

# BACK OF THE LINE

**THE STATE OF AIDS  
AMONG BLACK GAY  
MEN IN AMERICA  
2012**



Back of the Line: The State of AIDS Among Black Gay Men in America, 2012 is a publication of the Black AIDS Institute, 1833 West Eighth Street, Los Angeles, California 90057-4257, 213-353-3610, 213-989-0181 fax, info@BlackAIDS.org, www.BlackAIDS.org.

© 2012 Black AIDS Institute. All rights reserved.

The slogan "Our People, Our Problem, Our Solution" is a trademark of the Black AIDS Institute.

Views and opinions expressed in this publication are not necessarily those of the Black AIDS Institute, its partners or the funders of this publication. Publication of the name or photograph of a person does not indicate the sexual orientation or HIV status of the person or necessarily constitute an endorsement of the Institute or its policies. Some photographs in this publication use professional models for illustrative purposes only.

Back of the Line: The State of AIDS Among Black Gay Men in America, 2012 is designed for educational purposes only and is not engaged in rendering medical advice or professional services. The information provided through this publication should not be used for diagnosing or treating a health problem or a disease. It is not a substitute for professional care.

This report was made possible, in part, by the generous support of the Elton John AIDS Foundation, Ford Foundation, M-A-C AIDS Fund, and Broadway Cares/Equity Fights AIDS.

