

# **HIV/AIDS and Health Related Needs and Risk Perceptions Among African-American Men who Have Sex with Men in Michigan**

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# **HIV/AIDS and Health Related Needs and Risk Perceptions Among African-American Men who Have Sex with Men in Michigan**

## **Executive Summary**

This study was conducted to understand the needs of African American men who have sex with men (MSM). The study involved 32 structured interviews and 6 ( $N = 37$ ) focus groups with people who self-reported as male or transgendered, African American, and behaviorally homosexual or bisexual. The interview and focus group protocols covered many of the same issues, but the protocols were different. Participants were from six communities around Michigan: Benton Harbor, Detroit, Flint, Grand Rapids, Lansing, and Ypsilanti. Quota and network sampling methodology were used to access participants on streets, in parks, at clubs, and at community-based organizations known to serve MSM.

The primary goals of this needs assessment were to understand:

- Primary health concerns and access to general and HIV-specific health information and services
- Reasons for using/not using services and trusting/not trusting particular sources of HIV information
- Perceptions of health concerns that are important for African American men
- Attitudes about HIV/AIDS and the importance of HIV relative to other health risks for participants, and for African American men in general
- Exploration of the role that race plays in seeking services and information
- Openness about sexuality and HIV/AIDS; the role of social networks in risk behavior

The focus groups were designed to address the above issues, as well as to gain an in-depth understanding of the following:

- The role of the so-called “down-low” (DL) in the African American community and discrimination of gays
- Trust of public health and the government around HIV/AIDS and the antecedents of that trust/mistrust

## **Selected Findings and Recommendations for Interventions**

- HIV/AIDS is a salient issue for respondents. Few of the interview participants listed it as their primary health concern (unless they reported as HIV positive), but many said they think HIV is the most important health issue facing African American men today; typically because most men perceived that African Americans are at higher risk for getting HIV. Other STD’s and lack of health insurance were issues that were also frequently raised by participants as salient concerns. Interestingly, this seems to

suggest that people are not seeing HIV as a personal risk factor, but as a risk for the larger African American community. However, when asked about the personal importance of HIV relative to other health risks, most rated it as more important or as important as other health issues. Further, most participants reported fear or negative emotion associated with hearing the term HIV. Given these findings, interventions targeting this population should keep the focus on raising the salience of this issue, enhancing perceptions of personal risk and responsibility to the larger community.

- The importance of confidentiality to this population was clear from analysis of both the focus group and interview data. A large number of participants cited confidentiality issues as reasons for seeking out and sharing personal information (e.g., about HIV, sexuality) with particular organizations, groups, and individuals as opposed to others. Organizations who desire to market their services to African American MSM should strive to practice and promote confidentiality of services.
- When participants were asked whether they think about HIV more or less than they have in the past, the responses were very mixed. For those who indicated a change in thinking, it was typically because of one of two factors: 1) a change in their knowledge or awareness about HIV caused them to think about it more or less, or 2) a change in their sexual behaviors (particularly becoming sexually active) caused them to think about it more or less.
- When asked about the places they would *not* go for HIV information, there was a very consistent pattern to participants' responses. Specifically, many participants said they would not go to: churches, clubs or bars, or parks. Generally because of confidentiality concerns and fears about the type of information they would get from the sources in these places.
- There were a number of places people listed that they *would* go for HIV-related information including their private doctor, the internet, the health department, hospitals, and community-based organizations. The reasons people gave for choosing these particular organizations was because they were perceived as being open (one can "speak freely"), confidential, and comfortable.
- Importantly, concerns about going to particular places for information seemed to be largely related to stigma around gay sexual identity and HIV, rather than about concerns about racism. Agencies targeting African American MSM with prevention interventions should carefully consider the venue in which these services are provided. It appears that the public nature of bars and clubs in particular, raises concerns among this population.

- Many men mentioned having people in their social networks with whom they could talk both about their sexuality and about HIV, but most only mentioned one or two particular people. Participants were asked whether or not they ever thought about things their family or friends had said to them when they were in a situation where they might be putting themselves at risk for HIV. Most indicated they did not. These factors raise several possibilities for interventions targeting this population: using peer-based networks to support risk reduction behaviors, creating interventions designed to change prevailing norms around testing and information sharing around HIV.
- It is clear from these data that MSM, or at least homosexual behavior, remains highly stigmatized in the African American community. Based on these data, some of the reasons for this stigma appear to be: 1) communicating about homosexuality is not normalized, particularly within family groups; 2) masculinity is highly valued in the African American community (a number of people mentioned attempts to maintain a “thug” image despite their inherent femininity); and 3) social institutions central to the African American community (particularly the church) are perceived to be openly hostile to homosexuality.
- Due to the apparent stigma associated with homosexual behavior in African American communities, the issue of disclosure of sexual identity is important among participants who choose not to openly disclose homosexual behavior (i.e., being on the “down low” or DL). Indeed, most of the participants are operating on the DL in some capacity (nearly all of the participants had someone to whom they were unwilling or unable to disclose their sexual preferences –most often a family member). The prevalence of men on the DL suggests African American men are most effectively served by prevention interventions that are not “gay” identified or marketed.
- In this sample, people’s perceptions of HIV risk and vulnerability did not seem to be closely tied with homosexuality. The MSM in this sample, who would not talk to others about their sexual orientation, were quite willing to talk with those same people about HIV (as long as they were talking about other people).

## INTRODUCTION

Although rates of bisexuality and homosexuality among African American males are consistent with rates in other racial and ethnic groups in the US, bisexuality and homosexuality remain highly stigmatized in the African American community (Herek & Capitano, 1995). Researchers have attempted to identify the basis of this stigma and have pointed to sources such as the predominance of religion in African American community, as well as a cultural emphasis on masculinity. Little research, however, provides empirical evidence for the roots of this stigma. Further, certain practices among African American men (including the so-called “down low,” i.e., men who have sex with men without disclosing this fact to others, particularly their female sex partners) may be a direct result of the stigma attached to homosexuality in the African-American community, and is believed to be related to increased rates of HIV infection among African American men and women. This needs assessment sought to understand these issues, as well as to understand the other HIV prevention-related needs of African American men who have sex with men (MSM) in the state of Michigan.

