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"To Me, Everybody Is infected": Understanding Narratives about HIV Risk among HIV-negative Black Men Who Have Sex with Men in the Deep South

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Abstract

For black MSM living in the Deep South, the intersection of sexuality, race, and geography impacts HIV risk substantially. Between July and September 2016, we conducted a qualitative study among HIV-negative black MSM in five southern cities in the US with elevated HIV prevalence. Analysis included assessment of interrater reliability, cluster analysis, and descriptive statistics. We enrolled 99 black MSM (mean age: 33.6; SD = 12.8; range: 17–68 years). Four overarching themes emerged: harboring fear of HIV and the internalization of HIV stigma;

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scrutinizing potential partners to assess riskiness and HIV status; embracing distance and isolation from those perceived as a threat to HIV status; and exhibiting self-efficacy toward HIV prevention and utilizing risk reduction strategies. Future HIV prevention efforts may benefit by balancing risk and deficit based strategies with those that emphasize resilience, address disenfranchisement via structural interventions, and assess and treat inherent trauma(s).

Keywords

HIV/AIDS; African-American; black; MSM; risk reduction; resiliency; protective factors

Introduction

In the United States, men who have sex with men (MSM) represent 75% of all new HIV infections despite accounting for about 2% of the population (CDC, 2017). Within this demographic, the rate of HIV infection is further marked by strong racial and geographic disparities, with the highest rates of HIV among black people and among those living in the Deep South[1] (Reif, Safley, McAllaster, Wilson, & Whetten, 2017). For black MSM living in the Deep South, the intersection of sexuality, race, and geography impacts HIV risk substantially, revealing some of the highest rates of HIV prevalence and incidence nationally.

In 2015, among all MSM who received an HIV diagnosis, black MSM accounted for 39% of cases, followed by 29% for white, and 27% for Hispanic/Latino MSM (CDC, 2016a). According to a recent report from the Centers for Disease Control and Prevention (CDC), if current HIV prevention, care, and treatment efforts maintain the same level of impact, one in two black MSM are predicted to acquire HIV within their lifetime (CDC, 2016b; Hess, Hu, Lansky, Mermin, & Hall, 2017). Such predictions are only more dire in the Southern United States, where more than 60% of all black MSM diagnosed with HIV in 2014 were reported as living in this region (CDC, 2016a).

In five of the major Southern metropolitan areas (Atlanta, GA; Jackson, MS; Miami, FL; New Orleans, LA; and Baton Rouge, LA), AIDS prevalence rates are some of the highest in the country for MSM (CDC, 2016a; Gardner, McLees, Steiner, Del Rio, & Burman, 2011; Hickson et al., 2015), and a disproportionate majority of these cases are black MSM (CDC, 2016a). HIV prevalence among black MSM in Atlanta, for example, is estimated to be 43% (Millett et al., 2012). Such disproportionate rates of HIV have led to a warranted increase in public health research that focuses on black MSM in the South in order to understand the risk factors and conditions that create epidemic rates of HIV infection (Hickson et al., 2015; McNair et al., 2017; Reif et al., 2017; Stephenson & Finneran, 2017; Sutton, Gray, Elmore, & Gaul, 2017).

Several studies have concluded that structural inequalities, rather than differences in sexual behavior based on race, are the greatest factor in accounting for racial disparities with regard

[1]The Deep South is defined as a nine-state region that includes Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas.

to HIV infection. For instance, in 2007 and 2013, comprehensive analyses of all data reported on black MSM and HIV infection found that poverty, lack of access to healthcare services, increased stigma, and high rates of STDs were likely the greatest factors impacting HIV infection rates among black MSM (Maulsby et al., 2014; Millett, Flores, Peterson, & Bakeman, 2007). These factors are exponentially greater in the Deep South, where higher rates of poverty and lack of access to medical care for black people is well known (Reif et al., 2017). However, while public health literature has addressed in large part the deficit-based risks and systemic factors that lead to such high rates of HIV infection for black MSM in the Deep South, few studies have focused on questions of resiliency or assets among this population (Kelly, St Lawrence, Tarima, DiFranceisco, & Amirkhanian, 2016).

In an environment where black MSM live with such threatening statistics (Lee et al., 2017), studies that can identify strengths and assets among black MSM must round out the traditional deficit-based approaches that identify barriers to HIV prevention, care, and treatment. The seeming inevitability of an HIV diagnosis must be counter-balanced with evidence that supports empowering pathways to HIV prevention for black MSM. Qualitative studies that provide context and rich descriptions with regard to HIV risk perception and the complicated matrix of social conditioning that impacts sexual behavior among black MSM are, therefore, vitally important to HIV prevention efforts (Wilson et al., 2016).

