the study?**

The focus group will take 1 – 2 hours to complete. The general demographic survey will take 10 -15 minutes.

### **Will you be paid for taking part in this study?**

You will be paid \$25 for your participation in this study. You will also be paid for any applicable travel costs (bus fare, mileage) to the interview site. You will be paid in cash immediately after you complete your participation.

### **What will it cost you to take part in this study?**

You will need to provide your own transportation to take part in the study.

### **What are the potential benefits if you take part in this study?**

- The information you provide will be used to help researchers, health professionals and other agencies understand the knowledge, attitudes, beliefs and life experiences of blacks with regard to sexual behaviors and HIV transmission. Findings may be used to develop prevention messages and intervention programs with the black community.
- You will receive written materials on HIV prevention.

### **What are the risks if you take part in this study?**

We do not anticipate any risks to you as you participate in this study. However, some of the interview questions about sexual experiences, beliefs and perceptions may make you uncomfortable. Please remember that your participation is voluntary and you are free to decline to answer any questions or to stop your participation in the study at any time. Should you experience any mental distress during the interview, you will be referred to mental health resources in your community.

### **Who will see the information that you give?**

In our research, we use and share information about people and their health. We know that this information is private. Federal law protects health information.



The law lets us use and share health information for research if you agree to let us do this. If you let us use and share information about you, we will protect it as required by law.

If you sign this form, it means you are letting us use and share this information for research.

Your information will be stored on a password protected computer. When we write up the study, your information will be combined with that of other participants and shared with research participants, other researchers, and community members. Your name or other identifying information will be kept confidential. *Because of the group setting, absolute confidentiality cannot be guaranteed. However, we ask that you keep what is discussed during the group confidential and not disclosed to others outside the group.*

Authorized research personnel, the USF Institutional Review Board and its staff and other USF personnel may inspect the records from this study. The results of this study may be published. However, the published results will not include your name or any other personal information that could identify you in any way.

**Your Rights:**

You can refuse to sign this form. If you do not sign this form:

- **You will not be able to take part in this research study**

You will be given a copy of this consent form. PARTICIPATION IN THIS STUDY IS VOLUNTARY. You may withdraw from the study at any time.

**What if you join the study and decide you want to stop later on?**

You can decide after signing this informed consent document that you no longer want to take part in this study. If you decide you want to stop taking part in the study, tell the study staff as soon as you can.

**You can get the answers to your questions.**

- If you have questions about the study, please call Shalewa Noel-Thomas at (813) 230-0210.
- If you have questions about your rights as a person who is taking part in a research study, you may contact the Division of Research Compliance at the University of South Florida at (813) 974-5638.

**Signatures for Consent for this Research Study**

It is up to you to decide whether you want to take part in this study. If you want to take part, please read the statements below and sign the form if the statements are true.

**I freely give my consent to take part in this study.** I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

---

Signature of Person Taking Part in Study

Date

---

Printed Name of Person Taking Part in Study

### **Statement of Person Obtaining Informed Consent / Research Authorization**

I have carefully explained to the person taking part in the study what he or she can expect.

I hereby certify that when this person signs this form, to the best of my knowledge, he or she understands:

- What the study is about.
- What procedures/interventions/investigational drugs or devices will be used.
- What the potential benefits might be.
- What the known risks might be.

I also certify that he or she does not have any problems that could make it hard to understand what it means to take part in this research. This person speaks the language that was used to explain this research.

This person reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her.

---

Signature of Person Obtaining Informed Consent

---

Date

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Printed Name of Person Obtaining Informed Consent

*Appendix H: Interview Guide*

**Interview Guide**

**Introduction:** Hello. My name is Shalewa Noel-Thomas and I am a student at USF. How are you? [Icebreaker]. I am conducting this study to help understand the HIV knowledge, attitudes, beliefs and behaviors of black men and women in our community. I will be asking you a series of questions about your own attitudes, beliefs and behaviors about sexual health and HIV.

I appreciate your time and respect your privacy; your answers are completely confidential. More importantly, your name will not be used when we use the data we collect. I do want to let you know that I am recording our conversation so that I don't miss any of your responses, is this okay with you?

The first thing I would like to do is get your consent for participating in this study. I will read the consent form to you and then ask you to sign it.

**CONSENT SHOULD BE TAKEN HERE!**

ASSIGN ID #, ID should consist of the first 3 digits if their ZIP CODE and first 2 letters of their LAST NAME. Example: Tony Thompson at (33515): ID = 335TT.