Specifically, the primary goals of this needs assessment were to understand African American MSMs:

- Primary health concerns and access to general and HIV-specific health information and services
- Reasons for using/not using services and trusting/not trusting particular sources of HIV information
- Perceptions of health concerns that are important for African American men
- Attitudes about HIV/AIDS and the importance of HIV relative to other health risks for participants, and for African American men in general
- Exploration of the role that race plays in seeking services and information
- Openness about sexuality and HIV/AIDS; the role of social networks in risk behavior

The focus groups were designed to address the above issues as well as to gain an in-depth understanding of the following:

- The role of the so-called “down-low” in the African American community and its relationship to stigmatization of homosexual behavior
- Trust of public health and the government around HIV/AIDS and the antecedents of that trust/mistrust

## METHOD

### Sampling

The needs assessment involved structured interviews and focus groups with individuals who self-reported as male, African American, and behaviorally bi- or homosexual. Participants were from six communities around Michigan: Benton Harbor, Detroit, Flint, Grand Rapids, Lansing, and Ypsilanti. Quota and network sampling methodology were used to recruit participants on streets, in parks and other venues. The quotas were set based on U.S. Census Bureau year 2000 estimates of the size of the general population in each of the cities, with the largest number of interviews and focus groups coming from the city of Detroit.

### Procedure

Interviews and focus groups were conducted from October 2004 to April 2005. The interview and focus group protocols are included in Appendix A and B, and were developed in order to address the primary goals of the needs assessment and were based on tools used in previous research. Both the interview and focus group protocol were piloted prior to initiating data collection; the interview protocol with 4 participants in Detroit, and the focus group protocol with 2 groups in Detroit. The purpose of the pilot was to assess question flow, wording of items, participant willingness and ability to answer the questions, and to allow the interviewers to practice the protocols. The protocols were modified slightly following the pilots, but because these changes were not substantial, the data from the pilot is included in the final analyses.

After administering informed consent and requesting consent for tape recording, interviewers completed a structured interview, or focus group protocol, with questions designed to address the primary goals of the study. Following the interviews, all interview and focus group participants received cash compensation for their participation. The interviews and focus groups were audio taped and transcribed. The transcriptions were used to create a data set of quantitative data. Thus, the data collection yielded both quantitative and qualitative data. The qualitative data were reviewed for emergent themes by the research team. The quantitative data were analyzed using the Statistical Package for the Social Sciences (SPSS).

### Interview Participants

The interview sample consisted of 32 participants. The participants from the pilot were included in the final sample. The breakdown of number of interviews per city is presented in Table 1 below.

*Table 1. City in which the interview was conducted.*

|               | Frequency | Percent |
|---------------|-----------|---------|
| Ypsilanti     | 5         | 15.6    |
| Detroit       | 7         | 21.9    |
| Flint         | 5         | 15.6    |
| Lansing       | 5         | 15.6    |
| Benton Harbor | 5         | 15.6    |
| Grand Rapids  | 5         | 15.6    |
| Total         | 32        | 100.0   |

Interview participants were asked to self-report their gender, race/ethnicity, age, and educational background. Participants were primarily men (3 reported as trans-gendered) and Black or African American (3 reported as mixed race). The average age was 27.65 (SD= 9.74) with a range from 17 to 47 years of age. The gender of sex partners of participants over the year prior to the interview is reported in Table 2. The highest level of education completed by respondents is reported in Table 3 below, and indicates a fairly well educated sample.

*Table 2. Gender of sex partners of interview participants.*

|       |                    | Frequency | Percent |
|-------|--------------------|-----------|---------|
| Valid | Men Only           | 24        | 75.0    |
|       | Both, Mostly Men   | 6         | 18.8    |
|       | Both, Mostly Women | 2         | 6.3     |
|       | Total              | 32        | 100.0   |

*Table 3. Highest level of education completed by respondents in the interviews and focus groups.*

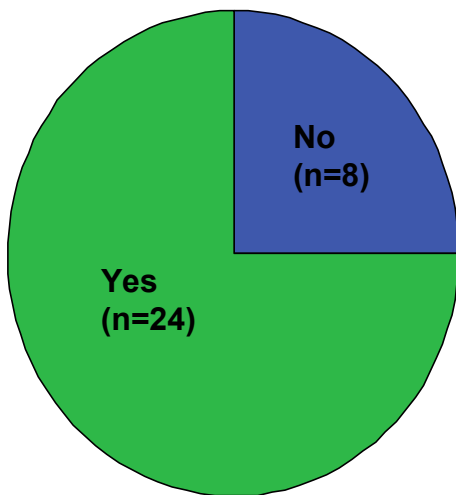
|                                | Interview Frequency (Percent) | Focus Group Frequency (Percent) |
|--------------------------------|-------------------------------|---------------------------------|
| Middle School                  | 2 (6.3)                       | 4 (10.8)                        |
| High School                    | 9 (28)                        | 15 (40.5)                       |
| Some College                   | 13 (40.6)                     | 13 (35.1)                       |
| Two Year Undergraduate Degree  | 3 (9.4)                       | 0                               |
| Four Year Undergraduate Degree | 2 (6.3)                       | 4 (10.8)                        |
| Graduate Degree                | 2 (6.3)                       | 0                               |
| Other                          | 1 (3.1)                       | 1 (2.7)                         |
| Total                          | 32                            | 37                              |

Interview participants were asked about their HIV testing patterns. Of the interview participants, all of the participants from Detroit, Flint, and Lansing had tested for HIV in the past; 4 participants indicated they were HIV positive. For the other cities, there were some who had never tested. Only one of the 5 participants from Benton Harbor had been tested. When asked the number of times they had tested in the year prior to the test, numbers ranged from 0-8, with a mean of 1.45 (Standard Deviation = 1.78).

*Table 4. Interview participants year of last HIV test.*

|         |         | Frequency | Percent |
|---------|---------|-----------|---------|
| Valid   | 1988.00 | 1         | 3.1     |
|         | 1989.00 | 1         | 3.1     |
|         | 1995.00 | 1         | 3.1     |
|         | 2003.00 | 2         | 6.3     |
|         | 2004.00 | 15        | 46.9    |
|         | 2005.00 | 3         | 9.4     |
|         | Total   | 23        | 71.9    |
| Missing | System  | 9         | 28.1    |
| Total   |         | 32        | 100.0   |

*Figure 1. Interview participants' responses to the question "Have you ever been tested for HIV?"*



### **Focus Group Participants**

Six focus groups were conducted with a total of 37 participants; 4 in Detroit and 2 in Lansing. Participants were asked to self-report their gender, race/ethnicity, age, and educational background in a short questionnaire following the group interaction. Participants were all men, with the exception of one person who reported as transgendered, and one person who did not answer the question. All participants reported as Black or African American and most were behaviorally homosexual (see Table 5). The average age was 30.14 (SD= 13.17) with a range

from 17 to 55 years of age. The highest level of education completed by respondents is reported in Table 3 above. Several participants (n=2, 5.4%) were married, most were single (n=29, 78.4%), several were divorced (n=2, 5.4%), and 3(8.1%) reported as “Other”.