As such, this study seeks to contribute to knowledge regarding the complex HIV environmental “riskscape,” or the set of multi-level risk and protective factors associated with HIV risk of black MSM in the Deep South (Hickson et al., 2015), by assessing respondents’ self-identified protective factors contributing to their HIV-negative status. While there are some recent studies that compare sexual behaviors of HIV-positive and HIV-negative black MSM, these studies focus on whether or not HIV-positive men are engaging in protective sex so as not to infect others (Crosby, Mena, & Geter, 2017). To our knowledge, there have been little to no recent studies published that identify the basis of risk and protective factors solely among HIV-negative black MSM in the Deep South.

Methods

Between July and September 2016, we conducted a qualitative study with 99 black/African American adolescent and adult MSM in five cities with elevated HIV prevalence among minority MSM in the Deep South: Atlanta, GA; New Orleans, LA; Baton Rouge, LA; Jackson, MS; and Miami, FL (CDC, 2016a). Our intent was to: (1) understand issues surrounding HIV risk for MSM; (2) learn more about how gay community or peer norms, and community identification influence risk behaviors; (3) understand individual HIV risk management, such as having an HIV-positive partner with suppressed viral load, and barriers and facilitators for use of biomedical interventions, i.e., pre-exposure prophylaxis (PrEP); and (4) understand factors that promote resiliency among HIV-negative MSM. All participants provided voluntary informed consent. Study procedures were approved by the Emory University Institutional Review Board.

Eligibility and recruitment

Eligibility criteria were: age 16–17 for minors and 18 and over for adults; evidence of an HIV negative test result in past six months [self-reported negative/unknown status accepted for minors]; identify as cisgender male; identify as black/African American; reside in one of the five cities; report oral or anal sex with another man at least once in the past six months or indicate physical attraction to other males if a minor; and, be proficient in either English or Spanish. Respondents were screened by phone or in-person.

Participants were referred to the study in the selected cities through flyers disseminated by local health departments, clinics, and HIV testing centers or sites (e.g., AIDS service organizations). In addition, we recruited via word-of-mouth referrals or flyers distributed by community-based, advocacy, faithbased, and service-providing agencies. Our study aimed to recruit a sample of eligible Black/African-American (n = 99) adolescent and adult MSM. We conducted a purposive sampling strategy to ensure that sufficient quotas were met based on city and age group to achieve our projected data saturation for subgroups within the framework of our qualitative research design.

Procedures

Eligible men were invited to complete a face-to-face interview. Interviews were approximately one hour long. Respondents were asked to provide sociodemographic characteristics such as age, race/ethnicity, sexual identity, education, employment, housing, history of homelessness, health insurance coverage, sex seeking behaviors, number of sex partners, relationship status, and internet use. The interview also included open-ended questions pertaining to respondents' perceptions of HIV prevention, HIV risks and behaviors, personal and community relationships, contributors and inhibitors to remaining HIV-negative including fatalism, perceptions of HIV prevention and care, HIV testing, knowledge of PrEP, and condom use. Interviews were digitally recorded and transcribed verbatim. Personal identifying information was redacted.

Analytic methods

In-depth interview transcripts were coded for patterns and themes present in the data using a qualitative content analysis approach (Schreier, 2012). The coding process was facilitated by NVivo qualitative data analysis software (QSR International [Americas] Inc., Burlington, MA). We developed a codebook to list and define possible factors related to remaining HIV negative present in the transcripts (e.g., reported reasons why MSM indicated they are not living with HIV).

To ensure reliability in the coding process regardless of coder, four coders independently coded a sample of interviews, and the lead coder assessed pairwise comparisons of each team member (A vs. B, A vs. C, A vs. D, etc.) as well as each team member against the group (A vs. the combined codes of B, C, and D). Agreement was measured by calculating Cohen's Kappa, and any agreement scores lower than 0.8 were reviewed and discussed as a team. Coders were allowed to proceed to the full data set when an average agreement score (both between individuals and between the individual and the team) was greater than or

equal to 0.8. This is considered “substantial to near perfect agreement” as described in the literature (Gwet, 2014; Landis & Koch, 1977).

After completing the content analysis and transcript coding, we developed frequency counts to identify the most frequent codes (‘nodes’ in NVivo) in the data. We used NVivo’s cluster analysis tool to create a dendrogram of co-occurring codes related to men’s perceptions of remaining HIV negative (Bazeley, 2013; Bernard, Wutich, & Ryan, 2016). We then conducted a focused review of the transcripts looking for exceptions or outliers to this pattern. This method resulted in identifying a series of factors frequently associated with remaining HIV negative that fit the majority of the MSM in the study sample.

