Published in final edited form as:
J Health Dispar Res Pract. 2014 ; 7(6): 1–25.

Perceptions of HIV Risk and Explanations of Sexual Risk Behavior Offered by Heterosexual Black Male Barbershop Patrons in Brooklyn, NY

Tonya N. Taylor, PhD, MS
SUNY Downstate Medical Center, Medicine/STAR Program

Michael Joseph, PhD, MPH
SUNY Downstate Medical Center, School of Public Health

Kirk D. Henny, PhD
Centers for Disease Control and Prevention

Angelo R. Pinto, JD
Correctional Association of NYC

Francis Agbetor
Arthur Ashe Institute for Urban Health

Brignel Camilien
Arthur Ashe Institute for Urban Health

Kim M. Williams, PhD
Centers for Disease Control and Prevention

Ruth C. Browne, ScD
Arthur Ashe Institute for Urban Health

Marilyn White, MD
Arthur Ashe Institute for Urban Health

Yolene Gousse, DrPh, MPH
SUNY Downstate Medical Center, STAR Program

Humberto Brown
Arthur Ashe Institute for Urban Health

Raekiela D. Taylor, PhD
Centers for Disease Control and Prevention

Tracey E. Wilson, PhD
SUNY Downstate Medical Center, School of Public Health

Abstract

To describe HIV risk factors among adult heterosexual Black men recruited from four barbershops located in high HIV seroprevalent neighborhoods of Brooklyn, NY. Data on HIV-risk related behaviors and other characteristics were collected from barbershop clients. All participants (n=60) completed brief risk assessments; and a subset (n=22) also completed focus groups and/or individual interviews. Of the subset of 22 men, 68% were US born, 59% had been in jail/prison, 32% were unemployed; and during the 3 months before the interviews, 68% reported at least two partners and 45% reported unprotected vaginal or anal sex with two or more women. Emergent themes included: 1) the psychological function of multiple partnerships; 2) calculated risk taking regarding condom use; 3) the role of emotional attachment and partner trust in condom use; 4) low perceived HIV risk and community awareness; and 5) lack of relationship between HIV testing and safer sex practices. Interventions among heterosexual Black men should focus not only on increasing HIV awareness and reducing sexual risk, but also on contextual and interpersonal factors that influence sexual risk.

Keywords

HIV risk behaviors; Non-Hispanic Black men; Non-injection drug users; Heterosexual men; Brooklyn, NY

INTRODUCTION

HIV and AIDS disproportionately affect non-Hispanic Black persons living in the United States. Persons identifying as Black or African American (including individuals from sub-Saharan Africa, South America and the Caribbean) make up approximately 14% of the U.S. population, but in 2009, non-Hispanic Blacks accounted for 44% of new diagnoses of HIV infection (Prejean et al., 2011). From 2001-2004, HIV rates for non-Hispanic Black men with high-risk heterosexual contact were 35.5 per 100,000, compared with 1.1 for whites, and 10.9 for Hispanics (Centers for Disease Control and Prevention, 2006). Black men with heterosexually acquired HIV are more likely to have a dual diagnosis of HIV and AIDS at the time of testing and have decreased survival after an AIDS diagnosis than do men with heterosexually acquired infection belonging to other racial and ethnic groups (Espinoza et al., 2007; Sutton et al., 2009).

There have been many significant contributions to our understanding of the predictors of HIV risk among Black men and women as it relates to populations of injection drug users, men who have sex with men and men who have sex with both men and women (Blankenship, Smoyer, Bray, & Mattocks, 2005; Centers for Disease Control and Prevention, 2009; Fuller et al., 2005; Operario, Smith, & Kegeles, 2008; Oster et al., 2011; Peterson, Rothenberg, Kraft, Beeker, & Trotter, 2009). There have also been impressive inroads made into understanding factors related to Black women's heterosexual risk behavior (Moreno, El-Bassel, & Morrill, 2007; Neblett, Davey-Rothwell, Chander, & Latkin, 2011; Tillerson, 2008). Significantly less is known, however, about Black men's heterosexual risk behavior, and about the individual and contextual factors that put these men at risk for HIV infection. Consequently, there is a large gap between the prevention

needs of these men and the number and quality of prevention programs demonstrated to meet these needs.

In a recent meta-analysis on HIV and STI behavioral interventions for heterosexual African-American men in the United States, researchers identified poverty, incarceration, health disparities and *machismo* (an exaggerated sense of masculinity that emphasizes bravery, physical aggression, virility, and the domination of women) as key social and structural factors that are correlated with the risk of HIV infection (Henny et al., 2012). Although researchers have noted that it is important to understand the social and environmental context in which individuals view HIV and other STIs, as well as their motivations for engaging in sexual behaviors and risk taking (Adimora et al., 2001; Shain et al., 1999), the role of these factors has not been adequately explored among Black men who report heterosexual risk behavior and who do not engage in injection drug use (Adimora & Schoenbach, 2002, 2005; Farley, 2006; Morris & Kretzschmar, 1997).

In this paper, we present formative data on the individual and contextual factors that are linked to HIV transmission risk behaviors among non-injection drug using, heterosexually-active Black men of unknown or HIV-negative serostatus in Brooklyn, NY to identify determinants of HIV risk sexual behaviors in this population. These data were collected to inform the development of an intervention program focused on reducing HIV transmission risk behaviors in this priority population.

METHODS

Project Overview and Organization

Using mixed methods and a cross-sectional research design, this study included a brief risk assessment survey (BRA), followed by focus group interviews, and one-on-one, semi-structured individual interviews. Combining quantitative and qualitative approaches to collecting, analyzing, and interpreting the data provides both an overview of the individual and contextual factors that are linked to HIV transmission risk behaviors among heterosexually-active, non-injection drug using Black men of unknown or HIV-negative serostatus in Brooklyn and a more detailed understanding of how those factors are shaped and experienced among men with varying levels of risk behaviors. We collected data from eligible clients from four barbershops that were selected because they cater primarily to Black men and are situated in neighborhoods of Brooklyn, NY with high HIV seroprevalence. At the time of the study the prevalence of people with HIV/AIDS in these neighborhoods was 2.3%, 1.6% and 1.7%, which rose to 2.4%, 1.8% and 1.7% respectively (New York City Department of Health and Mental Hygiene, 2009, 2012). Given that barbershops represent a widely used male social space in our priority community, we recruited from barbershops with the intention to deliver HIV-related risk reduction messages in these venues.

An interdisciplinary team of investigators from the Arthur Ashe Institute of Urban Health (AAIUH) and SUNY Downstate Medical Center (DMC) conducted the study. This team was comprised of a behavioral scientist, epidemiologist, lawyer, physician, anthropologist, a doctoral student in public health, and two community health workers (one of whom was a

part-time barber). All but one member of the team was a person of African descent and all of the recruiters, facilitators and interviewers were Black men. The research team consulted regularly with a Steering committee comprised of barbershop and beauty salon owners, barbers, and community health liaisons. The shop owners at all four barbershop sites played an active role in participant recruitment and provided feedback throughout the development and implementation phases of the study.

Participants

Trained field staff screened 122 barbershop customers using an audio computer-assisted self-interview (ACASI) for BRA eligibility. Inclusion criteria for the BRA included: 18-45 years of age; self-identify as a man; understand and read English; self-identify as Black; and report at least one female sexual partner in the last 3 months. We targeted men between the ages of 18 and 45 because in Brooklyn, men within this age range have the highest HIV burden (New York City Department of Health and Mental Hygiene, 2009). Ninety percent (n=105) of the screened men (n=122) were both eligible for the study and all (100%) agreed and completed the ACASI BRA survey. The BRA surveys were collected at all four barbershops (Shop 1 N=22, Shop 2 N=36, Shop 3 N=32, Shop 4=15).

Among the 105 BRA participants, 57% (n=60) represented our priority population of non-injection drug using, heterosexual Black men and were eligible for focus group and individual interview participation. The 45 men who were ineligible for participation in focus group and individual interviews were excluded for the following reasons: participated in an HIV prevention or substance use prevention project in the previous 6 months (n=13); reported having no female sexual partners in past 3 months (n=7); had at least two female sexual partners and had unprotected sex with no more than one of them (n=15); fell outside age range of 18-45 (n=2); reported having HIV (n=1) or injecting illicit drugs in the last 3 years (n=1); reported ever having oral or anal sex with a man (n=3); did not self-identify as Black (n=3).