Among 37 focus group participants, 32 (86.5%) had been tested for HIV. Importantly, two of the focus groups included all people reporting as HIV positive, so many of their responses were quite different from those in other groups making aggregation across groups difficult. The data from these groups will be included as appropriate.

*Table 5. Gender of partners of focus group participants.*

|                    | Frequency | Percent |
|--------------------|-----------|---------|
| Valid Men Only     | 32        | 86.5    |
| Both, Mostly Men   | 4         | 10.8    |
| Both, Mostly Women | 1         | 2.7     |
| Total              | 37        | 100.0   |

## FINDINGS

Key findings obtained from the interviews and focus groups are presented below. When participants are quoted directly, available demographic information is included to contextualize their comments. Their participant or focus group ID number, city in which the data were collected, and whether the participant was part of the focus groups (FG) or interviews (INT) occurs after each quote.

### **Primary Health Concerns, Access to Health Information and Services**

When asked if they had any health concerns or problems, most interview participants did not list HIV/AIDS as a health risk about which they are concerned. Participants in the focus groups more frequently brought up HIV/AIDS as a primary health concern, in part because they were primarily members of existing groups receiving HIV-related services. As one man said,

“If you are a young black man and you are gay in the community, some look at you different, some are cool with it and some are not. But we got to worry about AIDS. That’s our number one...(inaudible)...black people today.” (#1, Lansing, FG)

Four interview participants and a number of the focus group participants, particularly those who indicated they were HIV positive, listed concerns related to living with HIV and HIV drug therapies as their central health challenge. Many participants indicated they do not have any health concerns at all. Of those who

cited concerns, these participants generally only listed one or two concerns, most frequently asthma, diabetes, or substance use.

Participants reported going mainly to hospitals/medical centers and health departments for health concerns. Seven of the thirty-two interview participants indicated they go to a private doctor about their health concerns. Several also mentioned going to community-based organizations (CBO's) and looking online for information regarding their health. There were a number of places in each city that were mentioned by respondents as the places they go when they have health concerns. These places are listed in Appendix C.

When asked their reasons for going to the above places, the primary reasons were: they were in a habit of going there (they went to a particular place for services one time and just kept going there), cost and convenience, the perceptions that services are confidential, and feeling comfortable with the service providers. One person said about a particular agency in the Detroit area:

“People there are real sensitive and are aware of what’s going on in the community and about HIV/AIDS and they keep a wide variety of information like pamphlets, a wide variety of pamphlets, a wide variety of condoms and lube, and a lot of times I can get it free.”  
(#7, Detroit, INT)

Several participants from both the focus groups and interviews talked about the importance of free or inexpensive services, because of a lack of health insurance. When asked why he goes to a particular hospital in Detroit, one man said:

“It’s cheaper...they will take you with no insurance.”  
(#4, Detroit, INT)

Other access issues, such as location, were also mentioned as important. Several talked about services that they used because of their proximity to a bus route. One man indicated he chose to use a particular health care service based on location alone:

“Well, that’s the closest one to me, because I don’t have transportation.”  
(#12, Flint, INT)

### **Perceptions of health concerns important for African American men**

Participants were asked about health issues that they viewed as important for African American men, and their thinking about why these issues are important for African American men in particular. Most participants listed a number of diseases or conditions that they believed to be a problem for African American men specifically. Of those who provided a rationale for why health concerns were

important to African American men in particular, it was usually because of the perception that African Americans are at elevated risk for the disease, or because of not accessing health care on a regular basis. One focus group participant explained that he felt there were many health problems that occurred among African Americans because of not visiting health care providers regularly. He said:

“I think that in the African American community, um...alone there’s a lack of, um...importance put on like regular checkups to the doctors and stuff. So, little things can a lot of times blossom to bigger problems. I think these are major problems in our community because we a lot of times let them go unchecked at minor levels.”  
(#1, Lansing, FG)

HIV/AIDS was the issue that was most often raised as a health issue important to African American men; generally because participants perceived that HIV rates are higher among African American men and women than other groups. When asked why HIV was important for African American men, the participant said:

“Because over the past four years, I mean, it’s like the highest rate of AIDS has been, really, black men. So it’s like it’s kind of scary being gay, then having to worry about AIDS. You know what I’m saying?” (#13, Flint, INT)

Another man, said he believed that the “down low” was one reason HIV is an important issue for African American men and women:

“I don’t know, I guess I’ve been learning like this new “down low” phenomenon, and how their saying that women are like the number one carrier...black women are the number one carrier of HIV, and so since black women tend to be with black men, I would assume that, you know, that would be a rather vigorous thing they need to look out for.” (#4, Grand Rapids, INT)

Participants also mentioned sexually transmitted diseases/infections (STD/I) and prostate cancer as primary concerns for African American men. When one participant from Flint was asked about why STDs are a particular concern for African American men, he stated:

“Because some black men are really like naïve and they think that if they have sex one time, they won’t catch anything. They think they can have one, two, three or four times and have sex and you get something, but it’s not that, it’s that one time. It don’t matter if you have protection or not, you can still catch something.”  
(#12, Flint, INT)

Another said STDs are a problem for African American men because:

“...a lot of black men don’t use protection. They want pleasure, but then they don’t want to use protection. And that’s why they get problems. If you don’t want to burn, wrap it up.”  
(#5, Grand Rapids, INT)

Three participants in the interviews, and a number of people in the focus groups, talked about lack of health insurance and poor financial situations as the major health issue for African American men. As one man stated:

“Given the fact that the majority. . . quite a few black men that are unemployed in our country, and in our city and state, health insurance is at a premium for black American men.” (#2, Detroit, FG)

Other health issues mentioned by participants included diabetes, high blood pressure, asthma, heart disease, and simply “staying healthy.” Importantly, a number of participants did not list any health concerns as being particularly important for African American. When interviewers probed for “why” some health concerns were particularly important for African American men, many people had trouble explaining why they believed particular health issues were important.