**ID:** \_\_\_\_\_

|                   |                                                                               |                                                                                     |
|-------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Interviewer Name: | Date:                                                                         | Location:                                                                           |
| Coder:            | Gender: <input type="checkbox"/> M<br><input type="checkbox"/> F              | <input type="checkbox"/> Consent Signed<br><input type="checkbox"/> Incentive Given |
| ID:               | <input type="checkbox"/> Haitian<br><input type="checkbox"/> African American | Age:                                                                                |

**Interview Guide**

**Knowledge, Attitudes, Beliefs:**

5. When you think about HIV & AIDS, what comes to your mind?
6. What can increase a person's risk of getting HIV/AIDS?
7. What can a person do to protect themselves from HIV?
8. Where do you believe HIV originated or how do you believe it first started?

**Probes:**

- a. Do you think HIV is a real disease?
- b. Do you think HIV may have been invented or created by someone?

**[The next set of questions will ask about your sexual relationships. Please be assured that all your responses and any identifying information will be kept confidential. One of the aims of the survey is to use this information to develop better HIV prevention programs in the community]**

**HIV Risk Behaviors:**

1. Tell me about the nature of your sexual relationship/s with your partner/s.

**Probes:**

- a. Have you been sexually active in the past 12 months?
- b. Do you have a steady/regular sexual partner? If yes, describe your level of commitment to your steady sexual partner.
- c. Do you have sexual partners other your steady/regular sexual partner? If yes, how many? If yes, tell me about your decision to have multiple sex partners.
2. Do you think [African American/Haitian] men you associate with tend to have one steady/regular sex partner or do you think they tend to have multiple partners at the same time? [Feel free to be honest and open , you will not be judged because of your answer]

**Probe:**

- a. [If the response is *multiple partners*], Tell me why you think black men you associate with may have multiple sex partners?
- b. [If the response is *one partner*], Tell me why you think black men you associate with may have one steady sex partner?

**Condom Use**

1. Tell me what you think about male condoms and condom use during sexual intercourse?

**Probes:**

1. Do you always use condoms during sexual intercourse? If no, why not?
2. Describe the reasons for using a condom during sex?
3. When you use condoms, what type do you use, latex or lambskin?
4. Do you think condoms are easy to use?
5. Do you feel comfortable going to the store to buy condoms?
6. Is it difficult to afford condoms?

2. Tell me about your condom use with your steady/regular sexual partner.

**Probes:**

- a. In the past 12 months, have you always used condoms during vaginal sex

with your steady sex partner? If no, why not?

- b. In the past 12 months, have you always used condoms with your steady sex partner during anal sex? If no, why not?
- c. Describe a situation when you had sexual intercourse in the past 12 months and **did not** use a condom.
- d. Why did you decide not to use a condom?
- e. Describe a situation in the past 12 months in which you **did** use a condom.
- f. Why did you decide to use a condom?
- g. What factors do you think about when you are deciding whether or not to use a condom during sex?

**Cultural Norms:**

1. How do your friends and family members influence your sexual relationships?

Probes:

- a. What do your friends and family members say about condom use?
  - b. What do your friends and family members say about HIV and AIDS?
2. How do you think the media/hip-hop culture affect sexual behavior among black men?
3. Tell me some other factors/things in black culture that influence sexual behavior (i.e. number of sex partners, condom use) in black men.
4. What does the term heterosexual mean to you?
5. What does to term bisexual mean to you?
6. What does homosexuality mean to you?
7. Do you know anyone who is homosexual? What do you think of when you think about this person?
8. What does the term “down low” mean to you? [Explain if the interviewee is not familiar]
9. Do you know of anyone who is on the “down low”? If so, what comes to mind of when you think about this person?
10. How do you feel about the whole “down low” behavior?
11. How do you think the “down low” affects HIV transmission in the black community?
12. Do you know anyone who has HIV or AIDS? If so, what comes to mind when you think about this person?
13. If you were going to educate black men about HIV prevention: what would you say to them? Where would be the best places to go to reach them? How would you get the word out to men (radio, TV, DVD, CD, iPod)?

**Gender Norms:**

1. Tell me about decision-making between you and your sexual partner/s in your relationship/s.

Probes:

- a. How does your female partner make decisions about condom use in your relationship?
  - b. Is your female partner dependent on you financially? If so, how does that make you feel?
2. What role do you think women play in HIV transmission in the black community?

**[The next set of questions will ask about your use of alcohol and recreational drugs. Please be assured that all your responses and identifying information will be confidential. One of the aims of the survey is to use this information to develop better**

**HIV prevention programs in the community]**

**Behavioral Health:**

a. Tell me whether or not alcohol or recreational drugs play a role in your sexual relationships.

**Probes:**

a. Do you or your sexual partners use recreational drugs or alcohol?

b. Have you ever felt high or drunk before or during sexual intercourse? Has your partner been high or drunk before or during sexual intercourse?

c. If so, how do you think recreational drugs or alcohol affected your judgment prior to and during sex?

d. Are you able to think about using a condom after using alcohol or recreational drugs?