We then purposefully selected a subset of participants for focus group and individual interviews to represent an equitable distribution along several strata. The strata include age (18-24 versus 25-45), levels of sexual risk (“higher risk” denoted as unprotected sex with two or more women in past 3 months versus “lower risk” denoted as no unprotected sex or unprotected sex with 1 partner in past 3 months), and country of origin (US versus non-US). About one-third of eligible participants (n=22) were willing and available to participate in focus group and individual interviews. The involvement of the 22 selected participants was as follows: eight in focus group only, one in individual interview only, and thirteen in both focus group and individual interviews.

Procedures

Trained field staff recruited participants at barbershops that provided services during time periods that included daytime, evening, weekday, and weekend services. We employed this strategy so that all potential time periods for recruitment were equally covered throughout the study period. During each time period, staff systematically approached clients waiting for services, explained the study objectives, and screened participants. We employed this

sampling approach to increase the extent to which our sample reflected the population of customers receiving services at participating barbershops. Men who appeared to be younger than 18 years or older than 45 years of age were not approached by the field staff. Eligible participants provided written informed consent and then completed the BRA, which took on average 11 minutes to complete. Participants were provided $20 for completing the BRA.

Three focus groups and 14 individual interviews were conducted in private rooms at SUNY Downstate. Each 2 to 2.5 hour focus group had 5-10 participants and was moderated by a trained Black, male facilitator while study staff took notes and audio recorded the session. Individual interviews, also lasting 2-hours, were conducted one-on-one with a study facilitator and were audiotaped. Participants were provided $60 for each focus group and individual interview. All procedures were approved by each of the Institutional Review Boards at SUNY Downstate Medical Center and the Centers for Disease Control and Prevention. A federal Certificate of Confidentiality was obtained for this study.

Measures

The Brief Risk Assessment Survey—To characterize the level of HIV risk among the population of men who receive services at the barbershops in our target neighborhoods, the BRA survey explored the following topics: sexual behaviors, alcohol and drug use, and HIV testing history. Sociodemographic information (age, place of birth, education, employment, income, housing situation, history of incarceration, and health insurance) was also collected in the BRA. Self-reported sexual behavioral items, similar to those used in the BRA survey, are predictive of HIV risk behaviors (Fishbein & Pequegnat, 2000).

Focus Groups & Individual Interviews—To explore how the level of HIV risk reported among the men who completed the BRA are linked to individual and contextual factors, we conducted focus group and individual interviews with a subset of younger men (18-24), and older men (25-45), with varying levels of risk behaviors. Key topics explored in the focus group and individual interviews included: masculinity, gender-role conflict and strain; sexuality; types of sexual partners, partner selection and networks, sexual risk behaviors with different partner types; perceptions of STIs in comparison to HIV; attitudes, beliefs and intentions regarding HIV-testing; myths and stigma surrounding HIV; and intervention suggestions. The focus group questions targeted group behaviors and norms of Black heterosexual men in general, while the individual interviews aimed at eliciting each participant's subjective knowledge, attitudes and behaviors toward risky sexual behaviors and HIV/AIDS.

Combining quantitative and qualitative approaches to collecting, analyzing, and interpreting data provides a more comprehensive understanding of how individual and contextual factors are linked to HIV transmission risk behaviors among the study participants.

Data Analysis

BRA data were analyzed for all of the men who completed the survey irrespective if they participated in focus group/individual interviews. Demographic, lifestyle and sexual behavior characteristics are expressed as means (SD) for continuous variables and as

percentages for categorical variables. The distribution of variables was examined separately for 1) the men who completed the BRA and met eligibility criteria for participation in focus groups/interviews (n=60); 2) the men who participated in focus groups/interviews (n=22); and 3) the men who were eligible to participate in focus groups/interviews but who were not selected to participate (n=38). Independent samples t-tests or chi-square tests were performed to assess differences between the focus group/ interview participants (n=22) and the men who were not selected to participate (n=38). Data were analyzed using SPSS version 20 (IBMCorp, 2011), with statistical significance set at a two-sided alpha level of 0.05.

All focus group and individual interviews were transcribed verbatim by a professional transcription service and were double-checked for accuracy. Following a review of the aforementioned *a priori* topics from the interview guides, five researchers conducted a thematic analysis to identify emerging patterns and codes. The coding framework was refined to ensure common interpretation and all discrepancies were resolved through discussion. The coding scheme was finalized at the point of saturation, or when additional transcripts did not elicit new themes.

Codes were entered into NVivo qualitative data analysis software (QSR, International, Pty, & Ltd, 2010) and five investigators recoded all focus group and individual interview transcripts based on the final codebook. Each transcript was coded by a minimum of three researchers and one researcher coded all transcripts. Using NVivo, we calculated the inter-rater agreement with 95% confidence intervals for all the individual interviews, comparing the first author's coded text to those of each of the members of the coding team. For the purpose of this paper, we report the Kappa coefficients for only 6 codes that correspond with the 5 emergent themes discussed below: multiple partners (89-95%), different levels of risk with different types of partners (89-95%), condom use (89-94%), risk situations (89-97%), HIV testing (90-99%), and HIV knowledge (89-98%). Quotations throughout this paper reflect participants' typical comments that addressed the primary themes unless otherwise noted.

RESULTS

Sample Characteristics

Sociodemographic and behavioural characteristics of participants who completed the BRA and were eligible for the focus group and individual interviews (n=60) are presented in Table 1, column 1. The majority of these participants were born in the U.S. (60%), with a mean age of 29 (SD=6.76). Most of the men had more than a high school diploma or GED (52%), lived with their parents or others (62%), were employed (73%), and made less than $40,000 a year in income (75%). More than half of the participants also reported ever being in jail/prison (55%). The majority of the men had health insurance (58%) and sought medical care from private medical doctors or community health centers (67%).

Most reported ever having an HIV test (93%), with many having had an HIV test within the past year (72%). Eighty-three percent of the BRA participants reported having a primary sexual partner, and the majority reported having more than two sexual partners in the last 3

months (55%). Sixty-two percent reported inconsistent condom use within the last 3 months; and 37% reported having sex without a condom with two or more partners in the same time period. Very few (7%) reported an exchange for sex, or that they had sex while drunk (28%) or under the influence of drugs (12%). Sixty-nine percent reported talking with some or every partner about their HIV status, while 60% reported talking to their sexual partners about their partner's HIV status, and 90% believed that none of their partners had HIV.

Sociodemographic and behavioural characteristics of the subset of men who completed the focus group and individual interviews (n=22) are presented in Table 1, column 2. The majority of the 22 participants who completed focus groups and/or in depth interviews were born in the U.S. (68%) and the rest were from the Caribbean (32%). The mean age for the focus groups and indepth interviews was 27 (SD 5.35). Fifty-nine percent had less than a high school diploma or GED, while 41% had a high school diploma, GED or higher degree. Eighty-one percent of these respondents lived with their parents or others, most were employed (68%), made less than $10,000 a year in income (55%), and reported having ever been in jail or prison (59%). Half of the focus group and in-depth interview respondents had health insurance and the majority of the men sought medical care from private medical doctors or community health centers (76%). Finally, 96% reported ever having an HIV test, with 73% also having had an HIV test within the past year.

Seventy-seven percent of the men in the focus groups and interviews reported having a primary sex partner. Sixty-eight percent of the respondents also reported having 2 or more female sexual partners in the past 3 months, 77% reported unprotected sex with two or more partners in the past 3 months, and 94% reported infrequent condom use. Only 4.5% reported an exchange for sex. Sex under the influence of alcohol or drugs was reported by 41% and 18% of the respondents respectively. Eighty-six percent of the focus groups and interviews participants reported talking with "some" or "every" partner about their HIV status and 73% reported talking with "some" or "every" partner about their partner's HIV status. Eighty-six percent of the focus groups and interviews participants believed that none of their sexual partners had HIV, 5% reported that some of their sexual partners had HIV, and 9% reported that they did not know their partner's HIV status.

Due to the fact that we purposely selected sexually active respondents to participate in the focus groups and in-depth interviews, we expected these individuals to look different from the cross-section of barbershop clients from whom these participants were drawn. As shown in Table 1, column 3, the focus group and interview participants tended to be younger ($p=0.046$), have lesser income (less than $40K per year; $p=0.011$), live with parents or others ($p=0.015$), and were more likely to talk about their own HIV status with some or every partner ($p=0.054$) than those eligible men who did not participate in the focus groups and in-depth interviews. No other variables produced statistically significant differences.