### **Attitudes about HIV/AIDS and the importance of HIV relative to other health risks for participants, and for African American men in general**

In order to understand participants’ attitudes toward HIV and in particular, their perceived risk for HIV, participants were asked about what things come to mind when they think about HIV. A number of participants mentioned terms such as “death”, “dying”, “unhealthiness” and other negative terms. One participant said:

“First thing comes to mind is - wow - something I really don’t want to catch, something that serious. People need to be educated on it. It’s a lot of myths and a lot of misunderstandings about the disease as a whole, and I think a lot of people need to be educated on it.”  
(#19, Lansing, INT)

People who self-reported as HIV-infected typically responded with a sense of regret. As one HIV positive participant said:

“Guilt, low self esteem. If only I would have done this or done that, I wouldn’t be infected now. If I could just turn back the hands of time, things would be different.” (#11, Ypsilanti, INT)

Only one person linked HIV/AIDS with homosexuality when responding to this question. Several people also mentioned that they thought about HIV as a “manageable” disease. When people were asked if they worry about HIV, most

indicated that they do. Those who said they are not worried about HIV indicated that they engage in activities to keep themselves “safe” including using condoms and abstaining from or minimizing sexual contact.

In order to get a sense of how HIV ranks relative to other health risks, participants were asked whether or not they perceive HIV as more or less important than other risks for themselves personally, and for African American men in general, and how their thinking about HIV has changed, if at all, over the years. Participants across focus groups and interviews generally stated that HIV was either more important, or equally important to them personally, than other health risks. The typical reason for this was that participants indicated that they have had personal association with HIV positive persons and that this has impacted their thinking about HIV. As one participant said:

“Well (I) think about it a lot more because, you know, I’ve known people to catch it. And then, you know what I’m saying...I’ve actually seen like someone die.... someone that I’ve engaged in sex with, and now he has it. But you know, I’m saying I’ll go and get tested, and then I’m clean. You know what I’m saying? But see, that could have been me. So that makes me think about it a whole lot more. So, I am more protective and more careful, you know.” (#1, Detroit, FG)

People who self reported as HIV positive were likely to indicate that HIV was more important to them than other health concerns. As one man said:

“I guess because I have it. [It’s] reality for me, day in and day out. So it’s precedence over prostate cancer or heart disease, or eating fatty foods like that. So sometimes I might have that Big Mac thinking I have HIV, so what.” (#7, Detroit, INT)

There were some respondents who did not report as HIV positive, who thought that HIV was not as important as other health risks. One person said:

“Because of the hereditary issues, like, you know, diabetes and high blood pressure and things like that, which I’m more likely to become diabetic because there are a lot of things that becoming diabetic that I don’t have any control over, whereas with HIV there are things that I can control.” (#17, Lansing, INT)

Another said there were certain situations that he thought HIV as more important than other risks, but generally it was less of a concern:

“I don’t really worry about that. Sometimes I do have to worry about it, like if I’m with a guy. He’s just trying to take the condom off, or pretend that the condom came off, things like that.” (#7, Detroit, INT)

When participants were asked whether they think about HIV more or less than they have in the past, the responses were very mixed. Most people indicated that their thinking had changed in some way; with some saying they think about it more than they once did, others indicating they think about it less. For those who indicated a change in thinking it was typically because of one of two factors: 1) a change in their knowledge or awareness about HIV caused them to think about it more or less, or 2) a change in their sexual behaviors (particularly becoming sexually active) caused them to think about it more or less. For example, one man indicated that he thinks about it more than he used to:

“Probably because I’ve been sexually active more over the years, than I was before. When I first learned about AIDS or when I even first heard about it, I don’t think I was sexually active at the time. Knowing that I could be doing things that could pose a risk, you know, would certainly increase my awareness.”

(#15, Ypsilanti, INT)

Another respondent stated:

“I have a better understanding as far as how it’s diagnosed, and the different stages and things like that, and how people with HIV are living healthy lives. My understanding before was you got HIV, you got sick as a dog, and it’s not really necessarily true.”

(#15, Flint, INT)

Some participants indicated that their thinking has not changed over the years. These participants said because they have been maintaining a particular standard of behavior, they did not need to think about HIV differently than they had in the past. Others, particularly some participants who said they were HIV positive, said they do not think about HIV at all. One man said:

“I only think about it when I’m in group setting just like this, or I’m dropping those six or seven pills down. I don’t let it bother me, or the after effects of taking the pills is when I think about it...I haven’t thought about it and I don’t think about it. The more you think about it, the worst you get.” (#2, Detroit, FG)

In response to questions about whether HIV is more or less important for African American men generally than it has been in the past, the perceptions of respondents were that it is more important, but that people may not be “catching on” to this importance. As one respondent said:

“To be honest, I really don’t know. I feel like there’s still the mentality that it is a gay disease, and that it really hasn’t hit home to a lot of people. That they think that they have the potential to be carriers for HIV or something like that. ...there are statistics out

there to certainly show that there is something going on. And that something is progressing. I don't know if people are necessarily catching on to that feeling and thinking about HIV in the same way that it's progressing throughout the community.”  
(#15, Ypsilanti, INT)

One respondent highlighted the feeling that HIV is more important to African American men now than in the past, because actors outside of the community have made it so:

“Kind of maybe more important, simply because the finger gets pointed at African American males more so than anyone else, for being carriers of it, of the virus. The fact of the “down low” and just being gay on top of that. Since African American women are one of the fastest growing population of people to contract the virus.”  
(#18, Lansing, INT)

A focus group respondent echoed this perception:

“I think (on one hand) it's more of an issue with the African American community, but (on the other hand) I don't think it's more of an issue in the African American community because of the prevalence. But I think it's the media representation, and a lot of the research that has been done about HIV and AIDS that has made it seem like it's more...of an issue for African Americans. Well, it's an issue that's people wide. It doesn't seem that it's based on race. It's just more prevalent because of various other issues.”  
(#1, Lansing, FG)

A respondent from Flint said:

“It should be more of a concern because of the rate that people are dying of it, and that women are getting it from people that are living the down low lifestyle, and they're just passing it on because they don't use protection.” (#16, Flint, INT)

### **Sources of HIV-Related Information and Reasons for Trusting/Not Trusting Particular Sources of Information**

People were asked about the places they would and would not go to get information about HIV, and their rationale for choosing these particular places. There were a number of places people listed that they would go for HIV-related information, including their private doctor, the internet, the health department, hospitals, and community-based organizations. The reasons people gave for choosing these particular organizations was because they were perceived as

being open (one can “speak freely”), confidential, and comfortable. Confidentiality, in particular, was a major draw for respondents:

“I feel that whatever I go to them about, it stays there and the information doesn’t leak out into the community. Now there’s communicating all the time within [agency]. I feel strongly that it stays there at [agency].” (#11, Ypsilanti, INT)

Some people in the focus groups said they would go to particular places for HIV information, specifically because they identified with staff there. As one Lansing man said:

“One reason why I associate with people from [agency], ...is because there are people who identify like they do. They have people of color, um...so you feel more so connected with them. So, that’s why.” (#1, Lansing, FG)

A number of respondents indicated there is no place or person to whom they would go for HIV- related information.