This is the end of the interview. Do you have any other thoughts/comments/questions?

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**GIVE EACH PARTICIPANT HIV EDUCATIONAL/RESOURCE MATERIALS HERE!!!**

Thank you so very much for your time. Have a wonderful day!

## *Appendix I: Focus Group Guide*

### Focus Group Guide

Hello. I am Shalewa Noel-Thomas from USF and I would like to welcome you here this afternoon/morning. We appreciate you taking time out of your busy schedules to participate in this discussion. The information you offer about your thoughts will help to provide a better understanding of HIV health issues in the black community. This is a USF research project. I want to assure you that nothing you say will be identified with you. The final report will say things like “most people said” or a “few women said”, but no names or

identifying information will be given. We will take notes and if everyone is in agreement we will also audiotape this discussion and will not ask any of you for your names. It is important that we tape the discussion so that we are able to capture all the information you share to accurately analyze the data.

We have a lot of ground to cover in a short period of time. Please turn off all cell phones, pagers, beepers etc. I want to be sure I honor the timeframe I promised for this focus group. For this reason I may cut you off if I need to move to the next question. However, I will remain after the session if there are any questions that we did not cover during the focus group.

Does everyone know what a focus group is and how it works? For this particular group we want to know what you think about HIV in the black community. There are no wrong or right answers – this is not a test. We just want to know what you think. Are there any questions at this time?

We want you to feel comfortable to say what you think without your real name attached to it. For this reason, we invite you to create a name tag with whatever name you wish to be called. You may use your real name if you want to but you don't have to. Please write down a name for us to refer to you for the purposes of the tape recording. Please remember that what is discussed in this room stays in this room. You are free to talk about your opinions and thoughts to anyone you choose, but please do not share what you have heard others say.

Before we begin I want to mention a few house rules: 1) The session is being taped, please limit any extra noise such as tapping the table, pen clicking, etc. 2) Please refrain from talking when someone else is talking or having side conversations, these make it difficult to get a good tape. You may hear me remind you “only one person can talk at a time”. 3) Please do not make negative comments about another person's opinion or feelings. We want to know what everyone thinks and your opinion or experience may be different than the next person. 4) Please respect the opinions of everyone in the group, by allowing them to finish their thought and not interrupting.

Ice-breaker – What was the last movie you saw? Recommend it or not?

Now we are going to switch gears and I am going to ask you your beliefs and thoughts about sexual practices, condom use, and HIV/AIDS.

OK, let's begin:

1. Sometimes we may hear that black men do not like to use condoms? Tell me your thoughts about this?

**Probes:**

a. We sometimes hear men say that using condoms removes the spontaneity from sex. Tell me what you think about this belief.

b. Some men may say that their female partners do not want to use condoms. What do you think about this?

2. How would you say black men respond when they are asked to use a condom by their female partners?

3. Sometimes you may hear/read that black men tend to have multiple sex partners? What do you think about this?

4. What do you think happens when black men use drugs or alcohol before having sex?

5. We have talked about black men's beliefs and sexual behaviors such as condom use and sex partners. From your experience, how do you think black men's sexual behaviors affect your own health?

6. What can we do as a community to help men to protect themselves and their partners against HIV?

7. Tell me your thoughts about black men and the hip-hop culture.

8. Tell me what you think black men believe about HIV and gay men.

9. Some men may say they never discussed sex or condom use with a parent, guardian or family member while growing up. What do you think about this?

10. Is there anything else you would like to share?

Thank you very much for your time and I appreciate your participation.

End of Focus Group Guide



Appendix J: Itemization of Coding by Independent Coders

Secondary Coder: Male Interviews (U.S.-born)