Emergent Themes

From the qualitative data that surveyed normative and subjective attitudes, beliefs and behaviors toward sexual risk behaviors and HIV/AIDS, we found five emergent themes linked to the sexual risk behaviors of the men in our sample. These themes include: 1) multiple partnerships and emotional buffers; 2) calculated risk taking regarding condom use

(e.g., the loss of an opportunity to have sex); 3) risk and emotional attachment/trust in condom use decisions; 4) low awareness/knowledge of HIV transmission/risk; and 5) HIV testing does not correspond to subsequent safer sex practices. Each theme is described in the following paragraphs.

1.Multiple partnerships and emotional buffers—Most studies on men's concurrent sexual partnerships in the US have focused on the prevalence, distribution, and behavioral correlates (Adimora, Schoenbach, & Doherty, 2007; Adimora et al., 2004; Manhart, Aral, Holmes, & Foxman, 2002; Martina Morris, Kurth, Hamilton, Moody, & Wakefield, 2009). Few studies have explored qualitatively the patterns or rationale for sexual concurrency (Carey, Senn, Seward, & Vanable, 2010; Gorbach, Stoner, Aral, Whittington, & Holmes, 2002). Stereotypes, or widely held and oversimplified notions, beliefs or ideas about what type of man pursues multiple sexual partners circulate in the Black community and in society-at-large (Ford, Vieira, & Villela, 2003; Gupta, 2000). Reasons for engaging in concurrent sexual partnerships vary. In contrast to stereotypes that heterosexual Black have insatiable sexual appetites or pursue multiple partners for self-aggrandizement (Courtenay, 2000), we found that some respondents pursued multiple partners to protect themselves from emotional and/or psychological distress or harm. One respondent described his having concurrent sexual partners as a strategy to mitigate fears of loneliness.

> … the fear of being alone… not having that partner in life to just …lay down in bed with, you know, and talk {expletive} and hold, … I can call them any time… And so… that abandoned feeling was minimized because they were there (Bob: 25 years old, 3 sexual partners, and in higher risk group)

Another man suggested that having multiple partners provides an emotional buffer to the disappointment of infidelity or betrayal from his main partner.

> …I don't care who you are, everybody cheats… And once their main (i.e., partner) cheat on them, they'll go crazy, you know, ready to kill, [and] ready to stab her. You see it every day on the news - ex-boyfriend stabbing the wife…shooting the ex-girlfriend because it's jealousy…If they had a side (i.e., a girl on the side), they won't be as angry. But they'll be angry, but they won't be as angry. You know? (Chris: 20 years old, 2 sexual partners, low risk group).

Finally, another described his emotional need to have more than one sexual partner at a time as a "back-up plan" or "safety net" in case he is unable to pursue his first choice for sex.

> Other people would like that sense when you argue with this one, you got this one to fall back on… for most people, it's a safety net that if you know this relationship ain't going to work out, at least you know you still got a lover to fall back on (Darrin: 28 years old, 1 sexual partner, low risk group).

Again, sexual risk behaviors with concurrent partners were common among the BRA respondents eligible for participation in the study: 55% reported having more than two sexual partners in the last 3 months and 37% reported having sex without a condom with two or more partners in the same sexual relationships may be a strategy to manage or

regulate emotions that contribute to feelings of vulnerability, fears of loneliness and or the need for intimacy.

2. Calculated risk taking regarding condom use—In this study, we found low levels of reported condom use during vaginal sex within the past 3 months. Only 3% of the 60 BRA respondents and 4.5% of the focus group/interview participants reported "always" using condoms during vaginal sex while 62% of the BRA respondents and 73% of the focus group/interview participants reported never or infrequent ("sometimes" or "often") condom use. Reasons for inconsistent condom use during vaginal or anal sex that are often cited in other studies include: limited access to condoms, prohibitive cost of condoms, lack of pleasure, and "heat of the moment" situations (Cue Davis et al., 2013; Davis et al., 2013).

Although the research suggests that sexual impulsivity, disinhibition, and sensation seeking in unplanned or unanticipated opportunities for sexual intimacy (e.g., "the heat of the moment") are involuntary reactions (Donohew et al., 2000; McCoul & Haslam, 2001; Zuckerman, 1979, 1994), some men in this study reported taking calculated sexual risk for fear of losing an opportunity for sex. For the following respondent, the intentional choice not to wear a condom was based on his belief that if he gave his partner too much time to think that she will change her mind.

> …sometimes you got a girl in a position where you can have it right there…[but] …one bad move… messes up the whole flow…if I had [to] take the time to use protection, she might not want to do it…remember, once you move away for that one second, it gives each other [sic] time to think…She's going to think about it, [and] I'm going to think about it, and then after, she might say she don't want to do it again. (Frank: 19 years old, 5 sexual partners, high risk group).

Consequently, many reported often having sex at their sexual partner's apartment or under constrained or impromptu circumstances (e.g., laundry rooms, back of a car, public spaces). For example, one respondent mentioned that his haste to seize the moment was influenced by the fact that his partner's parents were around and they had limited time alone.

> … it was just the moment, and the adrenalin, and the feelings that come over me… But at the same time, something was telling me, "Hey, you need to get the condom." …But I was like, all kissing up and everything, and she was all over me and everything, and I just want to hurry up because… her parents were there (George: 30 years old, 1 sexual partner, low risk group).

Several men in the study reported access to regular and or mandatory HIV testing through their employer and consequently displayed similar calculated risks regarding condom use. One man who was also in the military noted that high risk sexual behaviors were common among soldiers stationed abroad because of the assumption that everyone is HIV-negative due to mandatory testing before deployment.

> … The military is like Vegas, like when I went to Iraq, whatever happens in Iraq stay in Iraq. A lot of chicks was (sic) doing dirt with their rings on, and it was accepted because you out there going through stress… So, you know, it was allowed. The bigwigs didn't say nothing… because they was [also] doing… dirt,

> too. But… yeah, and then we get tested. That's mandatory. Whenever you ship out, you going to get tested (Hank: 41 years old, 1 sexual partner, low risk group).

Although many men report not using a condom because they were caught up in "the heat of the moment," some reported their decisions to not have protected sex as intentional and deliberate. Calculated sexual risk, for fear of a loss of opportunity to have sex, limited access to privacy, or an assumption in partner safety, expands our understanding of how contextual or situational variables may affect some men's decisions not to wear a condom.

3. Emotional attachment and partner trust in condom use decisions—

Participants reported varying degrees of sexual risk taking according to the nature and length of the relationship. Normative gender expectations of women influenced levels of risk taking within different partnerships that included unprotected sex with the "good girl" (e.g., wifey, their main partner, or their main "girl on the side" with whom they have trust) and consistent condom use with the "bad girl" (e.g., "girl on the side" or casual "hook-up." For example:

> … the main one, that's the one you mostly care about, you know?…And the side chicks is [sic] the ones you don't even care about. They're just there. [with] all three partners, I use protection [but] not protection with the main…But everybody else, I use protection." (Chris: 20 years old, 2 sexual partners, low risk group).

As expected, most men reported having unprotected sex with their main partners because"… when you're married…you're not supposed to use a condom with your wife" (George: 30 years old, 1 sexual partner, low risk group). However, many also reported having unprotected sex with both their main partner and an ex-main partner, with whom they have established trust.

> I will not use protection with my wife and the baby's mother just because there is some kind of trust between those two and me (Unidentified respondent from 1st focus group).

> So if I know you, and I feel comfortable having sex with you without a condom, I will continue to (Jack: 31 years old, 4 sexual partners, high risk group).

For most respondents a decline in condom use over time was considered a natural progression in long-term committed relationships; although some reported pressure from their female partners to discontinue condom use to prove that trust has been established.

> … I was still using protection, and she was like: "Yo! Why you still using protection? Are you {expletive} a lot of people?" I was like, "no!" "So, why you still use this thing?… It's three months now we living together. Come on. When you going to stop?" From that time on, I stopped using condoms. (Luis: 26 years old, 3 sexual partners, high risk group).

Many men noted that they would use condoms with their girls on the side, especially if they also had other sexual partners:

> [With] those two [girls on the side] in the last two year, I probably wouldn't go down on them (have oral sex), 'cause I know I'm not the only one they with (Marcus: 29 years old, 3 sexual partners, high risk group).

> And being that you cheating on me with your man, and I think you probably {expletive} like another nigga, I'm going to throw on a condom because you never know. I could probably get the clap from you. I could probably get burnt from you. (Bob: 25 years old, 3 sexual partners, high risk group).

For many men the thought of reintroducing condom use with an old partner is challenging; many fear that the suggestion of using condoms again would signal either their infidelity or suspicions that their partner has been unfaithful.