Descriptive statistics were compiled to describe the sociodemographic characteristics of participants using IBM SPSS Statistics (IBM Corporation, Armonk, NY). We evaluated salient factors related to HIV risk, prevention, and protective factors using frequencies and cross-tabulations.

Results

Sociodemographic characteristics

The sample included 99 HIV-negative, non-Hispanic, black MSM. Table 1 depicts the descriptive sociodemographic characteristics. About two thirds of the sample was from both Atlanta, GA (33.3%, n = 33) and Jackson, MS (32.3%, n = 32). The remaining proportion of the sample was from New Orleans, LA (18.2%, n = 18), Baton Rouge, LA (11.1%, n = 11), and Miami, FL (5.0%, n = 5). Mean age was 33.6 (SD = 12.8, range: 17–68) years old. Over a third (39.4%, n = 39) of the sample had attended some college or had obtained an associate’s or technical degree. A third (33.3%, n = 33) of the sample was unemployed at the time of the interview. In addition, over a quarter (28.3%, n = 28) of respondents reported staying on the street, in a shelter, or temporarily in someone’s home because they did not have a regular place to live or stay in the twelve months prior to the interview. Of those, 64.3% (n = 18) considered themselves to be currently homeless at the time of the interview. Less than half (41.4%, n = 41) reported being currently uninsured and 21% (n = 21) had not seen a doctor or nurse for healthcare in the past twelve months. However, around 69% of the sample reported testing for HIV every 3 (35.4%, n = 35) to 6 (33.3%, n = 33) months. Forty-one percent (n = 41) of the sample reported having only one male oral and/or anal sexual partner within the past 6 months and 34.3% (n = 34) reported being in an intimate relationship at the time of the interview. In addition, a little over a third of the sample (35.4%, n = 35) reported using the internet recreationally to meet other men for casual sex.

Key thematic findings

In this study, black MSM residing in the Deep South described a multitude of factors that impacted their HIV-negative status. Quantitative analysis of the demographic data depicted disenfranchisement evidenced by unemployment, homelessness, and lack of healthcare. Team-based analyses of the qualitative data resulted in the identification of four overarching themes: (1) harboring fear of HIV and the internalization of HIV stigma; (2) scrutinizing potential partners in an effort to assess riskiness and HIV status; (3) embracing distance and

isolation from those that they perceive as a threat to remaining HIV-negative; and (4) exhibiting self-efficacy toward HIV prevention and utilizing risk reduction strategies, such as condoms, pre-exposure prophylaxis (PrEP), sero-positioning, masturbation, and regular HIV testing.

Harboring fear of HIV and the internalization of HIV stigma

Respondents were aware of the effect of HIV in their communities and directly attributed their fears of HIV as reasons why they had remained uninfected. One 32 year old from New Orleans stated, “I think what kept me from getting HIV was, first and foremost, my fear of it.” A 27 year old from Miami admitted, “I will say some level of paranoia and overthinking does help in keeping me HIV-negative.” One respondent added his views on what influenced his behavior:

> I read a lot of things about HIV and STDs and I’ve known people who’ve had STDs. Heard stories. Horror stories. So, I think that me just thinking about all of those situations just keep me on a path where I can make sure I am not going to be the next person in one of these stories.
>
> —25 years old, Jackson, MS

Another respondent stated:

> I was wild. I was in bars and clubs and bathrooms and parks. I would get on a plane and I would travel to Montreal and three hours after the plane hit the ground I was staying with somebody I’ve never known. I was notorious and when the epidemic came and I saw people who I knew and, you know, dying, and people were hearing about people dying and people who were in the circle that I belonged to … seeing the whole scene. I was living in Boston and there was a group of gay black men in Boston and I found out about them later on in the game … some of them were positive. Some of them were dying and I found out, fortunately, that they were sleeping with each other and so that whole group kind of like died out and, fortunately, I did not get involved sexually with folk in that group and that group died out so, what kept me safe is being able to sit down and cross my legs or change my lifestyle, if you will, learning about HIV, sharing information with people and listening, and as I said before doing research …
>
> —63 years old, Atlanta, GA

Many of the respondents had friends and/or family diagnosed with HIV or whom had died from AIDS related complications. These experiences with HIV/AIDS disclosure or witnessing death imparted much fear. One respondent offered this narrative:

> I say by what I’ve seen, like again, my uncles, I’ve watched them die. Like, I literally watched them die. And it’s like, I don’t want to go through that, so anybody that’s gonna touch me, yeah, you gonna know this story, you gonna know the fact that I’ve watched these two men, who were amazing men, I watched them die. Because they were tired of fighting and I don’t want to have to fight that every day of my life, just to live.
>
> —17 years old, Baton Rouge, LA

Another respondent provided his perspective:

> … and my friends that are HIV positive. Just knowing what they have to go through even though they're living comfortable lives. Just all the extra stuff that they have to go through and you know having people you know falling for people and they finally feel comfortable enough to tell them that they're HIV-positive and they leave them. That kind of thing I just don't want to have to deal with that.
>
> —24 years old, Jackson, MS

These attributions of fear were common and were also sometimes projected onto other black MSM. One respondent offered his views on HIV risk perception and how he internalized the threat to protect himself:

> To me, everybody is infected. And I will hope that people will look at me the same way. I'm not wishing that upon me, but that's how you protect yourself. You look at it like everybody is infected.
>
> —30 years old, Atlanta, GA

Another respondent explained:

> It's just [that] things are just so scary out here. You know, and like I said, it makes you scared to have sex, really.
>
> —58 years old, New Orleans, LA

For some, these fear factors included HIV stigma wherein they described how they discriminated against potential partners who disclosed their HIV-positive status. One respondent provided his candid perspective on these interactions:

> It seems like when I encounter guys who are HIV-positive, it's like the conversation gets a little bit dull because, like, I know me personally, like, in my heart, I try to act like I'm okay with it. I'm not. I'm not okay with that. I just don't want that. We are not going to get into a relationship. I'm not going too deep with someone who's HIV positive [while] knowing it. Like, if I know that they're HIV [positive], I'm not going to do it.
>
> —32 years old, New Orleans, LA

Another respondent offered:

> Because, like, if I see, like, they're positive, I'm not going to talk to them. If they reach out to me, I ignore them. If they message me [on mobile dating apps], like I won't respond to it.
>
> —20 years old, New Orleans, LA

Scrutinizing potential partners in an effort to assess riskiness and HIV status

HIV related fear and stigma appeared to lead respondents to evaluate potential sexual partners in myriad ways as a means to reduce sexual risk. Although most fully recognized that there is no way to discern HIV status based on appearances, they still tended to look for aspects such as age, race, cleanliness, socioeconomic status, masculinity, and 'outness' of

sexuality as determinants of risk. One respondent summed up his experiences with prospective partners:

> A lot of the older men I don't trust to be honest. I actually, you know, at the time, me being young, I mess with the same young age, so like at time from like eighteen, you know, and up, a lot of the guys who I run into are like virgins or new or they just came out or they're not out yet. Or a lot of straight, bi men … having troubles coming out or even expressing that they like guys. I've secretly messed with them. I find them more safe than I do actual gay men who's older because they have more experience. They have messed around a lot more. The more life you have being gay, the more that it's prone to catching [HIV] just because you've messed with more guys and some people aren't safe or smart about it so it's a little iffy for me, I always try to like target certain kind of men. So … I wouldn't target African Americans. I actually only mess with white guys. [Not] necessarily preference wise, like, that's why. But, I don't know. In some ways maybe it's growing up with statistics … can't say that word right. Knowing that African Americans [are] more prone to having AIDS and the black guys that I know. They are more not caring about where they put it or how they put it or how they do it. They're more careless I find than they are with, you know, Caucasian … Yeah, pretty much that. Hispanics I find the same way as African Americans. In my opinion I really don't know. It, it shouldn't be. That's the sad part and it might not be, but it seems like it is. I feel like they're more sexual than your normal, any other races.
>
> —22 years old, New Orleans, LA

Another respondent added that even physical signs may not be indicative of a person's risk status. In his story, he offered this explanation:

> Years ago, in my teens I would probably look for those cliché things like lesions and things such as that, but in this situation, honestly this last experience I had the person there was no signs, in my opinion, that the person was positive. And being educated about the process, I don't think there's visible signs … Typically what I would look for is drug use or abuse. So typically if the person is … if the eyes look dilated, they looks troubled, if they smell as if their hygiene is not on key, those things are turn offs for me. So those red flags, but they don't always … again this last person I talked about … they didn't have anything. He was the perfect person in top shape everything seemed liked it was going to be perfect, but I did not engage in unprotected sex with them and so what I've learned throughout that process with that is to just to protect yourself.
>
> —30 years old, Jackson, MS

In some cases, these risk assessments admittedly led to the potential for increased risk of HIV exposure. One respondent stated:

> … like sometimes if he's really cute, really handsome, you know, and we be like, I'm like, "You want to use this [condom]?" And he be like, "Do you want to use it?" I said, "No. Do you want to use it?" And he be like, "No." Both of us like,

> "No." And the shit goes down. But afterwards, I be like, "Oh, fuck. What did I just do?" You know, what am I doing, having unprotected sex? But if I see a guy who doesn't look right, I'll be like, "We're using this shit [condom] right here! " But if he's cute and he's safe and he looks, you know, fucking like me, you know, I'll be like, "Yeah, fuck this [condom]."
>
> —39 years old, Miami, FL

Embracing distance and isolation from those that they perceive as a threat to remaining HIV-negative

Respondents also discussed their decisions to pull away from their community, described both socially and geographically, to protect themselves from HIV infection. A 35 year old from New Orleans, LA stated it as, "I went through this whole phase of just really trying to run away from people who I thought would put me at high risk for HIV." Another respondent added:

> It had me to a point where I really like sheltered myself and I wasn't talking to anybody like for over a year. I wasn't working … I got so scared that I got sick and I lost my job and everything so it was very serious to me, so that's why like as far as me just being in the community like that it's very, like, short. Like, the only way I say that I've even been in the community is probably, like, just going out a time or two, but other than that, like, I'm not in the community. I don't like to talk to anybody.
>
> —22 years old, Jackson, MS

Notably, they discussed the potential for HIV acquisition based on their knowledge of the sexual practices of other men in their community, as well as their other behavioral risks, and the need to distance themselves from people in these circles. Many explained that they came to recognize these situations as threatening to their well-being through observation. One respondent provided this insight:

> Well, I just know one thing that I've viewed myself from knowing are people who are actually on PrEP. They think that they can still have sex unprotected. I just feel like that's a mindset they need to get out of because they can still contract other things and there's always a one percent chance that they can still catch HIV, so … that and just sleeping with multiple people is just come to be a circle, so that's why I just try to stay as far away from … (laughs) *everyone actually.*
>
> —22 years old, Jackson, MS

Another respondent offered an important image that described the interdependence of those caught in a cycle of despair and community isolation that he attributed to the high prevalence of HIV cases and escalating HIV incidence in his city and, conversely, his decision to move away from the city toward the rural outskirt areas in an effort to protect himself from negative influences. In part, he stated:

> I don't feel very connected to the gay community, like, I'ma always support the gays. I'm just not really into the gay scene in Jackson. Now, I'm into the gay scene out of town, like when I go out, but in Jackson it's just kind of … it's "crab in the

> bucket" mentality. Everybody wants to know everybody else's business and they're not really trying to uplift each other and help each other, just like probably most of the community probably don't even know about this bill that they just passed in Mississippi.[2] They probably don't even know what that bill, you know … entails. Like a person … instead of uplifting, like when you have crabs in a bucket … like they're trying to get on top of the next crab trying to get out, instead of you know uplifting, you know, that's how I kind of see it. Of course, I don't know every gay person in Jackson, so for me to try to speak on everybody, I can only speak on what I know …
>
> —24 years old, Jackson, MS

Exhibiting self-efficacy toward HIV prevention and utilizing risk reduction strategies

The risk reduction strategies described by respondents resulted in narratives detailing the extent to which they prioritized their sexual health and were well informed and educated on HIV prevention. Whether through condom use, discussions about HIV status with support for HIV prevention by partners, friends, and family, or limiting sexual activity via types of sex acts or number of partners, they revealed how they protected their own bodies from HIV infection. For example, a 34 year old from Atlanta, GA emphatically stated, "I've never been penetrated without a condom." Another respondent offered his views on why it is important to know your own status and not place trust in the words of others:

> It's not trust because, like I said, someone could say that they're HIV-negative and they could actually be positive. Or they could be HIV-negative, but never taken a test in four years and they've been having unprotected sex for a year. So you wouldn't know your status because your last status was from four years ago. And all of a sudden you decide to do raw sex. So it's not [that] so much. I trust myself more than I trust anybody else.
>
> —28 years old, New Orleans, LA

Some respondents were aware of the relative risk for HIV transmission via exposure by certain sex behaviors. They made explicit decisions to forgo particular sex acts, and even sex partners, in an effort to reduce overall risk. One respondent revealed what he was or was not willing to do:

> I don't put myself in [a] high risk category, you know, unprotected anal and stuff like that. And I don't have anal. I don't do anal anyway. I don't want that at all.
>
> —50 years old, Miami, FL

Another respondent discussed his experiences:

> I would have to say the fact that mainly those relationships are oral sex only. And the other relationship is [mutual] masturbation only. I think the lack of intercourse, the lack of penetration is a main factor [that] I don't [perceive risk]. I don't think it completely, you know, eliminates me from being exposed to it. But I think the lack

[2]Mississippi House Bill 1523, a religious liberty bill officially known as "The Protecting Freedom of Conscience from Government Discrimination Act."