| File Name                                  | AA336JA25                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | AA336DM19                                                                                                                                                                     | AA336JJ26                                                                                                                 |
|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| <b>Overall Themes</b>                      | <input type="checkbox"/> Monogamy/Trust determines condom use<br><input type="checkbox"/> Spiritual beliefs and homosexuality<br><input type="checkbox"/> Spiritual beliefs and condom use<br><input type="checkbox"/> Interpersonal communication and beliefs about condom use<br><input type="checkbox"/> Familial communications about sexual behavior<br><input type="checkbox"/> Conflicting media messages and the application of preventive behaviors<br><input type="checkbox"/> Non-condom use and gender roles (mutual decision)/Condom use and decision making<br><input type="checkbox"/> HIV/AIDS risk and decision making among women (victim blaming) <ul style="list-style-type: none"> <li>▪ Condom use is crucial but not a perpetual act</li> <li>▪ Stigma and HIV/AIDS risks</li> <li>▪ Promiscuity</li> </ul> |                                                                                                                                                                               |                                                                                                                           |
| <b>Knowledge, Attitudes, &amp; Beliefs</b> | -Fear & worry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | - Want to learn more, undetectable<br>-Thought it was curable                                                                                                                 | -Risky behaviors, promiscuity                                                                                             |
| <b>What increases risk?</b>                | -Unprotected sex                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | -Unprotected sex, needles, etc.                                                                                                                                               | - Promiscuity                                                                                                             |
| <b>How can you protect yourself?</b>       | -Abstinence<br>-Protective intercourse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | -Condoms                                                                                                                                                                      | -Universal precautions: condoms, having one mate, no drug usage                                                           |
| <b>Origination of disease</b>              | -Experiment on Africans by Whites                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | -Something from the White man                                                                                                                                                 | -Originated from Africa; a disease to punish mankind for being promiscuous<br>-Wasn't invented or created; it's by chance |
| <b>HIV Risk Behaviors</b>                  | -One sex partner-have mutual understanding<br>-Believe black men more likely to have multiple sex partners<br>-Reasons: not satisfied trying something new                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | -Multiple sex partners<br>-Women dishonest about partners                                                                                                                     | -Monogamous<br>-Black men tend to have multiple partners.<br>-Reason: want to fit in or it's just something to do         |
| <b>Risk Behaviors</b>                      | -Condoms always necessary<br>-Prevent disease and death, safety<br>-Had engaged in unprotected sex<br>-Reason: Partner was a virgin; trust and care for partner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | -Don't always use condoms<br>-Didn't have one and it felt good without it<br>-Acknowledges and states that he needs to use condoms<br>-Reasons for needing to use them: don't | -It's good to protect yourself<br>-Reasons: to prevent unplanned pregnancies and STD's<br>-Inconsistent condom use        |

|                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>want anything to fall off, AIDS, pregnancy, catching something, regrets</p> <p>-Reasons for not using them: spur of the moment, condom unavailable, does not perceive need to use condoms at moment of intercourse</p>                                                                                                                                                                                                                  | <p>-Reason: trusts partner; heat of the moment</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <p><b>Cultural Norms</b></p> | <p>-Mother discussed safe sex</p> <ul style="list-style-type: none"> <li>▪ Pushed having safe sex</li> </ul> <p>-Little dialogues with father “stay out of trouble”</p> <p>-Stigma associated with HIV/AIDS</p> <p>-Impacted his interaction with such individuals</p> <p>-Equated homosexuality to being “fruity” or a “punk”.</p> <p>-The media has a strong influence on black men’s sexual behavior</p> <p>-what they converse about and believe, the type of women they express interest in or attract</p> <p>-Bisexual women more acceptable.</p> <p>-Spirituality introduced when speaking about homosexuality.</p> <p>-“Down low” men are freaks and basically gay.</p> | <p>-Friends encourage condom use</p> <p>-Family encouragement to carry condoms</p> <p>-The media stimulates the excitement to have sex (i.e. women shaking their booties and pornography).</p> <p>-Doesn’t want to be affiliated with a homosexual individual.</p> <p>-“Down low” was equated to going through a phase; unable to define the term.</p> <p>-Use scare tactics to educate black men about HIV; outcomes driven education</p> | <p>-No condom usage in his family; parents taught him to have one partner and abstain until marriage.</p> <p>-Discussions about settling down and the risks associated with doing otherwise but no real discussions about sex; his parents are old-fashioned.</p> <p>-Believes the media has a severely negative impact on sexual behavior among black men.</p> <ul style="list-style-type: none"> <li>▪ Scantly clad women</li> <li>▪ Sex sells and always talked about</li> </ul> <p>-Bisexuality and homosexuality is more accepted in the black culture if its women.</p> <p>-Reasons: guys’ fantasy (i.e. threesome)</p> <p>-Doesn’t condone homosexuality</p> <p>-Feels guys are confused when they are on the “down low”; they</p> |