> Yeah. I think she would say that, or she'll think I'm disrespecting her, like I don't trust her, like she's {expletive} somebody else. (Bob: 25 years old, 3 sexual partners, high risk group).

However, the pattern of unprotected sex with trusted partners is further complicated when that trusted partner is also having unprotected sex with another man.

> … I think we broke up for a period of time, and she started messing with someone… and then after that little while…she kept saying, I think I've got to go to the hospital (for STI testing)…But I wasn't seeing no signs [of an STI] or nothing [on me] … I 95% think [sic] she (his main partner; wifey) gave me [something] from that dude…And I wasn't going to go back with her because that was critical but being that we want to talk about marriage and love, I end up messing with her [again] (Bob: 25 years old, 3 sexual partners, high risk group).

Consequently, we found that concurrent unprotected sex with trusted old and new partners creates recurring cycles of risk as many men move from long term partnerships to another yet continue to engage in unprotected sex with former partners.

> …My wifey was my young girl, my little side thing [and] I wasn't {expletive} her raw at that time. But my wife… the [now] ex-wifey … I was {expletive} her raw and {expletive}. And any given day, if a freak, I'm down with the train. If there four dudes and we pop off with two freaks, I'm down with the train. But I'm never {expletive} them raw (Bob: 25 years old, 3 sexual partners, high risk group).

According to some of the participants, during these recurring cycles of risk, many of their previous female partners pursued similar patterns of concurrency, and were most likely also having unprotected sex with both their previous and new male partners.

4. Low Perception of Risk and HIV Awareness—An unexpected finding in this study was the low level of HIV awareness among respondents, which most attributed to the low visibility of HIV in the community and low perceptions of personal risk. One respondent noted:

> …I would say I don't care…they (health educators) come into our schools and talk but don't do much. They won't tell you that your community it is rampant they just say [that there are] high percentage but they won't put health care centers where they are needed…we just see that sex is sex but y'all got to show us…[that] not everything is good. [Until then] I'm gonna just keep having sex with all these girls and not think about the consequences… why worry because if I was worried I

> would have protected myself. (Frank: 19 years old, 5 sexual partners, high risk group).

For some the lack of visibility has rendered AIDS 'without a face' and without a visual reminder of its presence, many do not think about the risk of HIV infection:

> …as long as it's not happening to us and our friends, we don't see it…we don't see the big picture…We don't see it happening to nobody in our community. Remember, AIDS … It don't have a face. So, you tell me about AIDS, I'm like, oh yeah, I'm scared. But after I don't see her with AIDS, I don't see her with gonorrhea; I don't see her with nothing. So, she's got a fat butt, she look good. All right, let's go. (Frank: 19 years old, 5 sexual partners, high risk group).

Younger participants felt that the lack of urgency among their peers was due to generational differences:

> …almost everybody I know knows somebody that got it but I can't say I know somebody personally with it right now. Or I can't say I know a lot of people that died from it or anything like that. I don't think that was really my era. (Marcus: 29 years old, 3 sexual partners, high risk group).

Low awareness of HIV is further fueled by conspiracy theories, mistrust of medical statistics, and skepticism that AIDS is a serious problem.

> … I think the whole AIDS epidemic [was] done strategically from day one…I think AIDS [was] meant to kill the powerful Black people… like the Black Panther-type people, the Malcolm X's, the Martin Luther King's, the militant Black men…just as the drugs [were] brought out here to kill off all those people…it…gradually spilled over to White America… But I think strategically it was meant for you. (Jack: 31 years old, 4 sexual partners, high risk group)

> …to me, the statistics [are]… a lie…Show me the website … to show …how [many] females, [and] how [many] males have AIDS…the direct information is hard to [find] … I don't know where to go to get this information, so, for the most part…I think everything is exaggerated because I don't see it (Bob: 25 years old, 3 sexual partners, high risk group).

However, not all respondents in the study prescribed to conspiracy theories about HIV/AIDS:

> … A lot of [people in the community] heard it was created in a lab. You know what I mean? …[and] a lot of them don't believe [that HIV/AIDS is a problem] … because they haven't did [sic] the knowledge (i.e., acquired information)… If you really get down on the computer and …do your knowledge (i.e., research) and read your book or whatever, you going to see like, oh yeah…But I do think it's created in a lab (Paul: 19 years old, 3 sexual partners, low risk group).

Instead, many commented on the more pressing issues in Black men's lives, such as starting a career, having a family or concerns about gun violence, limited economic resources, and re-entry back into the community after incarceration.

> …a lot of people [are] walking [around] with blinders on. They think it can't happen to them… 'cause there's not enough [HIV/AIDS] cases coming at them… There [are] more cases of… their friends being shot, or somebody being shot in the community than [HIV] (Hank: 41 years old, 1 sexual partner, low risk group).

> …My goal is to kind of get to where my mom and dad is or [become] a counselor in a high school…but [its] just [that my] criminal background hindered me…I got caught with a gun recently and five years ago. So, that hindered a lot of opportunities for me (Bob: 25 years old, 3 sexual partners, high risk group).

Although HIV was described as "out of sight" or "out of mind," many men in the study also alluded to how Magic Johnson's openness about his positive HIV status and perceived good health may inadvertently lead to more high-risk behaviors.

> …they see how Magic Johnson is still alive today, and people still have the hope that there still is a cure for AIDS, cancer, and a lot of different type of diseases. So now, people are more inclined to take a risk, based on new things that they have now to get rid of different type of diseases or to help you live longer with it. People are more inclined to take risks these days (George: 30 years old, 1 sexual partner, low risk group).

> Well, when you got living cases like Magic Johnson…and he still walking around doing his thing and not being the stereotypical poster child of AIDS, where [he's all] skin and bones, you know, that's… putting a couple of male minds at ease (Hank: 41 years old, 1 sexual partner, low risk group).

Respondents suggested that Magic Johnson's perceived good health fosters the notion that the consequences of contracting HIV are no longer serious or life-threatening because there is treatment available.

5. HIV Testing and Behaviors Change—HIV testing was high among all study participants, especially within the last year. Many of the focus group and interview participants reported access to HIV testing through their employer, military service or recent incarceration, which for some was perceived to be compulsory. From these data, however, we are unable to estimate how common HIV testing was through these sponsors or venues. Despite high levels of HIV testing, we found evidence from the individual interviews that suggests that regular HIV testing does not necessarily correspond with reduction in sexual risk behaviors. For some, the effect of HIV testing on behavior change appears to be short-lived, lasing for a couple of weeks before risky sexual behaviors return.

> It depends on the results… If I'm clean… I'll go right back to square one…If I'm not, I might then get a reality check…But {if I'm} okay, I might do the same nonsense. (After HIV testing) I did it (change my behavior) for like a week and a half…that whole week, I was like: I'm not having sex. But then after, you know, you get that out of your mind; you're back to square one (Frank: 19 years old, 5 sexual partners, high risk group).

Many men also reported that after episodes of unprotected sex with their new partner often prompted pursuing HIV testing:

> …I had the condom; I just didn't put it on. And then, … She asked me a question… "Well, how do you know that I'm clean?" Well, I said, "It's not that I know that you're clean, I see how you carry yourself, you know, and I know that you're not going to be just sleeping around with anybody like that openly." So she said, "Okay." And I got tested right there. Yes, I got tested. I got tested (George: 30 years old, 1 sexual partner, low risk group).

Although the BRA data indicate that the majority of participants talked to at least some of their partners about their HIV status or their partner's serostatus, the qualitative data suggest that communication about HIV testing seldom occurs:

> Honestly, it comes up, but I can't say that it comes up [a lot]… like, two people seriously discussin' their [HIV status]. Like, yo! …this is my paper, you know. See I got tested… you got tested? … But… when you sittin' down talkin' to a female… you're not gonna really say it like you …, you look like you got that thing. You know what I mean? (Jack: 31 years old, 4 sexual partners, high risk group).

Although HIV testing through work, the military or prison has normalized the process of testing for many, low levels of communication about HIV status and the inability to sustain safer sex practices after testing suggest that the experience may not inform subsequent sexual decision making.