> of penetration and actual sexual intercourse is what has allowed me to maintain [an] HIV negative status.
>
> —27 years old, Atlanta, GA

Another respondent stated:

> It's just different things to do to not to contract it, like, honestly I can say me pleasuring myself, you know, sexually pleasuring myself like I even recently bought sex toys, you know. Just to pleasure myself to not have that urge to actually want to go out and search for sex with other people. So I'm very, you know, now I'm just very, very careful, like, if I'm not with someone, I'm actually, you know, pleasuring myself, per se. It's a safe thing. It's safe sex to me. Safest because you don't have to worry about contracting nothing from no one, nothing. So, it's just how you take care of yourself and you are in the knowledge of HIV and the whole thing as a whole. Just the knowledge of knowing everything.
>
> —24 years old, Jackson, MS

In addition, many respondents described how they are regularly tested for HIV. A 30 year old from Jackson, MS described his patterns of testing, "Typically, I test for STIs along with HIV every six months, but I [also] do at least a home rapid test every three months." Another respondent described what he does to manage his status:

> I care so much about my health and I get tested every ninety days and for the most part my boyfriend, he actually helping me, too. Like, you know, getting on PrEP and, you know, and telling me, 'We need to use protection.' You know, and things like that, and I'm a say sticking to one partner. You know, each time I was in a relationship, I only dealt with one person sexually, so that helped me, also.
>
> —23 years old, New Orleans, LA

Another respondent detailed his process of getting tested for HIV with his partner:

> The first time I brought my partner and talked to him about getting tested, oh, he had a hissy fit. I told him, I don't know what to tell you. Cause if you gonna give me something, I'm gonna hurt you. Because it does not have to happen. I told him, if I could come here and be tested and be honest enough with you to show you my results, to let you know that I'm dedicating myself to what, whatever this is that you and I have going on, [and] you can't do the same for me? I'm here to show you my results.
>
> —52 years old, Baton Rouge, LA

Some respondents indicated that they decided to enroll in PrEP, not only due to changes in their sexual relationships, but also because they had access to the regimen and lived in what they construed to be "high risk" areas.

> They [providers] told me about it. They introduced me to it. I was going through one of their studies and they introduced me to it. They asked me what I would be interested in trying and I was like yeah, what is it first? What is it? They told me what it was, what it'll help me do, what it help, you know, what it'll help prevent.

> And I told them, 'Yeah I be willing to do that, you know, how can they get it [to me]? [They tell me] 'Next time [at] your appointment.' And they start telling that I have to watch this educational video about it. They told me the risk it has, like, it can mess with your kidneys and stuff and I've been trying to use it ever since. And I try to get people to use it 'cause I know that Jackson got … Jackson got it everywhere. I'm not saying PrEP, but they got HIV everywhere. It's everywhere here and Jackson is not very big and you get it, if you don't take care of yourself.
>
> —23 years old, Jackson, MS

Discussion

The narratives in this study illustrate what it is like to be a black, gay, bisexual or other MSM residing in high HIV prevalent areas of the Deep South, while being keenly aware of HIV epidemiology and knowledgeable of the HIV prevention messaging that targets them. Prior to this data collection, a press release from the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention at the Centers for Disease Control and Prevention (CDC) announced an estimate that one in two black MSM, compared to one in eleven white MSM, will acquire HIV in their lifetime if current HIV prevention, care and treatment efforts remain unchanged (2016b). This specific data point was widely disseminated. As shown in the findings, it and other HIV prevention messaging and strategies were regularly recited by respondents.[3] While this knowledge appeared to instill autonomy in protecting sexual health by HIV-negative black MSM residing in the Deep South, these data show that it also appeared to contribute to harboring fear of HIV and the internalization of HIV stigma, extreme scrutinizing and vetting of potential sexual partners, and embracing distance and isolation from some of their peers as they were often perceived as a threat to HIV status.

This suggests that HIV prevention interventions, especially those targeting black MSM in the Deep South, should consider 1) balancing risk and deficit based strategies to those with more emphasis on resilience and asset based components; 2) address disenfranchisement via structural interventions affecting the social determinants of health; and 3) assess and treat the inherent trauma as experienced by black MSM in the Deep South.