|                            |                                                                                                                                                                                                                                                     |                                                                                                                                                |                                                                                                                                                                                                                            |
|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                            |                                                                                                                                                                                                                                                     |                                                                                                                                                | <p>go through spurt when they want women and men.</p> <p>-Feels the message about HIV/AIDS is out there but black men have heard it so much it doesn't affect them anymore.</p>                                            |
| <b>Gender Norms</b>        | <p>-Believe women play a role in unprotected sex; he made the decision to use a condom or no sex.</p> <p>-Equated women having unprotected sex to looking for someone to be with-relationship, a marriage.</p>                                      | <p>-Condom used if female requests</p> <p>-Women not financially dependent</p> <p>-Women dishonest about disease status</p>                    | <p>-Both he and the female mutually decided not to use a condom.</p> <p>-Partner was somewhat dependent upon him financially.</p> <p>-Women need to initiate more precautions.</p>                                         |
| <b>Behavioral Health</b>   | <p>-Has been drunk during sex</p>                                                                                                                                                                                                                   | <p>-Using recreational drugs will impair your judgment and you are more likely not to protect yourself.</p> <p>-Never used them during sex</p> | <p>-Never used recreational drugs before or during sex.</p>                                                                                                                                                                |
| <b>Additional Comments</b> | <p>-Changing sexual behavior in black community can be impacted by rappers (positive messages), some women need to reconsider what they are attracting or are attracted to (i.e. thugs), &amp; parents have to be mindful of their involvement.</p> | <p>-Provide pamphlets with images and little paragraphs about the disease</p>                                                                  | <p>-Feels more visual aids should be used in terms of messages for prevention.</p> <p>-Ensure that HIV/AIDS medication developments are not desensitizing people are sending conflicting messages to teens and others.</p> |

Appendix J (continued)

Primary Coder: Male Interviews (U.S.-born)

| File Name                                  | AA336JA25                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | AA336DM19                                                                                                                                                          | AA336JJ26                                                                                        |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <b>Overall Themes</b>                      | <input type="checkbox"/> High knowledge levels<br><input type="checkbox"/> Importance of condom use<br><input type="checkbox"/> Conspiracy beliefs<br><input type="checkbox"/> Inconsistent/non-condom use<br><input type="checkbox"/> Trust in partner<br><input type="checkbox"/> Sexual spontaneity<br><input type="checkbox"/> Long term relationships<br><input type="checkbox"/> Multiple sex partners<br><input type="checkbox"/> Lack of family communications about sexual behavior<br><input type="checkbox"/> Negative media influence<br><input type="checkbox"/> Gender roles , mutual decision-making about condom use<br><input type="checkbox"/> Homophobia<br><input type="checkbox"/> Alcohol use prior to sexual activity |                                                                                                                                                                    |                                                                                                  |
| <b>Knowledge, Attitudes, &amp; Beliefs</b> | -Fear, worry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | - HIV curable<br>-White man has cure; conspiracy beliefs.                                                                                                          | -Risky behaviors, promiscuity.                                                                   |
| <b>What increases risk?</b>                | -Unprotected sex                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | -High knowledge levels (Unprotected sex, needles).                                                                                                                 | - Promiscuity, multiple sex partners, IDU.                                                       |
| <b>How can you protect yourself?</b>       | -Abstinence; protective measures                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | -Condoms<br>-Abstinence                                                                                                                                            | -Universal precautions: condoms, monogamy, no drug use.                                          |
| <b>Origination of disease</b>              | -Experimentation by white doctors; created to destroy blacks; conspiracy beliefs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | -Originated from the white man.                                                                                                                                    | -Originated from Africa; religiosity (HIV is punishment from God)                                |
| <b>Risk Behaviors</b>                      | -Inconsistent condom use<br>-Determined by level of trust; length of time in relationship; virginity of partner; immediate availability of condoms; female partner not wanting to use condoms.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | -Inconsistent condom use<br>-Better feeling; caught in the moment; immediate availability of condoms<br>-Recognize need for condom use<br>-Previous STI experience | -Inconsistent condom use<br>-Trusts partner, unplanned sexual encounters, long term relationship |

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|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Cultural Norms</b>      | <ul style="list-style-type: none"> <li>-Dialogue with mother about safe sex</li> <li>-Lack of safe sex dialogue with father</li> <li>-Lack of safe sex dialogue with peers</li> <li>-Strong media influence</li> <li>-Homosexuality viewed as lack of masculinity ( “fruity”)</li> <li>-Homophobia</li> <li>-Disapproval of “down low” sexual behavior.</li> </ul> | <ul style="list-style-type: none"> <li>-Lack of family dialogue</li> <li>-Family encourages condom use since contraction of STI</li> <li>-Media stimulates sexual urges.</li> <li>-Homophobia.</li> <li>-Unfamiliarity with “Down Low” terminology.</li> </ul> | <ul style="list-style-type: none"> <li>-Religiosity within family; family values centered on abstinence until marriage.</li> <li>-Little discussion about sexual health with peers.</li> <li>-Severe negative impact of hip-hop on sexual behaviors.</li> <li>-Male bisexuality and homosexuality not accepted in black culture.</li> <li>-Men on the “down low” perceived to be “confused”.</li> </ul> |
| <b>Gender Norms</b>        | <ul style="list-style-type: none"> <li>-Women play key role.</li> <li>-Women seek permanent relationships and do not insist on condom use.</li> </ul>                                                                                                                                                                                                              | <ul style="list-style-type: none"> <li>-Lack of genuine care for female partners.</li> <li>-Women dishonest about sexual history</li> <li>-Female partner financially independent.</li> </ul>                                                                  | <ul style="list-style-type: none"> <li>-Mutual decision with partner to stop condom use</li> <li>-Role of women: women to know their sex partners better</li> </ul>                                                                                                                                                                                                                                     |
| <b>Behavioral Health</b>   | <ul style="list-style-type: none"> <li>-Drug use; alcohol use; perception that alcohol is non-inhibitive</li> </ul>                                                                                                                                                                                                                                                | <ul style="list-style-type: none"> <li>-No condom use if high or drunk prior to sexual activity.</li> </ul>                                                                                                                                                    | <ul style="list-style-type: none"> <li>-Never used recreational drugs before or during sex.</li> </ul>                                                                                                                                                                                                                                                                                                  |
| <b>Additional Comments</b> |                                                                                                                                                                                                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>-No access to health care</li> </ul>                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>-Show the community the outcomes of HIV/AIDS</li> <li>-Utilize schools, churches for HIV education.</li> </ul>                                                                                                                                                                                                                                                   |