DISCUSSION

In a sample of adult heterosexual Black men who do not engage in injection drug use and reside in Brooklyn, results demonstrated heterogeneous patterns of sexual risk behaviors that include sexual concurrency and inconsistent or low condom use with new and old partners. Studies examining HIV among heterosexuals have largely focused on individual-level factors, such as partner concurrency, alcohol and substance use, depression, gender norms, sensation seeking, self-efficacy, and condom negotiation skills (Anderson, 2003; Anderson, Wilson, Doll, Jones, & Barker, 1999; Centers for Disease Control and Prevention, 2010; Centers for Disease Control and Prevention, BullsEye, & Resources, 2007; Holtgrave & Crosby, 2003; McCoul & Haslam, 2001; O'Sullivan, Hoffman, Harrison, & Dolezal, 2006; Santana, Raj, Decker, La Marche, & Silverman, 2006; Wallace, 1993; Wolfe, 2003). Other studies on heterosexual Black men have also explored the role of contextual factors such as joblessness, racial discrimination, male incarceration, and drug and alcohol marketing, housing, access to health care, and the number of male partners available to women (Blankenship, et al., 2005; Lisa Bowleg & Raj, 2012; Crosby, Holtgrave, DiClemente, Wingood, & Gayle, 2003; Thomas & Torrone, 2006). From the data presented here, we found that sexual risk behaviors might be further complicated by multiple factors that include: 1) emotional needs for multiple partners; 2) continued unprotected sex with old partners; 3) fears of a loss of opportunity to have sex; 4) low perceptions or awareness of community risk of HIV infection; and 5) regular HIV testing.

Little is known about how emotional needs impact heterosexual sexual risk behaviors, such as concurrency and low condom use. One US study found that concurrency was a specific strategy to avoid being alone (Gorbach, et al., 2002). Another study on concurrency among

African-American men found that the “emotional burden of dealing with the life stressor of multiple women” was a “negative” consequence of concurrency (Carey, et al., 2010). Our data suggest that some men pursue multiple sexual partners to protect themselves from the emotional pain of a partner’s infidelity or to fend off loneliness. The reported use of multiple sexual partners as emotional buffers in this study illustrates the need to further explore how diverse or alternative perspectives of masculinity also shape sexual risk in this population. The development of certain emotional skills, such as regulating or coping with emotions, may be protective against risk-taking behavior (Rivers et al., 2013).

The role of partner trust also emerges as a strong emotional reason for why some heterosexual men in new relationships might maintain risky sexual contact with previous partners, especially with individuals with whom these men have to maintain a relationship (e.g., the mother of their child). Having sex with an old sexual partner who is the *coparent* of a child has been described as a particular type of sexual concurrency that is considered to be more acceptable and tolerated (Gorbach, et al., 2002).

Partner trust and sexual risk taking has been primarily examined among homosexual men, youth and people living with HIV (Crepaz & Marks, 2002; McLean et al., 1994; Skidmore & Hayter, 2000). Very little is known about how partner trust impacts sexual risk taking among heterosexual Black men. Implicit in many men’s comments from interviews is that they cannot initiate condom use again once a pattern of unprotected sex has been established, even if the relationship has dissolved because it will signal a loss of trust in that partner. Some have noted that this behavior is paradoxical as sexual risk taking is interpreted as a form of love and trust (Appleby, Miller, & Rothspan, 1999).

Further research is needed to explore how affective or emotional ties impact sexual risk behaviors, especially within the context of obligatory social networks with former partners, especially when the former partners have had a child. This pattern of concurrent sexual risk taking with varying levels of partner trust might create a window of HIV risk. Moreover, patterns of serial concurrency might produce recurring cycles of risk-taking, as a long-term ‘girl on the side’ might become the girlfriend or wife while unprotected sex with a new or old partner continues. Consequently, the contributing factor associated with the windows of risk may be the challenge of reintroducing condom use with sexual partners with whom the respondents have had a long-term relationship.

Emotions might also play a role in calculating risk. Although some men noted the influence of being caught in the “*heat of the moment*,” some noted that their decisions to engage in risky sexual behaviors were based on an assessment of risk. For some, the fear of a loss of opportunity to have sex (especially with a new partner) resulted in a calculation of risk versus opportunity costs. The benefits of taking advantage of a (perhaps scarce) resource – a willing sexual partner – outweighed the risk of harmful consequences. The theme of a loss of sexual opportunity suggests that some men are consciously engaging in unprotected sex and many are aware of the potential risks.

After almost three decades of HIV prevention targeted to urban US minority communities, we found a surprisingly low level of HIV awareness among the men in our sample. Data

presented here suggest that public examples of the lifesaving effects of antiretroviral therapy (e.g. the Magic Johnson effect) has unintentionally undermined HIV prevention efforts for some by fostering a false sense of security that the consequences of contracting HIV are no longer serious or life-threatening.

In regards to HIV transmission, it is encouraging that we found high levels of HIV testing among the men in this study (especially within the last year); however, the qualitative data suggest that it is important to recognize that repeat testing among seronegative populations does not directly lead to sustained safer sex practices. This finding is confirmative of previous research on the relationship between HIV testing and continued sexual risk behaviors in seronegative populations. For example, in a meta-analysis of 27 published studies assessed the effects of HIV counseling and testing on sexual risk behaviors, researchers found that HIV-negative participants did not modify their behavior more than HIV-positive participants, HIV-serodiscordant couples, or untested participants (Weinhardt, Carey, Johnson, & Bickham, 1999). HIV testing among the respondents in this study might be an ineffective HIV prevention strategy among repeat testers because we found that behavior change is short-term. More research is needed to explore heterosexual Black men's understanding of HIV testing and how repeat testing might be part of self-care and thus a risk reduction strategy.

Finally, these data suggest the need for more research on how the relationship between multiple social identities and lived experiences such as race/ethnicity, class, gender, and sexual orientation underlie macro, social structural inequalities and health disparities and increase vulnerability to HIV/AIDS (Bowleg, 2012; Collins, 1990; Crenshaw, 1991; Kelly, 2009). Exploring the intersectionalities in the lives of the Black men in this study, we found that the pressure of starting a career, having a family or concerns about gun violence, limited economic resources, and re-entry back into the community after incarceration were common concerns for heterosexual Black men in this study.

A notable portion of the participants in this study were of Caribbean descent, however, we found that there were no differences in sexual risk behaviors between the US-born versus non-US-born men in this study. Several studies, however, did find differences in HIV testing and risk behaviors among Black West Indian immigrant and US-born Blacks (Hoffman et al., 2011; Hoffman, Ransome, Adams-Skinner, Leu, & Terzian, 2012; Ojikutu et al., 2013), although there were not always difference among Black West Indian immigrant and US-born Blacks men (Hoffman et al., 2008). In conjunction with nativity status, our data suggest that in conjunction with nativity status that generational norms may provide insight into the heterogeneous patterns of sexual risk behaviors between younger and older men in this community.

More research is needed to address structural HIV risks such as poverty, unemployment, underemployment, and unstable housing (Raj et al., 2013). Our data highlight the reality than most Black men in this community have low incomes and insufficient resources that may foster living in restricted housing situations (i.e., living with parents or others) with minimal privacy. More research is needed on how living with parents may impact notions of masculinity, perceptions of HIV risk and the likelihood of engaging in risky sexual behavior.

We also found that normative gender expectations may constrain men's ability to negotiate safer sex with particular partner types. The data indicate that normative gender expectations of female partners did influence levels of risk taking by partnership type (e.g., unprotected sex with the “good girl” (e.g., wifey, main partner, or their main ‘girl on the side’ with whom they have trust) and more consistent condom use with the ‘bad girl’ or ‘casual “hook-up.’ And, despite decades of HIV prevention messaging to heterosexual men and women in Brooklyn, our data illustrates how homophobic perceptions of HIV as a “gay” disease are still commonly held beliefs.

We acknowledge the limitations to our study. First, participants were convenience-sampled and information about those refusing to complete the survey was not gathered. This restricted our estimating a participation rate and elucidating potential biases. With a cross sectional convenience sample we cannot determine causation from this design. Although it would not have been feasible to randomize participants in this study, a lack of randomization presents a risk of bias. In our recruitment method, we did not approach only potential participants who “looked” like they were under 18 or over 45 years of age instead of approaching all potential participants and then screening out those individuals who were too young or old based on actual conformation of their age, potentially resulting in a participant selection bias.

The sample size of the study is relatively small and may not be reflective of the overall African American heterosexual male population living in Brooklyn, NY. Participants were a recruited from urban sites, so the representativeness of our findings to non-urban populations, remains unclear. The Brief Risk Assessment (BRA) survey is not a validated measure and the validity of self-reported information must be taken into consideration. While the use of ACASI to complete the BRA questionnaire may have mitigated some of the potential problems with self-report validity, the sensitive nature of some questions still could have influenced the likelihood of respondents providing honest, accurate responses. Another limitation is that the $60 participant incentive could have contributed towards a potential selection bias; however, anecdotal reports from men indicated their strong desire to be a part of the focus group and interview sessions despite the monetary incentive. Finally, the cross-sectional design of this study relies on the assessment of HIV risk behaviors based on antecedent measures of exposure. Longitudinal studies are needed to demonstrate the temporal relationships of sexual risk behaviors and HIV risk among heterosexual Black men.

