UCSF
UC San Francisco Previously Published Works

Title

Substance use experiences of HIV-positive and HIV-negative black, non-hispanic men who have sex with men (msm) ages 18-34 in the Bay Area: A qualitative narrative perspective.

Permalink

https://escholarship.org/uc/item/4hq9m1dp

Authors

Nation, Austin
Dawson-Rose, Carol
Waters, Catherine

Publication Date

2022-06-29

DOI

10.1080/15332640.2022.2090043

Peer reviewed

eScholarship.org Powered by the California Digital Library
University of California

Substance Use Experiences of HIV-positive and HIV-negative

Black men who have sex with men (MSM) ages 18-34 in the Bay Area: a qualitative narrative perspective.

Abstract

Objective: Young Black men who have sex with men (MSM) represent the majority of individuals with new HIV infections in the U.S. Substance use is related to risk and acquisition t of HIV. The purpose of this study was to explore the perceptions and experiences about the role substance use plays in the lives HIV-positive and HIV-negative young Black MSM between the ages of 18-34.

Methods: Using a qualitative, narrative perspective, we recruited and then interviewed participants in partnership with AIDS Service Organizations. Narrative and thematic analysis was used to analyze these Black men's personal stories with harm reduction used as the conceptual approach.

Results: Nine HIV-positive and 3 HIV-negative participants(n=12) shared stories about their own personal experiences with family relationships and substance use. Themes related to family included early exposure and initiation of substance use, substance use as a response to stigma around sexual orientation, kicked out of house, asked to leave or left home so they could be themselves and perceived benefits and advantages of methamphetamine.

Conclusions: The participants are subjected to adverse and stressful childhood experiences. These are important stories to understand if we expect to mount an adequate response, utilizing harm reduction, to the growing number of young Black MSM at-risk for HIV.

Introduction

The human immunodeficiency virus (HIV) infection statistics for Black, non-Hispanic men who have sex with men (MSM) between the ages of 13 and 34 is alarming and is a public health concern (Buttram & Kurtz, 2015; Matthews et al., 2016a). Over half of all new HIV diagnosis are among this population with approximately 3 out of 4 Black, non-Hispanic MSM who received an HIV diagnosis coming from this age group (Centers for Disease Control and Prevention [CDC], 2021a; CDC, 2021b). According to Centers for Disease Control and Prevention (2021) statistics, Black, non-Hispanic MSM between the ages of 25 to 34 have the highest rates of new HIV diagnoses (39%), followed closely by non-Hispanic Black MSM ages 13 to 24 (25%) (CDC, 2021b). Among Black, non-Hispanic MSM, HIV prevalence is three to four times higher than among their non-Hispanic White MSM counterparts (Nation et al., 2018).

According to Matthews et al. (2016b) and Duncan et al. (2020), HIV-infected young adults are generally racial and ethnic minorities who reside in poor urban neighborhoods, are unemployed, have limited education, and are vulnerable because of where they live and their likelihood of engaging in sexual risk behaviors at higher rates in comparison to other young adults. As a high-risk group, Black, non-Hispanic MSM are of concern if we are to get to zero new HIV infections and ending the HIV epidemic in the United States (Office of Infectious Disease and HIV/AIDS Policy, HHS, 2021; UNAIDS, 2016).

Research suggests that substance use lowers sexual inhibition and promotes unsound decision-making, leading Black, non-Hispanic MSM to engage in risky sexual behavior (Fields et al., 2020). Sexual promiscuity and experimentation, as well as lack of sound judgment around condom use, often occurs when someone is under the influence of drugs or alcohol (Mimiaga et al., 2009; VanDevanter et al., 2011). In addition, strong peer group pressure, a sense of invincibility, and diminished parental involvement during adolescence contributes to high rates of risky sexual behavior (Arnold et al, 2019). Also, while under the influence of drugs or alcohol, Black, non-Hispanic men seek out sex in high-risk venues such as public cruising areas or engage in sex work (Mimiaga et al., 2009; VanDevanter et al., 2011; Yang et al., 2018). Thus, Black, non-Hispanic MSM with substance abuse issues face the risk of acquiring HIV and passing it along, either knowingly or unknowingly, to their partners along with untreated STIs (Fields, et al., 2020).

Alcohol, marijuana, crack cocaine, and methamphetamine are the top four commonly used drugs among Black, non-Hispanic MSM (Harawa et al., 2008; Hotton et al., 2019). Previous studies also found sex while under the influence of crack cocaine, marijuana and alcohol, or sharing needles for injecting drugs strongly associated with HIV infection among this population (Hotton et al., 2019; Maskut et al., 2020; Maxwell et al., 2018). This subpopulation of MSM is at a greater risk of detrimental effects of illicit substance use leading to HIV (Reback, Fletcher & Swendeman, 2018). Understanding substance use and sexual behavior is an important strategy in preventing the spread of HIV among Black, non-Hispanic MSM, who have a disproportionately high burden of new HIV infections.