We were particularly interested in this study to learn about whether or not, and *why*, people mistrust certain sources of HIV information. When asked about the places they would not go for HIV information, there was a very consistent pattern to participants’ responses. Specifically, many participants said they would not go to churches, clubs or bars, or parks. Not because they reported negative experiences at these sites, but because they either believed that they would have a negative experience, or that they would not be able to get the appropriate information there. As one focus group participant said:

“[I would not go to] public bath houses, parks, churches and whatnot. However, those are places where we should be able to go for health information, because dealing with the fact that STDs are in our community at large, we should be able to go to those places and find this information in forms of pamphlets and whatnot available at those sites. We should be able to, now if we can, is another story.” (#2, Detroit, FG)

People also listed specific organizations they would not go to. Citations included specific community-based organizations, non-profit organizations and hospitals.

The reasons for not going to particular places were fairly consistent across respondents. For churches, there was a perception of a lack of openness to gay lifestyle and fear of judgment. As one middle-aged man said:

“The pastor preaches hell for gays.” (#12, Ypsilanti, INT)

For other places, the overriding concern was being seen by others, and fears about confidentiality about their sexual orientation or their HIV status. For example, when asked places he would not go, one man said:

“It would have to be the neighborhood health clinic. I would not go there. Everybody in the neighborhood goes there. I would go way out somewhere, where nobody knows me, so that would have to be it.” (#2, Detroit, FG)

Several participants talked specifically about concerns over the nature of the information they would get from particular organizations. For example, one man expressed why he would not go to religious organizations for HIV information, because he thought the information would be “unreliable”:

“I ...feel like that they're unreliable, like...sex education and abstinence is the first words out of their mouth. Not prevention, which is in some cases, abstinence is okay; but it's like...not very reliable right now.” (#1, Lansing, FG)

It is widely believed in public health that historical factors, such as the Tuskegee experiments may be driving African Americans perceptions of mistrust of the public health system and of the federal government. In this sample, when asked a series of open-ended questions about trusted sources of information, we did not find people expressing mistrust for public health or for the federal government. As a small test of the salience of historical factors in people's minds, we asked participants in the focus group one open-ended question: What were the Tuskegee experiments? If they did not know, they were to indicate “don't know”. Eleven people wrote responses such as “some syphilis experiments” or “syphilis experiments with African Americans”, 18 people said they did not know, and 8 people left the question blank. This indicates that about 30% of our sample of has some knowledge of what occurred in the Tuskegee experiments. Whether or not this influences how or whether they access health services, is an empirical question.

Importantly, negative attitudes about going to particular places for information seemed to be largely related to self-perception of gay sexual identity and HIV issues, rather than about race. Issues related to race and seeking access to services were more often raised in the context of why people **would** go to certain organizations –several people specifically mentioned choosing to go to specific organizations because of the racial diversity of the providers.

### **Openness about Sexuality and HIV/AIDS; the Role of Social Networks in Risk Behavior**

Many men mentioned having people in their social networks with whom they could talk to both about their sexuality and about HIV, but most only mentioned

on or two particular people. Most often these people were friends, people the participant considered “family” or some particular family member. One man said he would talk with friends about his sexual orientation, but not others:

“My friends, not necessarily my family. My family knows (about his sexual orientation) but I don’t go and talk about them. They’re like, Christians.” (#15, Flint, INT)

Similarly, another man was asked why he would talk to particular friends:

“Because I have some friends that ...have the same sex preference as me. We can talk about a lot of different things versus talking to my father.” (#4, Benton Harbor, INT)

Another man said:

“I really...my family knows about my situation, but I don’t...I mean they ask me about protection. I always say I have used it -which is not true- because I know they would really get into me. I really haven’t talked to my family about it. We don’t discuss it. Maybe if I was straight we would discuss it, but it’s something we don’t talk about.” (#2, Grand Rapids, INT)

Family members were the people most often mentioned as the people with whom respondents would definitely not discuss their sexual identity.

Participants were asked whether or not they ever thought about things their family or friends had said to them when they were in a situation where they might be putting themselves at risk for HIV. Most indicated they did not. Of those who did, it was often about what friends had said about a particular person. For example, one participant stated,

“Well, I know like I have friends that tell me like, you know, they think I’m going to hook up with like somebody, or somebody is like talking to me. They know that person has been around a lot and they were like, I don’t think you should do it because that person’s been around a lot, and if you do, just be careful or whatever. So I always have people like looking out for me as far as friends, not really family.”( #14, Detroit, INT)

Respondents were also asked whether they thought there was discrimination toward gay men in the African American community, and how this influenced their communication about sexuality. When asked about whether or not people could be open about sexuality in the African American community, one man said this is not possible:

“Because you can’t just come out and tell a black, “oh, I’m bisexual, dawg.” You got to be straight, and don’t let them know. You can’t tell people that. You can’t tell a straight man that he’s gay. You always got to talk to him and say “man, I know you ain’t gay, it’s just something you like - that’s what you want, that’s your fantasy.” That’s how I meet them. I tell them, hey, I had a man. I say, no, you gay by society, but you are what’s in your mind. I’m not homosexual. I’m not bisexual. I’m a “try” sexual. Whatever I want to try, I feel that’s how I can do it.” (#3, Detroit, INT)

Several participants also mentioned that they attempted to avoid discrimination from others in their local communities by camouflaging what they perceived as their more “feminine” side, and maintaining a “thug” image, a factor that was echoed when participants were asked specifically about the concept of the down low.