This study also has important strengths. Findings from this study are important, because they focus on a population (non-injection drug using, Black heterosexual men) that has until recently received little attention in HIV research. Moreover, the findings suggest that the Black barbershop is an ideal setting to recruit this target population. In addition, our interdisciplinary approach and commitment to using only study staff from the study population illustrates how intimate knowledge of the study population enhances the development of rapport with the participants and willingness to openly discuss sensitive issues. Finally, through qualitative methods we were able to examine in greater depth the issues that surround HIV risk among heterosexual men drawn from Black barbershops.

Information garnered from their experience can possibly provide insight into how to integrate HIV prevention into this unique, malecentered, community-based venue.

CONCLUSION

Our study identifies new and unexplored individual and contextual factors linked to HIV transmission risk behaviors among non-injection drug using, heterosexually-active Black men of unknown or HIV-negative serostatus in Brooklyn, NY. New insights into the use risk behaviors as emotional buffers, the calculated risks of engaging in unprotected sex, and the limited impact of repeat testing has important implications for future research to reduce HIV in Black heterosexual men and in the Black community in general. Our study also identifies key determinants of HIV risk sexual behaviors for Black men in this population. Structural inequalities and health disparities such as limited economic resources, unemployment, underemployment, unstable housing, and incarceration increase vulnerability to HIV infection.

Findings from this study are important, because heterosexual Black men are a population often neglected in HIV prevention. Because of the lack of resources, services and materials targeted to heterosexual men, heterosexual Black men have limited access to services that meet their needs. Additionally, heterosexual Black men in this community seldom develop sexual health promotion plans for themselves because of normative notions of masculinity and gender that result in the belief that strong men “don’t go to the doctor.” There is an urgent need for tailored HIV prevention interventions that integrate cultural factors, resource needs, social determinants and structural barriers with best practices. HIV prevention intervention development for Black heterosexual men needs to capitalize on men’s strengths, building on men’s positive roles in their communities and avoiding reinforcing stereotypes. The development of such an intervention is imperative because HIV and AIDS disproportionately burden non-Hispanic black persons that live in the United States; and there exists a gap between the prevention needs of heterosexual non-Hispanic black men and the number and quality of programs to meet those needs.

ACKNOWLEDGEMENTS

The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the US Centers for Disease Control and Prevention (CDC) or the National Institutes of Health (NIH). The authors would like to thank the barbers, barbershop owners and managers, and our community advisory board for their contributions to this work. This study was supported by the CDC (PS000691). M Joseph, F Agbetor, B Camilien, M White, Y Gousse, and T Wilson were also supported in part by the NIH’s National Institute on Minority Health and Health Disparities (P20MD006875, subproject 5174).

REFERENCES

Adimora AA, Schoenbach VJ. Contextual factors and the black-white disparity in heterosexual HIV transmission. Epidemiology. 2002; 13(6):707–712. doi: 10.1097/01.EDE.0000024139.60291.08. [PubMed: 12410013]

Adimora AA, Schoenbach VJ. Social context, sexual networks, and racial disparities in rates of sexually transmitted infections. J Infect Dis. 2005; 191(Suppl 1):S115–122. doi: JID32102 [pii] 10.1086/425280. [PubMed: 15627221]

Adimora AA, Schoenbach VJ, Doherty IA. Concurrent sexual partnerships among men in the United States. American Journal of Public Health. 2007; 97(12):2230–2237. [PubMed: 17971556]

Adimora AA, Schoenbach VJ, Martinson F, Donaldson KH, Stancil TR, Fullilove RE. Concurrent sexual partnerships among African Americans in the rural south. Annals of epidemiology. 2004; 14(3):155–160. [PubMed: 15036217]

Adimora AA, Schoenbach VJ, Martinson FE, Donaldson KH, Fullilove RE, Aral SO. Social context of sexual relationships among rural African Americans. Sex Transm Dis. 2001; 28(2):69–76. [PubMed: 11234788]

Anderson JE. Condom use and HIV risk among US adults. Am J Public Health. 2003; 93(6):912–914. [PubMed: 12773352]

Anderson JE, Wilson R, Doll L, Jones TS, Barker P. Condom use and HIV risk behaviors among U.S. adults: data from a national survey. Fam Plann Perspect. 1999; 31(1):24–28. [PubMed: 10029929]

Appleby PR, Miller LC, Rothspan S. The paradox of trust for male couples: When risking is a part of loving. Personal Relationships. 1999; 6:81–93.

Blankenship KM, Smoyer AB, Bray SJ, Mattocks K. Black-white disparities in HIV/AIDS: the role of drug policy and the corrections system. J Health Care Poor Underserved. 2005; 16(4 Suppl B):140–156. doi: S1548686905B01403 [pii] 10.1353/hpu.2005.0110. [PubMed: 16327113]

Bowleg L. The problem with the phrase women and minorities: intersectionality-an important theoretical framework for public health. Am J Public Health. 2012; 102(7):1267–1273. doi: 10.2105/AJPH.2012.300750. [PubMed: 22594719]

Bowleg L, Raj A. Shared communities, structural contexts, and HIV risk: Prioritizing the HIV risk and prevention needs of Black heterosexual men. Journal Information. 2012; 102(S2)

Carey MP, Senn TE, Seward DX, Vanable PA. Urban African-American men speak out on sexual partner concurrency: Findings from a qualitative study. AIDS and Behavior. 2010; 14(1):38–47. [PubMed: 18483847]

Centers for Disease Control and Prevention. Epidemiology of HIV/AIDS- United States, 1981-2005. MMWR Morb Mortal Wkly Rep. 2006; 55(21):589–592. [PubMed: 16741494]

Centers for Disease Control and Prevention. HIV Infection Among Injection-Drug Users --- 34 States, 2004--2007. MMWR Morb Mortal Wkly Rep. 2009; 58(46):1291–1295. [PubMed: 19940834]

Centers for Disease Control and Prevention. Disparities in Diagnoses of HIV Infection Between Blacks/African Americans and Other Racial/Ethnic Populations - 37 States, 2005-2008. MMWR Weekly. 2010; 60(4):94–130.

Centers for Disease Control and Prevention, BullsEye, & Resources. Epidemiology of STDs in African American Communities (presentation summary) Meeting Report. 2007

Collins, PH. Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment. Routledge; New York, NY: 1990.

Courtenay WH. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. Social Science & Medicine. 2000; 50(10):1385–1401. [PubMed: 10741575]

Crenshaw KW. Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. Stanford Law Review. 1991; 43(6):1241–1299.

Crepaz N, Marks G. Towards an understanding of sexual risk behavior in people living with HIV: a review of social, psychological, and medical findings. AIDS. 2002; 16(2):135–149. [PubMed: 11807297]

Crosby RA, Holtgrave DR, DiClemente RJ, Wingood GM, Gayle JA. Social capital as a predictor of adolescents' sexual risk behavior: a state-level exploratory study. AIDS Behav. 2003; 7(3):245–252. doi: 471178 [pii]. [PubMed: 14586187]

Cue Davis K, Stappenbeck CA, Norris J, George WH, Jacques-Tiura AJ, Schraufnagel TJ, Kajumulo KF. Young Men's Condom Use Resistance Tactics: A Latent Profile Analysis. Journal of sex research(ahead-of-print). 2013:1–12.

Davis KC, Schraufnagel TJ, Kajumulo KF, Gilmore AK, Norris J, George WH. A Qualitative Examination of Men's Condom Use Attitudes and Resistance:"It's Just Part of the Game". Archives of sexual behavior. 2013:1–13. [PubMed: 22996437]

Donohew L, Zimmerman R, Cupp PS, Novak S, Colon S, Abell R. Sensation seeking, impulsive decision-making, and risky sex: implications for risk-taking and design of interventions. Personality and Individual Differences. 2000; 28(6):1079–1091.