This study examined perception and experiences related to the role substance use plays in the lives of HIV-positive and HIV-negative Black, non-Hispanic MSM ages 18-34 in the Bay Area and provides contextual factors for this high-risk group (Riessman, 1993).

Methods

Recruitment

Using a purposive, targeted sampling strategy, HIV-positive and HIV-negative Black MSM between the ages of 18-34, were recruited in the Bay Area. Participants were recruited from community-based AIDS Service Organizations that serve Black MSM.. Each participants met the following inclusion criteria: (1) self-identified black male, (2) between the ages of 18-34, (3) born in the U.S. and live in the local area, (4) has had sex with men, (5) can speak, read, and comprehend English, (6) have a history or active substance use with alcohol, marijuana, cocaine, crack cocaine, or methamphetamine, and (7) provide informed verbal consent. Five participants did not meet eligibility requirements This age range was chosen to correlate to the two highest groups of Black MSM being diagnosed with new HIV infections, namely those who are 25-34, followed by those 13-24 (CDC, 2021b). We only wanted participants from the United States because we felt others born outside this country would have completely different experiences, which was not our focus for this study. Explanation of the study and informed consent was obtained first. To protect their privacy and anonymity, the researchers got approval to waive signatures of adult participants using an information sheet. Participants were provided with a copy of the informed consent and offered a twenty-dollar gift card for their participation to offset travel expenses.

Interviews

The Primary Investigator (PI) conducted individual, in-depth interviews with each participant that explored participants' own experience with substance use throughout their lives. Interview questions for Interview Guide (see Table 1) were semi-structured, containing broad, open-ended, non-judgmental questions to encourage participants to share their experiences and to allow themes to emerge that may not have otherwise been forthcoming (Holloway & Galvin, 2016). The interview guide was based on experience with community-based work and clinical work. The range of interview topics were generated in order to gather data specific to the research question. The questions allowed participants to tell their story about the role past substance use played in their life and how their substance use may have changed since they found out their HIV status–, whether positive or negative (Nation, Waters & Dawson-Rose, 2018).

All interviews were conducted by the PI, a Black, non- Hispanic male. One-on-one interviews were better for collecting personal and sensitive data, particularly in a population of young Black MSM with substance use and HIV sexual risk issues. A personal interview created a safe, private space for a participant to share openly about their experiences while also respecting their confidentiality and preserving anonymity. All interviews were conducted in person at community-based organizations, UCSF, private homes, and the public library. Interviews lasted between 80-90 minutes each. Interviews were audiotaped and then transcribed verbatim by a transcription service. Once completed, all transcripts were verified against the audio recording to address gaps and missing content where the transcriber did not understand the speech patterns, choice of word, or street lingo used by the participants.

Analysis

All transcripts were initially read to become familiar with its content while coding for the main ideas and themes. The researchers then began coding transcripts line-by-line and then paragraph-by-paragraph (Cresswell, 2017). To ensure rigor in coding these data, another member of the research team experienced with qualitative methods coded 50% of the transcripts. All the codes were compared and contrasted until agreement was reached. Narrative analysis method was used to portray events in the lives of participants that related to the story of their first exposure and experience with substance use. Narrative analysis is based on an assumption that individuals create meaning through telling their stories to others. Telling the story creates meaning (Viney & Bousfield, 1991). From this analysis, we identified both larger overarching themes, along with specific narrative themes.

We have not altered the words of the study participants' but have organized them according to the way we heard the stories shared about their substance use experiences. The initial stories are related to family, then move to the response of coming out to their family and conclude with stories about substance use during sex. (Viney & Bousfield, 1991) We felt that it was paramount to simply share each participants' words and narratives verbatim in order to represent each individual's experiences. Analytic commentary is presented to emphasize key themes of each narrative and then to examine the stories collectively.

Conceptual Approach

Harm reduction entails the idea of acceptance of the behavior brought on by substance use and drug addiction. The goal of harm reduction is not to eliminate but to minimize the harmful consequences brought on by alcohol and substance use (Erickson, 1995, Erickson, 1999; Hilton, Thompson, Moore-Dempsey & Janzen, 2000).Grounded in public health tradition and operationalized within a health promotion framework, the concept of harm reduction has been modified over time to reduce risk and promote personal and community health through social, environmental and cultural dimensions (Erickson, 1995; Erickson, 1999; Hilton, Thompson, Moore-Dempsey & Janzen, 2000). In this study, it allowed us to meet each participant exactly where they were at during our interview.

Results

Sample

Twelve participants, 9 HIV-positive and 3 HIV-negative, were recruited over a 6-month period. The average age of study participants was 26 (see Table 2). While all participants reported engaging in sex with other men, nine of these men identified as gay. Drug use was not exclusive to any one drug, but participants were asked their preferred drug of choice. Even though marijuana was the most frequently identified, the majority of participants (n = 7) included methamphetamine as part of their drug usage. Participants rarely spoke specifically about alcohol and marijuana during any of the interviews.