Appendix J (continued)

Secondary Coder :Male Interviews (Haitian-born)

| File Name                                  | HA336KS20                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | AA336WN36                                                                                                                                                                                                       | AA336BL50                                                                                                                 |
|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| <b>Overall Themes</b>                      | <input type="checkbox"/> Importance of protection<br><input type="checkbox"/> Personal responsibility<br><input type="checkbox"/> High knowledge of HIV risk factors<br><input type="checkbox"/> Resentment of Haitian origin of AIDS argument<br><input type="checkbox"/> Multiple partners<br><input type="checkbox"/> Lack of family discussion about sexual activity<br><input type="checkbox"/> Homosexuality unacceptable<br><input type="checkbox"/> Negative effect of hip-hop and societal portrayal of sex<br><input type="checkbox"/> Unequal gender roles pertaining to condom use decisions |                                                                                                                                                                                                                 |                                                                                                                           |
| <b>Knowledge, Attitudes, &amp; Beliefs</b> | -Perceived seriousness<br>-Abstinence<br>-Importance of testing<br>-Personal responsibility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | - Protection important<br>-Unclear about transmission                                                                                                                                                           | -Personal responsibility<br>-Not caused by God<br>-Homosexual causality<br>-Caused by promiscuity<br>-AIDs self-inflicted |
| <b>What increases risk?</b>                | -Needles<br>-Oral sex with cuts<br>-Blood transfusions<br>-Accurate knowledge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | -Unprotected sex                                                                                                                                                                                                | - Homosexuality, promiscuity, anal sex                                                                                    |
| <b>How can you protect yourself?</b>       | -Male condoms                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | -Condoms                                                                                                                                                                                                        | -Monogamy, heterosexuality, condoms                                                                                       |
| <b>Origination of disease</b>              | -Green monkey origin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | -Offended by accusation of Haitian origin of AIDS.                                                                                                                                                              | -Did not originate in Haitian as often argued                                                                             |
| <b>Risk Behaviors</b>                      | -Multiple sex partners<br>-Misogyny; multiple “chicks”<br>-Men vs. “girl” dynamic<br>-Uses condoms consistently <ul style="list-style-type: none"> <li>▪ Prevent STDs and pregnancy</li> </ul> -Weigh decision of risks vs. benefits                                                                                                                                                                                                                                                                                                                                                                     | -Multiple partners<br>-Desire for monogamy<br>-Inconsistent condom use<br>-Condoms sometimes used for STD protection and unwanted pregnancy prevention.<br>-Regret after non-condom use<br>-Self responsibility | -Monogamy<br>-Long-term marriage                                                                                          |