Espinoza L, Hall HI, Hardnett F, Selik RM, Ling Q, Lee LM. Characteristics of persons with heterosexually acquired HIV infection, United States 1999-2004. Am J Public Health. 2007; 97(1): 144–149. doi: AJPH.2005.077461 [pii]. [PubMed: 17138918]

Farley TA. Sexually transmitted diseases in the Southeastern United States: location, race, and social context. Sex Transm Dis. 2006; 33(7 Suppl):S58–64. doi: 00007435-900000000-00005 [pii]. [PubMed: 16432486]

Fishbein M, Pequegnat W. Evaluating AIDS prevention interventions using behavioral and biological outcome measures. Sexually transmitted diseases. 2000; 27(2):101–110. [PubMed: 10676977]

Ford NJ, Vieira EM, Villela WV. Beyond stereotypes of Brazilian male sexuality: qualitative and quantitative findings from São Paulo, Brazil. Culture, Health & Sexuality. 2003; 5(1):53–69.

Fuller CM, Borrell LN, Latkin CA, Galea S, Ompad DC, Strathdee SA, Vlahov D. Effects of race, neighborhood, and social network on age at initiation of injection drug use. American Journal of Public Health. 2005; 95(4):689–695. [PubMed: 15798131]

Gorbach PM, Stoner BP, Aral SO, Whittington WL, Holmes KK. “It takes a village”: understanding concurrent sexual partnerships in Seattle, Washington. Sexually transmitted diseases. 2002; 29(8): 453–462. [PubMed: 12172529]

Gupta, GR. Gender, sexuality, and HIV/AIDS: The what, the why, and the how. Paper presented at the Plenary Address, XIIIth International AIDS Conference; Durban, South Africa. Jul. 2000

Henny KD, Crepaz N, Lyles CM, Marshall KJ, Aupont LW, Jacobs ED, Willis LA. Efficacy of HIV/STI behavioral interventions for heterosexual African American men in the United States: A meta-analysis. AIDS and Behavior. 2012; 16(5):1092–1114. [PubMed: 22234436]

Hoffman S, Beckford Jarrett ST, Kelvin EA, Wallace SA, Augenbraun M, Hogben M, Wilson TE. HIV and sexually transmitted infection risk behaviors and beliefs among Black West Indian immigrants and US-born Blacks. American Journal of Public Health. 2008; 98(11):2042–2050. [PubMed: 18309140]

Hoffman S, Higgins JA, Beckford-Jarrett ST, Augenbraun M, Bylander KE, Mantell JE, Wilson TE. Contexts of risk and networks of protection: NYC West Indian immigrants’ perceptions of migration and vulnerability to sexually transmitted diseases. Culture, health & sexuality. 2011; 13(05):513–528.

Hoffman S, Ransome Y, Adams-Skinner J, Leu C-S, Terzian A. HIV/AIDS Surveillance Data for New York City West Indian–Born Blacks: Comparisons With Other Immigrant and US-Born Groups. American Journal of Public Health. 2012; 102(11):2129–2134. [PubMed: 22994194]

Holtgrave DR, Crosby RA. Social capital, poverty, and income inequality as predictors of gonorrhoea, syphilis, chlamydia and AIDS case rates in the United States. Sex Transm Infect. 2003; 79(1):62–64. [PubMed: 12576618]

IBMCorp.. IBM SPSS Statistics for Windows (Version 20.0). IBM Corp; Armonk, NY: 2011.

Kelly UA. Integrating intersectionality and biomedicine in health disparities research. ANS Adv Nurs Sci. 2009; 32(2):E42–56. [PubMed: 19461221]

Manhart LE, Aral SO, Holmes KK, Foxman B. Sex partner concurrency: measurement, prevalence, and correlates among urban 18-39-year-olds. Sexually transmitted diseases. 2002; 29(3):133–143. [PubMed: 11875374]

McCoul MD, Haslam N. Predicting high risk sexual behaviour in heterosexual and homosexual men: the roles of impulsivity and sensation seeking. Personality and Individual Differences. 2001; 31(8):1303–1310.

McLean J, Boulton M, Brookes M, Lakhani D, Fitzpatrick R, Dawson J, Hart G. Regular partners and risky behaviour: why do gay men have unprotected intercourse? AIDS Care. 1994; 6(3):331–341. doi: 10.1080/09540129408258645. [PubMed: 7948089]

Moreno CL, El-Bassel N, Morrill AC. Heterosexual women of color and HIV risk: sexual risk factors for HIV among Latina and African American women. Women Health. 2007; 45(3):1–15. doi: 10.1300/J013v45n03_01. [PubMed: 18032159]

Morris M, Kretzschmar M. Concurrent partnerships and the spread of HIV. AIDS. 1997; 11(5):641–648. [PubMed: 9108946]

Morris M, Kurth AE, Hamilton DT, Moody J, Wakefield S. Concurrent partnerships and HIV prevalence disparities by race: linking science and public health practice. American Journal of Public Health. 2009; 99(6):1023. [PubMed: 19372508]

Neblett RC, Davey-Rothwell M, Chander G, Latkin CA. Social network characteristics and HIV sexual risk behavior among urban African American women. J Urban Health. 2011; 88(1):54–65. doi: 10.1007/s11524-010-9513-x. [PubMed: 21234695]

New York City Department of Health and Mental Hygiene. 2009 New York City HIV/AIDS Annual Surveillance Statistics Retrieved August 22. 2009 2013, from http://www.nyc.gov/html/doh/html/data/hivtables.shtml.

New York City Department of Health and Mental Hygiene. 2012 New York City HIV/AIDS Annual Surveillance Statistics Retrieved May 10. 2012 2014, from http://www.nyc.gov/html/doh/html/data/hivepi.shtml.

O'Sullivan LF, Hoffman S, Harrison A, Dolezal C. Men, multiple sexual partners, and young adults' sexual relationships: understanding the role of gender in the study of risk. J Urban Health. 2006; 83(4):695–708. doi: 10.1007/s11524-006-9062-5. [PubMed: 16758335]

Ojikutu B, Nnaji C, Sithole J, Schneider KL, Higgins-Biddle M, Cranston K, Earls F. All Black People Are Not Alike: Differences in HIV Testing Patterns, Knowledge, and Experience of Stigma Between US-Born and Non–US-Born Blacks in Massachusetts. AIDS patient care and STDs. 2013; 27(1):45–54. [PubMed: 23259482]

Operario D, Smith CD, Kegeles S. Social and psychological context for HIV risk in non-gay-identified African American men who have sex with men. AIDS Educ Prev. 2008; 20(4):347–359. doi: 10.1521/aeap.2008.20.4.347 [pii]. [PubMed: 18673067]

Oster AM, Dorell CG, Mena LA, Thomas PE, Toledo CA, Heffelfinger JD. HIV risk among young African American men who have sex with men: a case-control study in Mississippi. Am J Public Health. 2011; 101(1):137–143. doi: 10.2105/AJPH.2009.185850. [PubMed: 21088266]

Peterson JL, Rothenberg R, Kraft JM, Beeker C, Trotter R. Perceived condom norms and HIV risks among social and sexual networks of young African American men who have sex with men. Health Educ Res. 2009; 24(1):119–127. doi: 10.1093/her/cyn003. [PubMed: 18281710]

Prejean J, Song R, Hernandez A, Ziebell R, Green T, Walker F, Hall HI. Estimated HIV incidence in the United States, 2006-2009. PLoS ONE. 2011; 6(8):e17502. doi: 10.1371/journal.pone.0017502 PONE-D-10-02530 [pii]. [PubMed: 21826193]

QSR, International, Pty, & Ltd. NVivo qualitative data analysis software (Version 8). 2010

Raj A, Dasgupta A, Goldson I, Lafontant D, Freeman E, Silverman JG. Pilot evaluation of the Making Employment Needs [MEN] Count intervention: Addressing behavioral and structural HIV risks in heterosexual Black men. AIDS Care(ahead-of-print). 2013:1–8.

Rivers SE, Brackett MA, Omori M, Sickler C, Bertoli MC, Salovey P. Emotion skills as a protective factor for risky behaviors among college students. Journal of College Student Development. 2013; 54(2):172–183.

Santana MC, Raj A, Decker MR, La Marche A, Silverman JG. Masculine gender roles associated with increased sexual risk and intimate partner violence perpetration among young adult men. J Urban Health. 2006; 83(4):575–585. doi: 10.1007/s11524-006-9061-6. [PubMed: 16845496]

Shain RN, Piper JM, Newton ER, Perdue ST, Ramos R, Champion JD, Guerra FA. A randomized, controlled trial of a behavioral intervention to prevent sexually transmitted disease among minority women. N Engl J Med. 1999; 340(2):93–100. doi: 10.1056/NEJM199901143400203. [PubMed: 9887160]

Skidmore D, Hayter E. Risk and sex: ego-centricity and sexual behaviour in young adults. Health, Risk & Society. 2000; 2(1,1):23–32.