The median age for both sex initiation and drug initiation is 15 (information about age of drug initiation was not obtained on the first 4 interviews). Most of the participants (n = 7) identified as single. Equal numbers of the participants completed some high school (n = 6) and some college (n = 6). In terms of employment status, most were either employed part-time (n =4) or unemployed (n =4). Half of the participants (n=6) were raised in the East Bay and the others were born outside of the Bay Area. Five of the participants spoke about adverse and stressful childhood events, including molestation (n = 1), sexual abuse (n = 1), and physical abuse (n = 3), including one with neglect and child protective services involvement.

Findings

The findings from the analysis of the transcripts revealed two overarching themes and eight narrative themes related to the substance use experiences of HIV-positive and HIV-negative Black MSM (see Table 3). The two overaching themes involve (1) social, environmental and insecurity issues and (2) benefits of methamphetamine use for numbing, masking and coping. The eight narrative themes will be further discussed

Narrative themes that came from the transcripts include (1) *issues with family because of sexual orientation/kicked out of the house, asked to leave or left home so they could be* *themselves* and (2) *early substance use exposure and initiation within the family*. Participants narrate stories of discrimination and homophobia that started in their homes, along with exposure and initiation of substance use. They discuss not being accepted at home because of their sexual orientation. The initial narrative theme includes early family experiences related to their sexual orientation. Participants described being unable to be who they were, which included being stigmatized for being gay, and having to live with homophobia, rejection, being judged and discriminated against at home. Participants tied this to them being different or because they were not traditionally heterosexual. Most of the participants were either kicked out of their family homes, asked to leave by their family, or wanted to get away from their family so that they could be themselves and feel more accepted.

The stories of these participants include a common narrative that was similar among these participants who responded to the question about their first experiences with substance use happening at a young age when they were living with their families of origin. Participants shared about early substance use exposure and initiation in family; their parents and caregivers being addicted to drugs. Another participant shared about his early exposure to both alcohol and other drugs with his father and described substance use in his family. There were a number of other difficult issues in the family settings of the participants in this study, including displacement of participants into the homes of other relatives, and involvement with Child Protective Services and foster care. These experiences fall within the definition of adverse and stressful childhood experiences, which includes household dysfunction where there is substance abuse of caregivers and any kind of parental separation (Schneenerger et al., 2014). These are further complicated with issues of neglect, molestation, sexual abuse, and physical abuse, which are all considered adverse childhood experience (ACE) and associated with substance use (Wong et al. 2010).

According to Brown, Masho, Perera, Mezuk & Cohen (2015), research using a United States population-based sample showed that sexual minorities, such as MSM, had higher rates of adverse childhood experiences (ACEs) and higher odds of experiencing multiple ACEs compared to heterosexuals.

Benefits of methamphetamine use for numbing, masking and coping

The remaining six narrative themes identified by participants, related to substance use, are included under this overaching theme. They are (3) *coping mechanism for gay sex and "being" gay, leaving home,* (4) *leaving home, moving to San Francisco and surviving homelessness,* (5) *methamphetamine exposure, prevalence and access in San Francisco,* (6) *peer pressure in new community to fit in with others*, (7) *to numb and mask feelings*, and (8) *sexual enhancement and transactional survival sex.*

Participants described their perceived benefits and advantages of methamphetamine use including coping with gay sex and "being" gay. Most of the Black MSM talked about leaving home, moving to San Francisco and surviving homelessness. Once the participants arrived in the Bay Area their exposure to methamphetamine continued and they identified their substance use as a method of coping with their lives. Methamphetamine use has already been clearly noted as a major problem among the dominant gay population in the city, primarily older White MSM. Substance use is influenced by peer pressure in the new community to fit in with others. It is important to note that most of the participants in this study were not fully aware of methamphetamine prior to arriving in San Francisco. Black MSM describe using substances so that they can deal with the circumstances that they find themselves in, as a way of coping with their situation.

Finally, sexual enhancement and transactional survival sex were discovered as a benefit of doing methamphetamine by the participants. The detail in the participant quote describes his experience with his boyfriend and the HIV-negative participant shared about how substance use makes it easier for him to bottom (be receptive anal partner) and feel sexier and more imaginative. Also included are excerpts from the narratives about methamphetamine use for sexual enhancement. This is considered chemsex, drugs before or during planned sexual activities to enhance, prolong, or sustain the experience (Maxwell, Shahmanesh & Gafos, 2018). In addition, the participants describe engaging in transactional survival sex. In a sense, methamphetamine allowed participants to have some kind of a mental escape from what they were having to do to get money.