### **The “Down Low” and Related Behaviors**

Given the prevailing talk in popular culture about the concept of the down low, some questions were included to uncover more information about how this factor might influence risk behaviors. Participants in the focus groups were asked a series of questions about the so called “DL” or down low, i.e., men who are behaviorally bi- or homosexual but have not disclosed this fact to others. A number of interview participants also brought up the issue of the DL without being asked specifically about the issue. The participants distinguished between two types of DL man. The first is a man who is behaviorally homosexual, identifies privately as such, but does not identify publicly as “gay”. As described by one respondent:

“You keep your s--- at home. Like you not out in the streets being a faggot doing like this (snapping of fingers).” (#1, Lansing, FG)

The second type of man on the DL, is behaviorally bisexual, but identifies privately and publicly as a heterosexual. As described by one respondent:

“Typically its black men, black men who sleep around who are in heterosexual relationships, but still sleep around with men. But they don’t consider themselves gay in any way.” (#1, Lansing, FG)

As another focus group participant said:

“Being down low is where you’re completely denying that aspect of your sexuality. Being in the closet is when you recognize it, but you just choose not to make that open in public.” (#2, Lansing, FG)

The focus group participants generally agreed that they perceive there are many people in their local African American community living on the DL. As one participant said:

“Now you have to say that DL brothers are everywhere. They are in the church, they are in your grocery store, and they are in bookstores. They are everywhere. Wherever you are, they are right there with you. And you know, it’s hard. You can go to church and you are going to get eyeballed. And that connection, right there, is another connection to get where you want to go.” (#2, Lansing, FG)

Participants discussed their beliefs about why men choose to live on the DL. Some reasons they highlighted were: people’s desire to conform to social norms around heterosexuality, embarrassment about being gay, the belief that the African American church has control over peoples decisions about their sexuality, and people wanting to “have their cake and eat it too” (#2, Lansing, FG). There was some debate among focus group participants over whether the DL is a “mental” or “social” problem. That is, some participants felt that men who are on the DL have personal “issues” with being publicly identified as gay, while others blamed society and the lack of acceptance of gay or bisexual men.

Several focus groups discussed their feelings about being or dating a man who is on the DL. One young man from Detroit, when asked what he feels when he hears the term DL said:

“Probably embarrassment. You know, because I ...think when I first started coming...coming around to my senses that I was attracted to boys, you know what I’m saying...it embarrassed me because, you know what I’m saying, society has that it’s crazy... why would you be attracted to another guy. And you know what I’m saying...you got all these pretty girls around you, what you want it with a n - - - ? You know what I’m saying...so after having that drilled into my head ever since I was born and everything, it embarrassed me, um... for someone to call me a fag or something, or say I’m gay.” (#3, Detroit, FG)

There were some participants who expressed particular concerns about dating a man on the down low. For those who did express concern, it was generally because they reported that they were “out” and secure with who they are, and viewed dating someone who was not “out” as a step backward. Several men expressed their anger over the attention that has been paid to the issue of the DL. One man expressed his bitterness and reasoning behind it:

“The reason I’m bitter is that it makes the gay community and especially the, um...the African American community look weak by comparison to the heterosexual couples. It makes it look like we

don't have our s--- together. That we can't come together in healthy relationships without having to have some sort of secrecy behind it. And it's just another way that the media is holding us down and making us look inferior." (#1, Lansing, FG)

Several mentioned they perceived that dating a man on the DL offered benefits including: a "no strings attached sex partner", no need for a public relationship with the person, and the fact that the person "goes home to his wife" (#1, Lansing, FG) at the end of a sexual encounter.

Participants were asked about the role of the DL, in what people do related to HIV/AIDS. Several focus group participants indicated that because people on the DL are usually "tops" (i.e., the insertive partner in anal sex), that these people are at less risk for getting HIV. Participants also raised the issue that they perceive gay men to be more sexually active than straight men and, therefore, more likely to transmit HIV. A few participants mentioned the idea that men on the DL were likely to infect both male and female partners with HIV, because of the perception that DL men are more likely to have unprotected sex.

### **Conclusions and Recommendations for Interventions**

- HIV/AIDS is a salient issue for respondents. Although few of them listed it as their primary health concern (unless they reported as HIV positive), but across focus groups and interviews many said they think HIV is the most important health issue facing African American men today; typically because most men perceived that African Americans are at higher risk for getting HIV. Other STD's and lack of health insurance were issues that were frequently raised by participants as salient concerns. Interestingly, this seems to suggest that people are not seeing HIV as a personal risk factor, but as a risk for the larger African American community. However, when asked about the personal importance of HIV relative to other health risks, most rated it as more important or as important as other health issues. Further, most participants reported fear or negative emotion associated with hearing the term HIV. Given these findings, interventions targeting this population should keep the focus on raising the awareness of this issue, enhancing perceptions of personal risk and responsibility to the larger community.
- The importance of confidentiality to this population was clear from analysis of both the focus group and interview data. A large number of participants cited confidentiality issues as reasons for seeking out and sharing personal information (e.g., about HIV, sexuality) with particular organizations, groups, and individuals. Organizations who desire to market their services to African American MSM should strive to practice and promote confidentiality of services. Similarly, a large number of participants mentioned the importance of providers they perceive to be

open-minded to a variety of lifestyles and behaviors as critical to their decisions about where to go for HIV information.

- When participants were asked whether they think about HIV more or less than they have in the past, the responses were very mixed. For those who indicated a change in thinking it was typically because of one of two factors: 1) a change in their knowledge or awareness about HIV caused them to think about it more or less, or 2) a change in their sexual behaviors (particularly becoming sexually active) caused them to think about it more or less. Others, particularly some participants who said they were HIV positive, said they don't think about HIV at all, sometimes as a denial strategy, other times as a coping mechanism.
- When asked about the places they would not go for HIV information, there was a very consistent pattern to participants' responses. Specifically, many participants said they would not go to churches, clubs or bars, or parks, generally because of confidentiality concerns and fears about the type of information they would get from the sources in these places. Importantly, concerns about going to particular places for information seemed to be largely related to stigma around gay sexual identity and HIV, rather than about concerns over racism. Agencies targeting African American MSM with prevention interventions should carefully consider the venue in which these interventions are conducted. It appears that the public nature of bars and clubs in particular, raises concerns among this population.
- Many men mentioned having people in their social networks with whom they could talk to about both their sexuality and about HIV, but most only mentioned one or two particular people. Most often these people were friends, people the participant considered "family", or some particular family members. Participants were asked whether or not they ever thought about things their family or friends had said to them when they were in a situation where they might be putting themselves at risk for HIV. Most indicated they did not. It may be useful to consider creating interventions designed to change prevailing norms around testing and information sharing around HIV.
- It is clear from these data that bi- and homosexuality remain highly stigmatized in the African American community. Based on our findings here, much of which is consistent with anecdotal findings on stigma, some of the reasons for this stigma appear to be: 1) communicating about homosexuality is not normalized, particularly within family groups; 2) masculinity is highly valued in the African American community (a number of people mentioned attempts to maintain a "thug" image despite their inherent femininity); and 3) social institutions central to the African

American community (particularly the church) are perceived to be openly hostile to homosexuality.