Sutton MY, Jones RL, Wolitski RJ, Cleveland JC, Dean HD, Fenton KA. A review of the Centers for Disease Control and Prevention's response to the HIV/AIDS crisis among Blacks in the United States, 1981-2009. Am J Public Health, 99 Suppl 2, S351-359. 2009 doi: 10.2105/AJPH.2008.157958 99/S2/S351 [pii].

Thomas JC, Torrone E. Incarceration as forced migration: effects on selected community health outcomes. Am J Public Health. 2006; 96(10):1762–1765. doi: 96/10/1762 [pii]10.2105/AJPH.2005.081760. [PubMed: 17008570]

Tillerson K. Explaining racial disparities in HIV/AIDS incidence among women in the U.S.: a systematic review. Stat Med. 2008; 27(20):4132–4143. doi: 10.1002/sim.3224. [PubMed: 18551508]

Wallace R. Social disintegration and the spread of AIDS--II. Meltdown of sociogeographic structure in urban minority neighborhoods. Soc Sci Med. 1993; 37(7):887–896. [PubMed: 8211307]

Weinhardt LS, Carey MP, Johnson BT, Bickham NL. Effects of HIV counseling and testing on sexual risk behavior: a meta-analytic review of published research, 1985-1997. Am J Public Health. 1999; 89(9):1397–1405. [PubMed: 10474559]

Wolfe WA. Overlooked role of African-American males' hypermasculinity in the epidemic of unintended pregnancies and HIV/AIDS cases with young African-American women. J Natl Med Assoc. 2003; 95(9):846–852. [PubMed: 14527052]

Zuckerman, M. Sensation seeking: Beyond the optimal level of arousal. Lawrence Erlbaum; Hillsdale, NJ: 1979.

Zuckerman, M. Behavioral expressions and biosocial bases of sensation seeking. Cambridge University Press; Cambridge, UK: 1994.

Table I

Demographics of barbershop clients completing a brief risk assessment (BRA) survey and those eligible, those selected and those not selected to participate in focus group and in-depth interviews, Brooklyn, NY, 2009.

		All BRA participants (N=105)	BRA participants eligible for focus group/interviews (%, N=60)	Focus group/ Interview participants (%, N=22)	BRA participants not selected for focus group/ interviews (%, N=38)
Age ¥	*Mean*	29	29	27	30
	(SD)	(7)	(7)	(5)	(7)
Place of birth	*US*	62%	60%	68%	55%
	Non-US	38%	40%	32%	45%
Education	*High school/GED or less*	49%	48%	59%	42%
	> High school/GED	51%	52%	41%	58%
Employed	*Yes*	73%	73%	68%	76%
	No	27%	27%	32%	24%
Income *¥	*Less than $10,000*	35	32%	55%	18%
	$10,000-19,999	19	18%	14%	21%
	$20,000-39,999	20	25%	23%	26%
	$40,000 or more	26	23%	9%	32%
Health insurance	*Yes*	58	58%	50%	63%
	No	42	42%	50%	37%
Living situation ^¥	*Have their own house/apt*	39	38%	18%	50%
	Live with parents or others	61	62%	82%	50%
Where receive medical care *	*No medical care*	7	8%	14%	5%
	Private/Community/Health	66	67%	73%	63%
	Emergency room	27	23%	9%	32%

*Percentages may not add up to 100% due to rounding and/or missing information

^All others under current living place include the following categories: someone else's home or apartment, shelter or single-room, or living on the streets.

¥Statistically significant differences ($p < 0.05$) between focus group/interview participants and remaining 38 eligible BRA respondents.

Table II

Lifestyle and sexual behaviors of barbershop clients completing BRA survey and those eligible, those selected and those not selected to participate in focus group and in-depth interviews, Brooklyn, NY, 2009.

		All BRA participants (%, N=105)	BRA participants eligible for focus group/interviews (%,N=60)	Focus group/ Interview participants (%, N=22)	BRA participants not selected for focus group/ interviews (%, N=38)
Ever HIV tested	*Yes*	89%	93%	95%	92%
Tested for HIV in past year	*Yes*	69%	72%	73%	71%
Ever in jail or prison	*Yes*	52%	55%	59%	53%
Number of female partners, past 3 months	*1* *2 or more*	39% 61%	45% 55%	32% 68%	53% 47%
Primary sex partner	*Yes*	78%	83%	77%	87%
Frequency of condom use during vaginal sex, past 3 months *	*Never* *Sometimes or often* *Always*	12% 42% 4%	17% 45% 3%	14% 59% 5%	18% 37% 3%
Number of female sex partners without condoms, past 3 months	*0* *1* *2 or more*	42% 31% 28%	35% 28% 37%	23% 32% 45%	42% 26% 32%
Sex while on alcohol, past 3 months	*Yes*	29%	28%	41%	21%
Sex while on drugs, past 3 months	*Yes*	12%	12%	18%	8%
Sex Exchange past 3 months	*Yes*	7%	7%	4%	8%
Talk about your HIV status w/ partner *	*None of my partners* *Some of my partners* *Every partner*	27% 27% 39%	32% 31% 37%	14% 46% 41%	42% 24% 34%
Talked about your partner's HIV status	*None of my partners* *Some of my partners* *Every partner*	31% 25% 37%	40% 27% 33%	27% 41% 32%	47% 18% 34%
Any sex partner believed to have HIV	*None of my partners* *Some of my partners* *Don't know*	83% 2% 8%	90% 2% 8%	86% 5% 9%	92% 0 8%

*Percentages may not add up to 100% due to rounding and/or missing information

¥Statistically significant differences ($p < 0.05$) between focus group/interview participants and remaining 38 eligible BRA respondents

Table III

Demographics of barbershop clients who were categorized according to the brief risk assessment (BRA) survey as having high versus low sexual risk behaviors, Brooklyn, NY, 2009.

		Low (%, N=76)	High (%, N= 29)
Age ¥	***Mean (SD)***	**29.39 (7.23)**	**29.04 (6.76)**
Place of birth	*US* *Non-US*	58% 42%	72% 28%
Education	*High school/GED or less* *> High school/GED*	47% 53%	55% 45%
Employed	*Yes* *No*	78% 22%	62% 38%
Income *¥	*Less than $10,000* *$10,000-19,999* *$20,000-39,999* *$40,000 or more*	32% 20% 22% 25%	41% 17% 14% 28%
Health insurance	*Yes* *No*	54% 46%	69% 31%
Living situation ^¥	*Have their own house/apt* *Live with parents or others*	42% 58%	31% 69%
Where receive medical care *	*No medical care* *Private/Community/Health* *Emergency room*	4% 65% 30%	14% 69% 17%

*Percentages may not add up to 100% due to rounding and/or missing information

^All others under current living place include the following categories: someone else's home or apartment, shelter or single-room, or living on the streets.

¥Statistically significant differences ($p < 0.05$) between focus group/interview participants and remaining 38 eligible BRA respondents

Table IV

Lifestyle and behaviors of barbershop clients who were categorized according to the brief risk assessment (BRA) survey as having high versus low sexual risk behaviors, Brooklyn, NY, 2009.

		Low % (N=76)	High % (N=29)
Ever HIV tested	*Yes*	88%	93%
Tested for HIV in the past year	*Yes*	67%	72%
Ever in jail or prison	*Yes*	45%	72%
Number of female sex partners, past 3 months	*0* *1* *2 or more*	9% 50% 41%	0 14% 86%
Primary sex partner	*Yes*	80%	72%
Frequency of condom use during vaginal sex, past 3 month *	*Never* *Sometimes or often* *Always*	11% 26% 5%	17% 83% 0
Number of female sex partners without condoms, past 3 months	*0* *1* *2 or more*	58% 42% 0	0 0 100%
Sex while drunk or buzzed on alcohol, past 3 months	*Yes*	22%	48%
Sex while on drugs, past 3 months	*Yes*	8%	24%
Sex Exchange, past 3 months	*Yes*	3%	17%
Talk about your HIV status w/ partner *	*None of my partners* *Some of my partners* *Every partner*	24% 24% 43%	35% 38% 28%
Talked about your partner's HIV status	*None of my partners* *Some of my partners* *Every partner*	28% 24% 40%	41% 28% 31%
Any sex partner believed to have HIV	*None of my partners* *Some of my partners* *Don't know*	84% 1% 5%	79% 3% 17%

* Percentages may not add up to 100% due to rounding and/or missing information

¥ Statistically significant differences ($p < 0.05$) between focus group/interview participants and remaining 38 eligible BRA respondents.