Discussion

The aim of this study was to understand the role substance use plays in the lives of HIV-positive and HIV-negative Black MSM and to provide contextual factors specific to a group at especially high-risk for HIV. The excerpts from the narratives reveal some of the factors contributing to substance use among this high-risk population. It is clear that these issues are complex and multifaceted. Thirty years into the AIDS epidemic, discrimination, stigma and homophobia continue to be an issue for these men with them having to leave their family of origin because of sexual orientation. These social, environment and insecurity issues contribute directly to the challenges they faced in the family home and their own early substance use initiation (median age 15), at times with parents/caregivers providing the drugs, as well as early sex initial (median age 15). Mean age for participants is 26. On average, that would indicate approximately 10 years of substance use experience for the participants in this study. In studies by VanDevanter et al. (2011) and Maksut et al. (2016) unprotected receptive anal intercourse was associated with substance use, being kicked out of the home because of sexual orientation and younger age at initiation of sexual behavior among younger Black MSM. These young Black men are exposed to and have to learn to navigate this lifestyle from a very early age. The impact of this early exposure probably impacts how they use substances in later years.

There are a number of adverse and stressful childhood experiences noted by the participants. According to Brown, Masho, Perera, Mezuk & Cohen (2015), ACEs are a particular set of negative childhood exposures, for example, emotional, physical, or sexual abuse, witnessing violence among household members, and substance abuse. Brown et al. (2015) adds, research using a United States population-based sample showed that sexual minorities, such as MSM, had higher rates of ACEs and higher odds of experiencing multiple ACEs compared to heterosexuals. ACEs have been shown to be associated with sexual debut in early adolescence compared to later adolescence or as an adult. Among MSM, sexual debut before age 16 was associated with exchanging sex for drugs or money, marijuana use, emotional and psychological problems associated with substance use, and suicide attempts. It was also noted that MSM had higher odds of exposure to child abuse (physical or sexual) and housing adversity (homelessness or being forced out of their homes by parents/caregivers) compared to heterosexuals.

Schneeberger, Dietl, Muenzenmaier, Huber, & Lang (2014) identified a similar problem called stressful childhood experiences (SCE) that are associated with many different health outcomes, such as alcohol and drug abuse and victimization experiences. Lesbian, gay, bisexual, and transgender (LGBT) people are at risk to be victims of SCE and show higher prevalence of SCE when compared with heterosexual controls. In a systematic review, studies reported childhood emotional abuse, childhood physical neglect, and childhood emotional neglect. Items of household dysfunction included substance abuse of caregiver and parental separation.

Moreover, Schneeberger et al. (2015) notes, problems with alcohol and illicit drug use, as well as promiscuity, were shown to be related to SCE. Crosby, Mena and Ricks (2016) noted that the drunkenness and intoxication of male partners may be one of the strongest antecedents of elevated sexual risk.

Since many HIV-positive and HIV-negative Black MSM were displaced from their homes of origin, Garcia et. al. (2015) suggests that safe spaces and safe places are needed for this population. Ideally, these spaces and places are located in minority communities where HIV is concentrated. These spaces must be racially and ethnically focused since it is already known that Blacks do not respond or attend interventions targeting mainstream White MSM and often experience racism in gay social settings (Wong, Weiss & Ayala, 2010).

Additionally, we now have a better understanding and insight in how substance use, particularly methamphetamine, contributes to the sexual risk-taking among Black MSM, since most of them were testing regularly for HIV in the past. It seems that once they are under the influence, they no longer care about using a condom for protection or are able or willing to negotiate safer sexual practices with their partners. There does not seem to be a heightened concern about then avoiding becoming infected with HIV, but instead almost a sense of complacency and expectancy in terms of acquiring the disease. Because of this mindset, the participants in our study stated they ended up eventually testing HIV-positive.

In addition to utilizing harm reduction to meet the participants where they are at, it could also be useful as an educational framework for HIV sexual risks behaviors and substance use since it works well for young people (Erickson, 1995). Of course, utilizing this model would require assessing their readiness for any kind of change. It is suggested that behavioral interventions with HIV-positive and HIV-negative Black MSM promote strategies for responsible sex, including a sober partner, and opportunities to practice HIV risk reduction strategies through role-playing (Crosby, Mena and Ricks, 2016). Harm reduction works well if a substance user is not yet interested, unwilling, or unable to abstain completely (Weiker, Edgingtom &Kipke, 1999). Another part of harm reduction would be to have substance abuse treatment, prevention education, and medical services available that specifically address the needs of this high risk vulnerable population (Mimiaga et al., 2009; Sutton, 2011; VanDevanter et al., 2011), remembering that Black MSM need interventions directly targeted towards them (Wong et al., 2008) and that address their specific social, environmental and insecurity issues. If we are to have an impact in reducing substance use and HIV among this population, then we must have our efforts be guided by the HIV-positive and HIV-negative Black MSM that we want to reach.

Limitation

The small sample size is a limitation to this study. It would have been helpful to have more participants to capture a broader range of experiences. Majority of the participants are living with HIV, so we are lacking the perspectives of those who are not living with HIV. Another limitation is the convenient sample since most participants were drawn from community-based organizations and not representative of the larger MSM community. Likewise, this study was completed with young Black MSM in the Bay Area and can't be moved to other racial populaces or comparable members in other geographic regions

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Grant Funding

This research is funded in part by the Substance Abuse and Mental Health Services Administration Grant # 5T06SM060559-03.