Balancing risk and deficit based strategies to those with more emphasis on resilience and asset based components

HIV prevention has traditionally taken a deficit-based approach that centers on identifying epidemiological evidence for factors that contribute to risk among MSM and then developing behavioral or biomedical interventions that reduce them. This makes logical sense, but it has limited impact among some MSM and does not address or utilize the full complexity of factors related to sexual health. It may also impart unhealthy fear and HIV-related stigma in this population.

[3]I just know that living in New Orleans, we have high transmission rates. There's a CDC study that came out. It said that in a couple years, like, half of all black, gay men are projected to be HIV positive, so it's kind of hard from me not to just associate the two. It's not like a moral judgment. It's just knowing the stats.—*35 years old, New Orleans, LA.*

Resilience theory is a conceptual framework for considering a strengths-based approach to grappling with health behaviors and outcomes. It is posited as being a process that includes positive adaption to adversity and risk, rather than a singular trait, and has been adapted for sexual minorities (Herrick, Stall, Goldhammer, Egan, & Mayer, 2014; Meyer, 2010). Although it is a developing field of inquiry, there is growing evidence for the incorporation of resilience and asset-based strategies among MSM to combat HIV and other adverse health conditions (Gonzalez et al., 2004; Greenwood et al., 2005; McNair et al., 2017; Wei et al., 2011). Findings from this study can contribute to those efforts. While many of the respondents fortunately displayed a healthy self-regard and a strong sense of self-efficacy and autonomy for HIV prevention, these data also show an abundance of HIV-related fear and stigma that could affect overall quality of life. HIV prevention interventions might allay these fears and stigma by emphasizing the biomedical successes of PrEP and HIV care and treatment and linking those with indications into care. It is important to balance HIV risk with assets. Interventions can detail PrEP efficacy and the safeguarding provided by nPEP, as well as the substantial benefits to viral suppression, such as studies showing that no case of HIV transmission has been linked to someone who had a suppressed viral load (Cohen et al., 2016), as a means to reduce HIV fear and anxiety while also acknowledging the disparities in HIV care and treatment, particularly in the Deep South (Meditz et al., 2011; Reif et al., 2017). HIV prevention interventions could also incorporate resilience theory to counter the narrative of the epidemiological “riskscape” and the demonization of black MSM by balancing curricula with an acknowledgment and celebration of cultural pride utilizing the works of prominent black gay male artists and HIV activists like Joseph Beam (1986), Marlon Riggs (1991), Essex Hemphill (1995), and Darnell L. Moore (2018).

Address disenfranchisement via structural interventions affecting the social determinants of health

The social determinants of health refers to the “complex, integrated, and overlapping social structures and economic systems that include social and physical environments and health services. These determinants are shaped by the level of income, power, and resources at global, national, and local levels. They are also often influenced not only through personal choices, but through policy choices as well” (WHO, 2008). Researchers continue to investigate the myriad ways by which the social determinants of health impact HIV risk and prevention, care, and treatment (Braveman & Gottlieb, 2014; Frye et al., 2006; Phillips et al., 2015; Sutton et al., 2017; White et al., 2013; Whiteside, White, & Jones, 2017).

The demographics and qualitative findings from this study show the importance of public health practitioners addressing disenfranchisement, as experienced by black MSM, in the Deep South. The respondents in this study reported high levels of unemployment, homelessness, and lack of healthcare. The conditions by which they live compounded by the threat of HIV infection are detrimental. Although we recognize that it may be out of scope for some public health agencies to address these conditions, practitioners could develop creative structural interventions that affect the social, economic, political and environmental factors that have an impact on resilience and vulnerability to HIV for black MSM in the Deep South. This includes education and job training, housing support, and increased access to affordable healthcare coverage that includes HIV testing and low cost biomedical

prevention options. Organizations could address the social and structural barriers by partnering with housing authorities or agencies that conduct job training and placement, and insurance navigation services.

Assess and treat the inherent trauma as experienced by black MSM in the deep South

Research has shown that post-traumatic stress disorder (PTSD) is associated with HIV risk in MSM (Reisner, Mimiaga, Safren, & Mayer, 2009). In addition, specific stressors related to negative media (Lee et al., 2017); sexual coercion (Kalichman et al., 2001), intimate partner violence (Stephenson & Finneran, 2017), AIDS-related bereavement (Gluhoski, Fishman, & Perry, 1997), and sero-discordant partnerships (Remien, Wagner, Dolezal, & Carballo-Dieguez, 2003) show an effect on emotional distress.