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|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Cultural Norms</b>      | <ul style="list-style-type: none"> <li>-No open discussion with family and sexual behavior</li> <li>-Personally touched by HIV – family member died of AIDS.</li> <li>-Sex education obtained in schools, friends</li> <li>-Heterosexuality is normative</li> <li>-Homosexuality acceptable in women but not in men.</li> <li>-Disagrees with homosexuality</li> <li>-”Down low” behavior perceived to be misleading.</li> </ul> | <ul style="list-style-type: none"> <li>-Hip-Hop and media affects sexual behavior</li> <li>-Lack of parental discussion about sexual behavior</li> <li>-Tolerant of homosexuals</li> <li>-Unfamiliar with “down low” term.</li> <li>-HIV a sensitive issue</li> </ul> | <ul style="list-style-type: none"> <li>-Embarrassed to discuss sex with children</li> <li>-Teen pregnancy an issue</li> <li>-Talk to friends about sex but not to children</li> <li>-Society gives too much sexual information – encourages sexual behavior</li> <li>-Homosexuals mentally ill</li> <li>-Homosexuality is wrong – religiosity</li> <li>-No fear of people with AIDS</li> </ul>                                                      |
| <b>Gender Norms</b>        | <ul style="list-style-type: none"> <li>-Condom negotiation is male role</li> <li>-Women should use the female condom</li> </ul>                                                                                                                                                                                                                                                                                                  | <ul style="list-style-type: none"> <li>-Women should negotiate condom use</li> <li>-Women may not be heard</li> </ul>                                                                                                                                                 | <ul style="list-style-type: none"> <li>-Gender roles not equal</li> <li>-More worried about daughters than sons</li> <li>-Young people lack knowledge of sex partners’ history</li> <li>-Discourages birth control</li> <li>-Male controls household and sexual decisions</li> <li>-Role of women: abstinence before marriage; use protection; get to know sex partners; HIV testing important; use protection even with negative status</li> </ul> |
| <b>Behavioral Health</b>   | <ul style="list-style-type: none"> <li>-No drug or alcohol use</li> </ul>                                                                                                                                                                                                                                                                                                                                                        | <ul style="list-style-type: none"> <li>-Frequent sex with alcohol use</li> <li>-Denial of impairment while tipsy or drunk</li> </ul>                                                                                                                                  | <ul style="list-style-type: none"> <li>-No drug or alcohol use</li> </ul>                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Additional Comments</b> | <ul style="list-style-type: none"> <li>-Need more HIV awareness</li> <li>-Utilize sports venues, message bulletins</li> </ul>                                                                                                                                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>-Educate within social venues</li> <li>-Need for abstinence education</li> <li>-Teen pregnancy an issue in U.S.</li> </ul>                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

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|  |  | -Less teen pregnancy among Haitians |  |
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Appendix J (continued)

Primary Coder : Male Interviews (Haitian-born)

| File Name                                  | HA336KS20                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | AA336WN36                                                                                                                     | AA336BL50                                                                   |
|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <b>Overall Themes</b>                      | <input type="checkbox"/> Religiosity<br><input type="checkbox"/> Personal responsibility<br><input type="checkbox"/> Angered by accusation that AIDS originated among Haitians<br><input type="checkbox"/> Multiple sex partners<br><input type="checkbox"/> Inconsistent condom use<br><input type="checkbox"/> Lack of family communication<br><input type="checkbox"/> Negative effect of pop culture<br><input type="checkbox"/> Male condom-use decision making<br><input type="checkbox"/> Male dominance |                                                                                                                               |                                                                             |
| <b>Knowledge, Attitudes, &amp; Beliefs</b> | -High knowledge levels about HIV risk and protective behaviors                                                                                                                                                                                                                                                                                                                                                                                                                                                  | - Unsure about HIV transmission<br>-Lack of education                                                                         | -Personal responsibility<br>-Religiosity – God protects married individuals |
| <b>What increases risk?</b>                | -Needles<br>-Blood transfusions<br>-Accurate knowledge                                                                                                                                                                                                                                                                                                                                                                                                                                                          | -Unprotected sex                                                                                                              | - Multiple sex partners                                                     |
| <b>How can you protect yourself?</b>       | -HIV Testing<br>-Protection<br>-Abstinence                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | -Condoms use                                                                                                                  | -Monogamy                                                                   |
| <b>Origination of disease</b>              | -Green monkey theory                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | -Resents accusation of Haitians being carriers of HIV                                                                         | -United States<br>-Homosexuals<br>-Multiple partners                        |
| <b>Risk Behaviors</b>                      | -Multiple sex partners<br>-STD and pregnancy prevention                                                                                                                                                                                                                                                                                                                                                                                                                                                         | -Multiple partners<br>-Inconsistent condom use prevention.<br>-Regret unprotected sexual behaviors<br>-Desire for spontaneity | -Married long-term<br>-Faithful<br>-Non-condom use                          |