References

Arnold EA, Kegeles SM, Pollack LM, Neilands TB, Cornwell SM, Stewart WR, Benjamin M, Weeks J, Lockett G, Smith CD, Operario D. (2019). A Randomized Controlled Trial to Reduce HIV-Related Risk in African American Men Who Have Sex with Men and Women: the Bruthas Project. *Prev Sci, (1)*:115-125. doi: 10.1007/s11121-018-0965-7. PMID: 30478804; PMCID: PMC6358465.

Brown, M. J., Masho, S. W., Perera, R. A., Mezuk, B., & Cohen, S. A. (2015). Sex and sexual orientation disparities in adverse childhood experiences and early age at sexual debut in the United States: Results from a nationally representative sample. *Child Abuse & Neglect*, *46*, 89–102. http://doi.org/10.1016/j.chiabu.2015.02.019

Buttram ME, Kurtz SP. A Qualitative Study of African American/Black MSM's Experiences of Participating in a Substance Use and Sexual Risk Reduction Intervention. (2015) *Am J Mens Health,11*(4):1155-1161. doi: 10.1177/1557988315584157. Epub. PMID: 25957249; PMCID: PMC5675315.

Center for Disease Control and Prevention. (2021a). HIV/AIDS. Retrieved from https://www.cdc.gov/hiv/group/age/youth/diagnoses.html

Center for Disease Control and Prevention. (2021b). HIV and African American Gay and Bisexual Men. Retrieved from: https://www.cdc.gov/hiv/group/msm/bmsm.html

Center for Disease Control and Prevention. (2021c). Gay and bisexual men's health: Substance abuse. Retrieved from http://www.cdc.gov/msmhealth/substance-abuse.htm

Creswell, J. W. (2017). *Qualitative Inquiry and Research Design* (4th ed.). Thousand Oaks, CA: Sage Publication.

Crosby, R., Mena, L. & Ricks, J. (2016): Correlates of sexual-risk behaviors among young black MSM: implications for clinic-based counseling programs, *AIDS Care*. http://dx.doi.org/10.1080/09540121.2016.1259449

Duncan DT, Sutton MY, Park SH, Callander D, Kim B, Jeffries WL 4th, Henny KD, Harry-Hernández S, Barber S, Hickson DA. (2020). Associations Between Neighborhood Problems and Sexual Behaviors Among Black Men Who Have Sex with Men in the Deep South: The MARI Study. *Arch Sex Behav, (1)*:185-193. doi: 10.1007/s10508-019-01619-4. Epub 2020 Jan 16. PMID: 31950381; PMCID: PMC7410008.

Erickson, P. (1995). Harm reduction: What it is and is not. *Drug and Alcohol Behavior, 14*, 283-285.

Erickson, P. (1999). Introduction: The three phases of harm reduction. An examination of emerging concepts, methodologies, and critiques. *Substance Use & Misuse, 34*(1), 1-7.

Fields EL, Hussen SA, & Malebranche DJ. (2020). Mind the Gap: HIV Prevention Among Young Black Men Who Have Sex with Men. *Curr HIV/AIDS Rep,* 17(6):632-642. doi: 10.1007/s11904-020-00532-z. PMID: 32914329; PMCID: PMC7483045.

Harawa, N., Williams, J., Ramamurthi, H., Manago, M., Avinia, S. & Jones, M. (2008) Sexual behavior, sexual identity, and substance abuse among low-income bisexual and non-gay-identifying African American men who have sex with men. *Archives of Sexual Behavior, 37,* 748-62. doi: 10.1007/s1058-008-9361-x.

Hilton, B., Thompson, R., Moore-Dempsey, L. & Janzen, R. (2000). Harm reduction theories and strategies for control of human immunodeficiency virus: a review of the literature. *Journal of Advanced Nursing, 33*(3), 357-370.

Holloway, I. & Galvin, K. (2016). *Qualitative research in nursing and healthcare* (4th ed). United Kingdom: Wiley-Blackwell.

Hotton A, Quinn K, Schneider J, & Voisin D. (2019). Exposure to community violence and substance use among Black men who have sex with men: examining the role of psychological distress and criminal justice involvement. **AIDS Care**, (3):370-378. DOI: 10.1080/09540121.2018.1529294.

Javier S., Abrams J., Moore M.,& Belgrave F. (2018). Condom use efficacy and sexual communication skills among African American college women. *Health Promotion Practice*, 19(2), 287-294. https://doi.org/10.1177/1524839916676253

Maksut, J., Eaton, L., Siembida, E., Driffin, D. & Baldwin, R. (2016). An evaluation of factors associated with sexual risk taking among Black men who have sex with men: a comparison of younger and older populations. *Journal of Behavioral Medicine*, *39,*665 674. doi:10.1007/s10865-016-9734-x

Maksut JL, Gicquelais RE, Jackman KM, Eaton LA, Friedman MR, Matthews DD, Bukowski LA, & Stall RD. (2020). Injection drug use, unknown HIV positive status, and self-reported current PrEP use among Black men who have sex with men attending U.S. Black pride events, 2014-2017. *Drug Alcohol Depend,1*;207:107808. doi: 10.1016/j.drugalcdep.2019.107808. Epub 2019 Dec 16. PMID: 31855657; PMCID: PMC7552112.