Although this study did not clinically measure PTSD or psychosocial issues among respondents, the findings describe specific events related to increased levels of stress and experienced trauma. Respondents frequently described interpersonal stressors (e.g., socioeconomic hardship, AIDS related deaths, HIV fear and stigma, isolation) when recounting their experiences surviving in their locales and maintaining HIV-negative status. Therefore, practitioners could develop interventions that assess and treat the inherent trauma experienced by black MSM in the Deep South. It is important that these interventions are culturally appropriate in an effort to inoculate the effects of traumas related to poverty, homelessness, violence, morbidity and other social and minority stressors experienced by black MSM. Public health practitioners might partner with mental health and psychology professionals who have also identified this need (Brown & Pantalone, 2011).

This study has several important limitations. First, the purposive sampling design was used to ensure that enough HIV-negative black MSM were included from the five cities and within specific age ranges to allow identification and investigation of factors related to HIV risk and protection. However, there also may be sampling biases, which means the findings from this study may not be transferable to other HIV-negative black MSM, or to other HIV-negative populations. For instance, a substantial proportion of referrals came from sites or agencies who conduct targeted, free HIV testing to black MSM. This is likely indicative of the high rates of regular HIV testing reported in the sample. Nevertheless, there remained other healthcare deficits as the sample reported low proportions who had health insurance and made regular visits to doctors.

In addition, the cross-sectional nature of the study design does not allow us to fully identify the temporal elements for how the respondents' HIV risk evolves over time. Also, as is typical with face-to-face interviews, social desirability bias may have been a factor. Notably, as this was a CDC-sponsored study, respondents may have been more inclined to offer positive viewpoints on their prevention practices in accordance with CDC HIV prevention guidelines for MSM.

Our analysis is not a comprehensive review of all potential factors that might affect HIV risk; for example, we did not include data on urban versus rural, community-level or societal-level economic, cultural, or political conditions that form the contextual background to the respondents' lives and HIV risk factors. Instead, our results relied on personal self-

reported experiences. The self-reported nature of our data also is an important strength, because it allowed the respondents to candidly explain their experiences and thoughts. The respondents themselves provide clear reasons for how and why they were or were not utilizing HIV prevention strategies.

Conclusion

This study highlights how psychosocial (fear of HIV, internalization of HIV stigma, HIV prevention self-efficacy) and socio-geographic (partner scrutiny in social networks and social/community/geographic distancing strategies) factors contribute to the retention of negative HIV status among black MSM. Public health practitioners could develop future HIV prevention interventions that balance risk and deficit based strategies to those with more emphasis on resilience, address disenfranchisement via structural interventions, and assess and treat the inherent trauma as experienced by black MSM in the Deep South. Finally, these findings also suggest that more research is needed to understand whether these purported strategies are viable over time and the implication and role of public health research, communication, and policy on the lives of HIV-negative black MSM in the Deep South.

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Table 1.

Sociodemographic characteristics of participants, understanding narratives about HIV risk among HIV-negative black men who have sex with men in the deep South, 2016.

	Total	
Characteristics	**No.**	**%**
City		
Atlanta, GA	33	33.3
Baton Rouge, LA	11	11.1
Jackson, MS	32	32.3
New Orleans, LA	18	18.2
Miami, FL	5	5.0
Age (years) Mean 33.6 (SD = 12.8; Range: 17–68)		
16–17	5	5.1
18–24	27	27.3
25–34	30	30.3
35–44	11	11.1
45+	26	26.3
Education		
Grades 1 – 8	2	2.0
Grades 9–11	11	11.1
High school diploma/GED	20	20.2
Some college, associate's, or technical degree	39	39.4
Bachelor's degree	12	12.1
Post-graduate studies	15	15.2
Employment status		
Unemployed	33	33.3
Employed full-time	43	43.4
Employed part-time	21	21.2
Homeless in past 12 months		
No	71	71.7
Yes	28	28.3
Currently homeless		
No	10	10.1
Yes	18	18.2
Health insurance		
None	41	41.4
Private	40	40.4
Medicare/Medicaid	14	14.1
Other	3	3.0
Don't know	1	1.0
Seen a doctor/nurse in past 12 months		
No	21	21.2

Characteristics	Total	
	No.	%
Yes	78	78.8
Frequency of HIV test		
Never been tested	2	2.0
Every 3 months	35	35.4
Every 6 months	33	33.3
Annually	19	19.2
Every few years	6	6.1
Other	4	4.0
Number of oral/anal sex partners in past 6 months		
0	2	2.0
1	41	41.4
2–5	43	43.4
6–10	12	12.1
11+	1	1.0
Currently in a relationship		
No	65	65.7
Yes	34	34.3
Used internet to meet for sex in past 6 months	64	64.6
No		
Yes	35	35.4
TOTAL	**99**	

May not sum to total due to rounding and missing values.