- One consequence of stigma is that people choose not to openly disclose behavioral bi- or homosexuality (the DL); something mentioned by a number of participants. Indeed, most of the participants in this study indicated that they are operating on the DL in some capacity (nearly all of the participants had someone to whom they were unwilling or unable to disclose their sexual preferences.) The prevalence of men on the DL suggests that services targeting African American men are best served by not identifying as “gay” targeted services.
- Interestingly, in this sample, people’s perceptions of HIV do not seem to be inextricably linked to homosexuality. The MSM in this sample who would not talk to others about their sexual orientation were quite willing to talk with those same people about HIV (as long as they were talking about other people). This is probably due to the nature of this sample and would not generalize to other populations, but it is good news for targeting HIV prevention interventions for men who do not see themselves as gay.

#### Reference

Herek, G. M., & Capitano, J. P. (1995). Black heterosexuals' attitudes toward lesbians and gay men in the United States. *Journal of Sex Research* 32(2), 95-105.

Appendix A

**Final Interview Questions**

Interviewer: \_\_\_\_\_

Participant ID: \_\_\_\_\_

Date: \_\_\_\_\_

Site (city, location of interview): \_\_\_\_\_

Verbally Administer Informed Consent  Yes  No

***Thanks for agreeing to take part in this study. The questions I will ask today will focus on health issues and where you go for health information. Some of the questions will address sensitive issues around sex and sexual diseases. If you feel uncomfortable about any question you do not have to answer it. Some of the questions ask specifically about your experience as an African-American/Black man. Your responses are very important to us and will be used to help agencies around this community and the state better serve the needs of African-American men.***

***I would first like to ask you a few questions about what you see as important health issues.***

1. Do you have any health concerns or problems?

If yes, what are your biggest health worries or problems?

2. Where do you go when you have concerns about your health?

Probe: Do you go to a private doctor?

Probe: Do you go to any health departments, local clinics or hospitals? (Where in the hospital?)

Probe: Do you go to any community organizations (e.g. substance use organizations, non-profits)?

Probe: Why do you go to ((\_\_\_\_\_)) (repeat the place they have named)?

3. Are there any health issues that are particularly important for you as an African-American/Black man?

Probe (for each): Why is this an important issue for Black men?

Probe: (for each): What is it about this issue that makes it particularly important for Black men?

Probe: What other issues?

I want to ask you about a particular health issue: HIV/AIDS.

4. When you think about HIV/AIDS, what do you think about?

5. Does HIV/AIDS seem more or less important to you than other health issues?

Probe: Do you worry about HIV/AIDS?

((IF YES)): What is it about it that worries you?

((IF NO)) Why aren't you concerned about it?

Probe: Are there things you do to try to protect yourself from HIV/AIDS?

((IF YES)): What are they?

((IF NO)): What are your reasons for not doing things?

6. How has your thinking about HIV/AIDS changed over the years if at all?

Probe: Have you generally thought about it more or less over the years?

Probe: Why do you think it is the case?

7. Do you think HIV/AIDS is more of a concern or less of a concern for African-Americans now than it used to be?

Probe: What about African-American men in particular?

Probe: Why is this the case?

8. Are there any organizations that you go to talk about HIV/AIDS?

Probe: Which organizations?

Probe: Do you go to a private doctor?

Probe: Do you go to any local clinics, the health department or hospitals?

Probe: Do you go to any community organizations?

Probe: What about to a church or minister?

9. What is it about these places that causes you to go to them for HIV/AIDS information?

Probe: Is it the people that work there? What is it about them?

Probe: Is it the location of the place? What is it about it?

Probe: Any other reasons?

((INTERVIEWER: PROBE THE RESPONSE TO THIS –IF THEY SAY THEY “TRUST THEM” TRY TO BETTER UNDERSTAND WHY THEY TRUST THEM))

10. Are there places you would **not** go for information about HIV/AIDS? Why?

Probe: Are there any places in your community that you as an African-American man would feel uncomfortable going for HIV information?

**IF YES:**

Probe: Where?

Probe: What is it about these places that makes you feel uncomfortable?

Probe: Are there other reasons that you feel uncomfortable going to certain places for HIV information?

11. What about talking to your friends or family about HIV/AIDS? Are there people among your friends and family that you talk to about HIV/AIDS?

**IF THERE ARE PEOPLE:**

Probe: Tell me more about why you feel comfortable talking to these people.

Probe: What are the kinds of things you talk about? Do you talk seriously or not?

Probe: Do you ever talk about the things that can be done to protect oneself from HIV? Like what?

Probe: Do you ever think about things that your family or friends have said when you are in situations where you could be putting yourself at risk for HIV? What do you think about?

**IF THERE ARE NOT PEOPLE:**

Probe: Tell me more about this, why do you think this is the case?

12. Have you been tested for HIV?  Yes  No (If NO skip to question 16)

**If YES:**

12a. When were you last tested for HIV? \_\_\_\_\_ (day –if remember, month, year)

12b. The last time you were tested, why did you decide to test?

12c. Where did you find out about testing/test site?

12d. The last time you were tested, what was the result?

Positive  Negative  Didn't find out results  Don't Remember

13. After this HIV test, did anything change in your life? (drug use, sex, views on risk)

Probe: Tell me a little about that...

14. How many times have you tested for HIV in the last year? \_\_\_\_\_

15. Why do you test for HIV?

I would now like to change topics and ask you some questions about your sexuality. I understand that these are sensitive questions. Please answer only those questions that you feel comfortable with.

16. Do you have sex with... (I am going to list several options)

Men only  Women only  Both men and women, mostly men  
 Both men and women, mostly women

17. Are there people among your family, friends, or acquaintances that you feel comfortable talking with about your sexuality?

**IF THERE ARE PEOPLE:**

Probe: Tell me more about why you feel comfortable talking to these people about your sexuality.

Probe: Why do you talk to these particular people and not others?

Probe: What are the kinds of things you talk about?

**IF THERE ARE NOT PEOPLE:**

Probe: Tell me more about this, why do you think this is the case?

Probe: What keeps you from talking with people?

Probe: Are there things you wish you could talk with people about, but can't?

18. Are there people that you definitely would not talk to about your sexuality?

Probe: Who are they?

Probe: Why wouldn't you talk to them?

I want to ask you specifically about bi-sexual and gay men in the African-American men in the Black community.

19. Do you think bi-sexual and gay men are discriminated against in the Black community?

Probe: Why do you think this is the case?

Probe: How do you think it impacts the things that people do?

**IF THEY ARE MSM (if not, go to question 20):**

Probe: Does this influence the things you do? How?