Marlatt, G. & Witkiewitz, K. (2002). Harm reduction approaches to alchohol use: Health promotion, prevention, and treatment. *Addictive Behaviors,* 27, 867-886.

Matthews D., Smith J., Brown A., & Malebranche D. (2016a). Reconciling epidemiology and social justice in the public health discourse around the sexual networks of Black men who have sex with men. *American Journal of Public Health*,*105*(5), 808-814. https://doi.org/10.2105/AJPH.2015.303031

Matthews D., Herrick A., Coulter R., Friedman M., Mills T.,Eaton L.,… Stall R. (2016b). Running backwards: Consequences of current HIV incidence rates for the next generation of Black MSM in the United States. *AIDS and Behavior*, *20*(1), 7-16. https://doi.org/10.1007/s10461-015-1158-z

Maxwell, S., Shahmanesh, M., & Gafos, M. (2019). Chemsex behaviours among men who have sex with men: A systematic review of the literature. The International journal on drug policy, 63, 74–89. https://doi.org/10.1016/j.drugpo.2018.11.014

Mimiaga, M., Reisner, S. Cranston, K., Isenberg, D., Bright, D., Dafflin, G., Bland, S., Driscoll, M., VanDerwarker, R., Vega, B.& Mayer, K. (2009). Sexual mixing patterns and partner characteristics of black MSM in Massachusetts at increased risk for HIV infection and transmission. Journal of Urban Health: Bulletin of the New York Academy of Medicine, doi: 10.1007/s11524-009-9363-6.

Nation, A, Waters. C. & Dawson-Rose, C. (2018). Experiences and perceptions of Black men who have sex with men about acquiring HIV: A qualitative narrative perspective. *Journal of the Association of Nurses in AIDS Care, (29)*5, 737–748. doi: https://doi.org/10.1016/j.jana.2018.04.010.

Office of Infectious Disease and HIV/AIDS Policy, HHS. (2021). What Is Ending the HIV Epidemic in the U.S.? Retreived from https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview

Pagkas-Bather J, Ozik J, Millett G, & Schneider JA. (2020). The last Black man with HIV in San Francisco: the potential role of gentrification on HIV getting to zero achievements. *Lancet HIV, 7*(12):e853-e856. doi: 10.1016/S2352-3018(20)30250-2. PMID: 33275918.

Quinn K., Dickson-Gomez J. (2016). Homonegativity, religiosity, and the intersecting identities of young Black men who have sex with men. AIDS and Behavior, 20(1), 51-64. https://doi.org/10.1007/s10461-015-1200-1

Reback, C. J., Fletcher, J. B., & Swendeman, D. (2018). Associations between Sociodemographic Characteristics and Sexual Risk Behaviors among Methamphetamine-using Men who Have Sex with Men. Substance use & misuse, 53(11), 1826–1833. https://doi.org/10.1080/10826084.2018.1436566

Riessman, C. (2016). *Qualitative Research.* Newbury Park, CA: Sage Publication.Schneeberger AR, Dietl MF, Muenzenmaier KH, Huber CG, & Lang UE. (2014). Stressful childhood experiences and health outcomes in sexual minority populations: a systematic review. *Soc Psychiatry Psychiatr Epidemiol.(49)*9. 1427-45. doi: 10.1007/s00127-014-0854-8.

Sutton, M. & Parks, C. (2011). HIV/AIDS prevention, faith, and spirituality among Black/African American and Latino communities in the United States: Strengthening scientific faith-based efforts to shift the course of the epidemic and reduce HIV-related health disparities. *Journal of Religion and Health*, doi: 10.1007/s10943-011-9499-z.

UNAIDS. (2016). The AIDS Epidemic can be ended by 2030 with your help. Retreived from https://www.unaids.org/sites/default/files/media_asset/UNAIDS_with-your-help_en.pdf

VanDevanter, N., Duncan, A., Burrell-Piggott, T., Bleakley, A., Birnbaum, J., Siegal, K., Lekas, H., Schrimshaw, E., Cohall, A. & Ramjohn, D. (2011). The influence of substance use, social sexual environment, psychosocial factors, and partner characteristics on high-risk behavior among young Black and Latino men who have sex with men living with HIV: A qualitative study. AIDS Patient Care and STDs, 25(2). doi: 10.1089/apc.2010.0100.

Viney, L. L., & Bousfield, L. (1991). Narrative analysis: A method of psychosocial research for AIDS-affected people. Social Science & Medicine, 32(7), 757-765.