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| <b>Cultural Norms</b>      | <ul style="list-style-type: none"> <li>-Lack of family communication</li> <li>-Lack of HIV/AIDS discussion among peers</li> <li>-Hip-hop negatively affects others</li> <li>-Personal detachment from hip-hop effect</li> <li>-Haitian men promiscuous</li> <li>-Homophobia</li> <li>-Cultural violence towards homosexuals</li> </ul> | <ul style="list-style-type: none"> <li>-Little family communication about sexual behavior.</li> <li>-Pop culture has tremendous effect on sexual behavior.</li> <li>-Aversion to those who “choose” to be homosexual.</li> </ul> | <ul style="list-style-type: none"> <li>-No family dialogue about HIV/AIDS</li> <li>-Does not speak to children about sex</li> <li>-Embarrassment</li> <li>-Media overly informative about sex which causes pregnancy and AIDS</li> <li>-Homosexuality brings sickness and AIDS</li> <li>-Anal sex causes disease</li> <li>-No fear of people with AIDS</li> </ul> |
| <b>Gender Norms</b>        | <ul style="list-style-type: none"> <li>-Male decides on condom use</li> <li>-Female condoms an option for women</li> <li>-Women to insist on condom use</li> </ul>                                                                                                                                                                     | <ul style="list-style-type: none"> <li>-Male makes condom use decisions</li> <li>-Women’s voices not heard during sexual activity</li> </ul>                                                                                     | <ul style="list-style-type: none"> <li>-Women should protect themselves</li> <li>-Women to more closely assess male partners</li> <li>-HIV testing important</li> </ul>                                                                                                                                                                                           |
| <b>Behavioral Health</b>   | <ul style="list-style-type: none"> <li>-No drug or alcohol use</li> </ul>                                                                                                                                                                                                                                                              | <ul style="list-style-type: none"> <li>-Commonly uses alcohol as sexual enhancement</li> <li>-Perceive alcohol does not affect judgment</li> </ul>                                                                               | <ul style="list-style-type: none"> <li>-No drug or alcohol use</li> </ul>                                                                                                                                                                                                                                                                                         |
| <b>Additional Comments</b> | <ul style="list-style-type: none"> <li>-Need more HIV awareness</li> <li>-Utilize sports venues, message bulletins</li> </ul>                                                                                                                                                                                                          | <ul style="list-style-type: none"> <li>-Other factors that influence HIV transmission:</li> <li>-income, education, welfare system, need for parental guidance.</li> </ul>                                                       |                                                                                                                                                                                                                                                                                                                                                                   |

Appendix J (continued)

Focus Group Coding

| File Name: U.S.-born Women (18-30 years) | Coder 1 – Primary Coder                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Coder 2 – Secondary Coder                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Themes</b>                            | <p>Negative male attitudes to condom use</p> <p>Female aversion to condom use</p> <ul style="list-style-type: none"> <li>▪ Low self-esteem</li> <li>▪ Need to “trap” a partner</li> <li>▪ Perceived trust</li> <li>▪ Late realization of consequences among women</li> <li>▪ Lack of parental dialogue about sexual behavior</li> <li>▪ Fear of discussing sex with parents</li> </ul> <p>Male partners have multiple sex partners</p> <p>Better sex while intoxicated</p> <p>Alcohol impairs thinking</p> <p>Lack of condom use while under the influence of alcohol</p> <p>Little sexual dialogue with partner</p> <p>Negative hip-hop lyrics</p> <p>Lack of HIV testing in black community</p> <p>Non-confirmation of conspiracy beliefs</p> <p>Need for community education</p> | <p>Women may not like to use condoms. Barriers among women:</p> <ul style="list-style-type: none"> <li>▪ Depression</li> <li>▪ Desire for pregnancy</li> <li>▪ Strategies to keep male partner</li> </ul> <p>Lack sex education within the family unit</p> <p>Family emphasizes pregnancy prevention</p> <p>Perceptions of male infidelity</p> <p>Male machismo – multiple partners proves manhood</p> <p>Intoxication inhibits clear thinking in men and women</p> <p>Some men intentionally transmit disease to women</p> <p>Women do not insist on condom use</p> <p>Lack of female empowerment to discuss sexual history with male partner</p> <p>HIV not perceived to be a problem in the black community</p> <p>Negative hip-hop role models</p> <p>Women also influenced by pop culture</p> <p>Blacks afraid to get tested for HIV</p> |

- History of mistrust in the black community
- Fear of AIDS inhibits testing

More education needed in black community

## ABOUT THE AUTHOR

Shalewa Noel-Thomas completed her Bachelor's degree in Biology with a minor in Chemistry at Florida Agricultural and Mechanical University in 1999. She then received her Master's in Public Health from the University of South Florida in 2002. In 2003 she began her doctoral studies in Public Health with a specialization in Behavioral Health.

Ms. Noel-Thomas is currently the Program Manager for the Tampa Bay Community Cancer Network (TBCCN), an NCI-funded Community Network Program. She has over 7 years of experience in program management, implementation and evaluation in public health programs. She has worked with public health providers, physicians, and community partners to address health disparities in cancer and HIV/AIDS. Her areas of expertise include program management, program implementation, community academic partnerships and health education. Her research interests include health disparities, HIV prevention, women's health, behavioral health, and psychosocial and ecological determinants of health.

Ms. Noel-Thomas has also served as the program coordinator for a perinatal HIV prevention program at the University of South Florida where she coordinated HIV educational programs for health care providers. Her ultimate goal is to make an impact on health disparities and contribute to efforts to decrease inequities in health.