Probe: Do you think this discrimination influences the things you do related to HIV/AIDS in anyway? How?

20. Sex (**interviewer circle one**):            Male            Female

21. What is your age? \_\_\_\_\_

22. What is your racial or ethnic background? \_\_\_\_\_

23. What is the highest level of education you have completed?

Elementary school degree

Two-year undergraduate degree

Middle/Intermediate school degree

Four-year undergraduate degree

High School

Graduate/Professional degree

Some College

Other \_\_\_\_\_

24. Is there anything else you would like to tell me related to any of the things we talked about today?

Appendix B

**Final Focus Group Protocol**

**Moderator:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Site** (city, location): \_\_\_\_\_

---

**Number of Participants:** \_\_\_\_\_

***((Focus Group Introduction))***

***Thanks for agreeing to take part in this study. The questions I will ask today will focus on health issues and where you go for health information. Some of the questions will address sensitive issues around sex and sexual diseases. If you feel uncomfortable about any question you do not have to answer it. Some of the questions ask specifically about your experience as an African-America/Black man. Your responses are very important to us and will be used to help agencies around this community and the state better serve the needs of African-American men.***

***I would first like to ask you a few questions about what you see as important health issues.***

1. What do you see as the biggest health issues or worries facing you today?

Probe (for each): Why is this an important issue?

Probe: What other issues?

2. What do you see as health issues that are particularly important for African-American/Black men?

Probe (for each): Why is this an important issue for African-American men?

Probe: What other health issues are important to you as African-American men?

3. Where do you go to find health information and what are some of the reasons you go to these places?

Probe: Which community organizations?

Probe: Which hospitals?

Probe: Which clinics?

Probe: What about friends or family?

Probe: What other places?

4. What are some places that you would NOT go for health information? Why wouldn't you go there?

Probe: Are there any places in your community that you as an African-American man would feel uncomfortable going for information? Where?

Probe: What is it about these places that makes you feel uncomfortable?

Probe: Are there other reasons that you feel uncomfortable going to certain places for information?

I now want to ask about a particular health issue, HIV/AIDS.

5. When I say the words “HIV and AIDS”, what do you think about?

6. How does HIV/AIDS fit in with these other health issues that you mentioned above?

Probe: Does HIV/AIDS seem more or less important? Why?

7. How has your thinking about HIV/AIDS changed over the years? Have you generally thought about it more or less over the years?

8. Do you think it is more or less of a concern for African-Americans now than it used to be?

Probe: What about African-American men in particular?

Probe: Why is this the case?

9. What about information about HIV/AIDS-where are places you would go to get information about HIV/AIDS? What are the reasons you would go to these places?

Probe: Which community organizations?

Probe: Which hospitals?

Probe: Which clinics?

Probe: What about friends or family?

Probe: What about going to your church or minister?

Probe: What other places?

10. What is it about these places that causes you to go to them for HIV/AIDS information?

Probe: Is it the people that work there? What is it about them?

Probe: Is it the location of the place? What is it about it?

Probe: Are there other reasons?

11. Are there places you would not go to for information about HIV/AIDS? Why?

Probe: Are there any places in your community that you as an A-A man would feel uncomfortable going for HIV/AIDS information? Where?

Probe: What is it about these places that makes you feel uncomfortable?

Probe: Are there other reasons that you feel uncomfortable going to certain places for HIV/AIDS information?

Probe: Are there particular clinics, hospitals, or community organizations that you would not go to?

Next I would like to know more about the times you talk, if at all, with your family and friends about sexuality and then about HIV/AIDS.

12. Are there people among your family or friends that you feel comfortable with talking about sex and sexuality? ((KEEP ON SEXUALITY HERE-NOT ON HIV))

IF THERE ARE PEOPLE:

Probe: Tell me more about why you feel comfortable talking to these people.

Probe: Why do you talk to these particular people and not others?

Probe: What are the kinds of things you talk about? Do you talk seriously or not?

IF THERE ARE NOT PEOPLE:

Probe: Tell me more about this, why do you think this is the case?

13. What about talking about HIV/AIDS? Are there people among your friends and family that you would talk to about HIV/AIDS?

IF THERE ARE PEOPLE:

Probe: Tell me more about why you feel comfortable talking to these people.

Probe: What are the kinds of things you talk about? Do you talk seriously or not?

Probe: What do you think that they think about HIV/AIDS?

Probe: Do you ever talk about the things that can be done to protect oneself from HIV?

IF THERE ARE NOT PEOPLE:

Probe: Tell me more about this, why do you think this is the case?

I would like to ask you about a term that people talk about and get your feelings about that term.

14. Have you heard of the term “down low” or “DL”?

Probe: What does it mean? Who does it apply to?

Probe: What does this term make you think about or feel?

Probe: What are the reasons that you think certain people choose to be on the DL?

Probe: What do you see as the relationship between the DL and stigma about being gay?

Probe: How do you think being on the DL influences people’s behaviors related to HIV/AIDS?

Probe: What do you see as the role of churches in this community related to the down low?

15. Do you think gay people are discriminated against in the black community?

Probe: Do you think this discrimination is different for men and women? How?

Probe: How do you think this discrimination influences the ways that people talk about sex and sexuality in the black community if it does at all?

Probe? How do you think this discrimination influences the ways that people talk about HIV?

I would like to thank you for talking with me today –you have been very helpful. Please let me know after we finish if you have any questions or concerns about the things we talked about today and we can talk further about them at that time. ((Also –offer referral to local CBO for HIV/AIDS or other information)).

**Situational Factors** (anything happen during group?):

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## Appendix C

**Benton Harbor:** most reported going to the clinic at Lakeland Hospital and one person reported going to Berrien County Health Department.

**Detroit:** participants from Detroit frequently mentioned going to Detroit Receiving and Herman Keiffer Hospitals. Also mentioned were Henry Ford Hospital, the Northwest Industrial Clinic, Oakland and Wayne County Health Departments, Ruth Ellis House. One person mentioned going to Midwest AIDS Prevention Project, and one to the Empowerment program in downtown Detroit, CHAG.

**Flint:** participants mentioned several unspecified clinics, and the health department

**Grand Rapids:** participants reported going to the Met Center, the Network, HIV/AIDS Services, and Spectrum House.

**Lansing:** Ingham Regional Medical Center, Sparrow Emergency, LAAN, and MSU's Olin Health Center, Planned Parenthood, and Ingham County Health Department.

**Ypsilanti:** the Veteran's Administration Hospital, HIV/AIDS Resource Center, and St Joseph Mercy Hospital.