Voisin D. R., Hotton A. L., Schneider J. A. (2016). The relationship between life stressors and drug and sexual behaviors among a population-based sample of young Black men who have sex with men in Chicago. *AIDS Care, 29*(5),545-551. https://doi.org/10.1080/09540121.2016.1224303

Wong, C., Weiss, G., Ayala, G. & Kipke, M. (2010). Harassment, discrimination, violence and illicit drug use among young men who have sex with me. *AIDS Education and Prevention, 22*(4), 286-298. doi: 10.1521/acap.2010.22.4.286.Yang, C., Latkin, C.,

Tobin, K., Seal, D., Koblin, B., Chander, G., Siconolfi, D., Flores, S. and Spikes, P. (2018). An Event-Level Analysis of Condomless Anal Intercourse with a HIV-Discordant or HIV Status-Unknown Partner Among Black Men Who Have Sex with Men from a Multi-site Study. *AIDS Behav* 22, 2224–2234. https://doi-org.lib proxy.fullerton.edu/10.1007/s10461-018-2161-y

Appendix A

Table 1

Interview Guide

Interview Questions

<u>Introductory questions</u>:

1) I'd like to begin by getting to know you better. Tell me a bit about yourself.
2) How do you see yourself as a person? How would you describe yourself to someone else?

<u>Intermediate questions</u>:

3) Tell me about what it is like to be a young man who has sex with men?
4) Tell me the story of how you came to learn your HIV status?
- What lead you to take the HIV test?
5) What ideas do you have about how you might have managed maintaining this HIV status?
6) Tell me about the role past substance use played in your life prior to testing for HIV?
7) How was your substance use once you found out your HIV-status?
- Has there been any change in your substance use recently?

If HIV-positive - Has substance use played a role in how you deal with being HIV- positive?

8) How does substance use relate to your sexual behavior or sexual risk?
- Has substance use changed the way you have sex?
- Does it make you feel sexy and more sexual? If so, tell me more….
- How has it changed your sexual behavior and sexual practices?
9) What role, if any, did substance use play in you acquiring HIV or any other STD?
10) Is there someone, someplace or a way that would have been best to communicate prevention messages to you?
11) Have you had any adverse childhood events (ACE), have they experienced sexual, physical, or emotional abuse?

12) Who is a part of your "family" and other social networks?

13) Have you experience problems in your life because of socioeconomics, stigma, racism, etc?
14) Do you have mental health or other health issues?
15) What are your words of wisdom or other things that would have helped you or other people your age to help them avoid becoming HIV-infected? (suggestions of peer prevention messages)
- To avoid risky sexual behavior?
- To avoid using drug and alcohol use?
- To avoid becoming a substance user?

Closing questions:

11) Are there questions that you thought I would have asked that I did not?

12) In light of everything we have spoken about, is there anything else you think is important to mention?

13) What questions do you have for me?

Prompts for interviewer:

- Tell me more about that?
- Can you give me an example of that?
- When that happened, what did you think or do?

Thank you very much for speaking to me today. Feel free to contact me, Dr. Carol Dawson-Rose, or the UCSF Committee on Human Subjects Research if you have any questions about the study. Let's set-up another date and time to meet for the next interview.

Appendix B

Table 2

Demographics

NUMBER OF PARTICIPANTS	n = 12
AGE (mean)	26
18-21	2
22-25	4
26-29	4
30-35	2
SEXUAL ORIENTATION	
GAY	9
BISEXUAL	3
HIV STATUS	
NEGATIVE	3
POSITIVE	9
DRUG OF CHOICE	
MARIJUANA	5
METHAMPHETAMINE	4
OTHER: CRACK, ALCOHOL	3
AGE OF SEX INITIATION (median)	15
AGE OF DRUG INITIATION* (median)	15
RELATIONSHIP STATUS	
SINGLE	7
REGULAR PARTNER	5
HIGHEST LEVEL OF EDUCATION	
GRADE SCHOOL	NONE
HIGH SCHOOL	6
SOME COLLEGE	6
COLLEGE GRADUATE	NONE
EMPLOYMENT/STUDENT STATUS	
FULL-TIME	NONE
PART-TIME	4
LOOKING FOR JOB	1
UNEMPLOYED	4

STUDENT	NONE
OTHER:SSI	2
CITY BORN*	
EAST BAY	6
OUTSIDE OF BAY AREA	5

*missing data

Appendix C

Table 3

Summary of Research Findings

OVERARCHING THEME	NARRATIVE THEMES	Representative Participant Quote
Social, environmental, and insecurity issues	(1) issues with family because of sexual orientation/kicked out of house, asked to leave or left home so they could be themselves	P3: *I wasn't really able to express myself at my home. I wasn't able to have a boyfriend or anything like that. Yes, after coming out to my father, it was just like I had nowhere else to go. So, I had to go into foster care, and I was staying with my father at that time. Because of his religious beliefs. So, he was like, "Being homosexual, you can't stay here, your brothers will catch onto it, pick it up, because they look up to you, and I don't need that," and he just kind of -- we just left it from there. I ran away.* (HIV-positive) *P8: It was just like negative sort of. All my mistakes or failures were just thrown in my face. I'm not the person to like talk bad, so I just kind*

		of …or ignored it and tried to look at the person sort of like their rage… Sexually, yes [there was abuse]. This wasn't a blood uncle. It was a family friend. This was when I was 12. Yeah, it was -- I don't know. I actually don't want to talk about it… And I was a latchkey kid. So, I would have the house to myself a lot as a child…I never saw it [abuse] physically, but I heard it…Yeah. And it was always just masked. (HIV-positive)
	(2) early substance use exposure and initiation within the family system	P1: *I would use it [drugs and alcohol] on a not really everyday all day, but I would be using this stuff. Then, I started hanging around with different family members who used it all day, every day. That changed my routine of using it* (HIV-positive) P6: *Man, I started smoking weed when I was 12. I started drinking alcohol when I was 13…And not only that, drugs really run in my family. My dad was an addict of cocaine… My thing was being introduced to pornography at a really young age, being introduced to drugs*. (HIV-positive)
Benefits of methamphetamine use for numbing, masking and coping	(3) coping mechanism for gay sex and "being" gay	P8: *I mean with [the new boyfriend] and the drugs I kind of like -- it was the time for me to explore like what it means to be kind of gay… It just like made the whole sexual exploration easier for me I guess...It [methamphetamine] puts me into a different sexual space...Maybe it's like getting rid of the shame of gay sex.* (HIV-positive) P10: *I know from when I was a bottom, alcohol played a big role because it helps your body calm down and then you don't feel like a lot of pain or whatever. And it's like it keeps you amped or whatever… The same thing with smoking weed or whatever, the weed will make you horny and shit. ... So, I'll start drinking and we'll start smoking and pop our pills [ecstasy] while we smoke and start drinking or whatever, and that make your*

		sex awesome.... And with me pills mixed with liquor make me get really imaginative. (HIV-negative)
	(4) leaving home, moving to San Francisco and surviving homelessness	P2: *What brought me here is I wanted to be somewhere where I felt I could be myself, and San Francisco is very open-minded, liberal, gay friendly. Because I came here by myself, no family here, didn't know nobody here in San Francisco. So, being that I'm a new person in San Francisco trying to survive and live, I was doing sex work mainly for survival reasons… to have a place to lay my head at night whether it be in a hotel room or somebody else's house or SRO [single room occupancy], what have you. I was just mainly doing it for survival, to have money… as a way of survival to keep from being homeless. (HIV-positive)*
	(5) methamphetamine exposure, prevalence and access in San Francisco	P12: *I'm living here in the city where the drug culture is so heavy…It's very confusing to me because I was unaware of the amount of drugs that actually float around the city…I never heard about crystal meth when I was in [another State]...Here in the city is a drug culture because you see it every day. You can see someone injecting when you're walking around. You can see someone smoking. So, to visibly see it is way more of an impact than just hear about it…when you see someone getting high and then the way they act after they get high it's like, "Oh, can I feel like that?* (HIV-negative)
	(6) peer pressure in new community to fit in with others	*P2: When I came here [San Francisco], meeting new people and getting introduced to the whole crystal meth thing because I never heard of crystal meth until I moved to the West Coast. I met some other people that are sex workers and they had introduced me to the whole crystal meth thing and then meeting tricks that were into meth use as well. So, the whole peer pressure of I*

		didn't want to feel like -- I didn't want to seem like I was a square. I didn't want to -- I wanted to be cool, or people to like me. I didn't want them to think I was boring…they tend to kind of push you or peer pressure you into experimenting, trying new things that you had never done before, and then, it just leads down a road of sex with no protection and just doing things that you wouldn't normally do if you weren't high. (HIV-positive)
	(7) to numb and mask feelings	P2: *It's like numbing the bad feelings about having to even do sex work just to like have money to survive, to live everyday life. So, yeah, the whole -- kind of like going through the motions, but you do it because that's your hustle, whatever, that's your way of survival…they're just a person, they have money, they're a trick, a john to use.* (HIV-positive) P5: *And also, it's [partying] like an escape. It's an escape from my situation, you know? For a minute I'm not homeless, like for a minute.* (HIV-positive)
	(8) sexual enhancement and transactional survival sex.	P1: *Well, basically, when I use drugs and I have sex, most likely I'm not going to want to use a condom. Most likely, I'm going to do some type of fetish. Some inappropriate behavior that could be harmful to either me or the partner because I'm on drugs. So, every sexual encounter I had was unsafe…I just wanted to get high…It [methamphetamine] kind of made me feel sexy in a way. It made me feel like a porno star. I could just go [have sex] for a long time. (HIV-positive)* P1: *I'd seen people getting money in a fast way. They were getting high. It really looked like they was living the life. I looked at them and I looked at drug dealers. I looked at different ways to get money-- I didn't care what I had to do. It was coming real fast. I jumped into that which was*

		male prostitution...I was just doing anything and everything with different people with different ways on how to get high. Money was coming in. I was like, "Oh man, this is the life." It was like, "Oh man, this is what I'd seen in those movies Paid in Full and Boyz n the Hood and all them. This is it. (HIV-positive)