ELTON JOHN AIDS FOUNDATION 

 FORD FOUNDATION

MAC AIDS FUND



Ver. 1.1



**1**

**Deciding Moment:  
Together We Are  
Greater Than  
AIDS**

**2**

**Connecting the  
Dots:  
The Fight Against  
AIDS Among  
Black Gay Men  
and the Struggle  
for Civil Rights**

**3**

**Back of the Line:  
The State of AIDS  
Among Black Gay  
Men in America  
Executive  
Summary**

**4**

**Back of the Line:  
The State of AIDS  
Among Black Gay  
Men in America**

**5**

**Worse Than Any  
Other:  
More Heavily  
Affected by  
HIV Than Any  
Population in the  
Developed World**

**6**

**A Physician  
Speaks:  
Health Care  
Barriers for Black  
MSM**

**7**

**At Risk No Matter  
the Age:  
A Lifetime  
Challenge**

**8**

**Profiles:  
Risk Among Black  
MSM Knows No  
Age**

**9**

**The Best and  
Worst:  
U.S. Cities Ranked**

**10**

**New Hope, New  
Opportunities:  
But Will Black  
MSM Benefit?**

**11**

**An HIV Prevention  
Leader Speaks:  
Growing AIDS  
Crisis Among  
Black MSM**

**12**

**Ending AIDS  
Among Black  
MSM:  
How Do We Move  
Forward?**

**13**

**Profiles:  
Gone Too Soon**

**14**

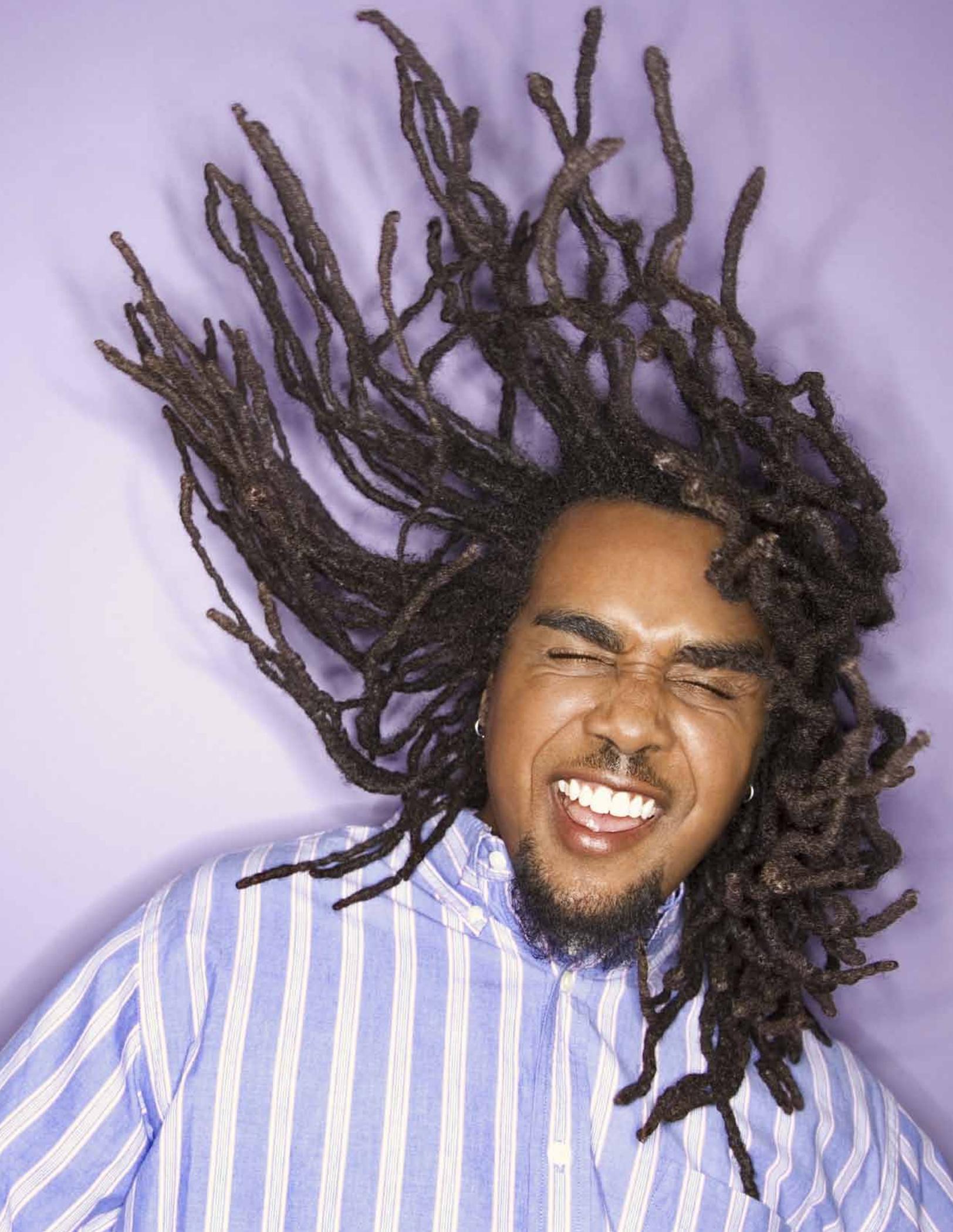
**Action Plan to  
End AIDS Among  
Black MSM:  
Priority Action  
Steps**

**15**

**Notes**

**16**

**About**



# 1 Deciding Moment

## Together We Are Greater Than AIDS

By Phill Wilson  
President and CEO, Black AIDS Institute

*“Black men loving Black men is a call to action, an acknowledgement of responsibility. We take care of our own kind when the night grows cold and silent. These days the nights are cold-blooded and the silence echoes with complicity.”*

Joseph Beam  
*Brother to Brother:  
Words from the Heart*

I was 24 years old when I became infected with HIV. I’m 56 now. The journey to prepare this report has been a very personal one for me. I am among a small number of Black gay men who survived the darkest days of the AIDS epidemic. The first thing I did when we decided to write this report was to take a long and hard look at two photographs hanging in the entryway of my house.

The first one is a photo of me with my friends Ken, Roger, and Steven. I am the only one of us still alive. The second photo is of me and my friend David who died in 1998.

The second thing I did was reread three very important books, *In the Life: A Black Gay Anthology* edited by Joseph Beam; *Brother to Brother: New writings by Black Gay Men* edited by Essex Hemphill; and *Sojourner* by the Other Countries collective. All of these books were published between 1986 and 1993. As I reread these anthologies, I was struck by how prolific Black gay writers were during the very worst years of the AIDS epidemic. It was as if they were writing for their lives. There were nearly 80 contributors to those three anthologies

and over 30% of them are dead today.

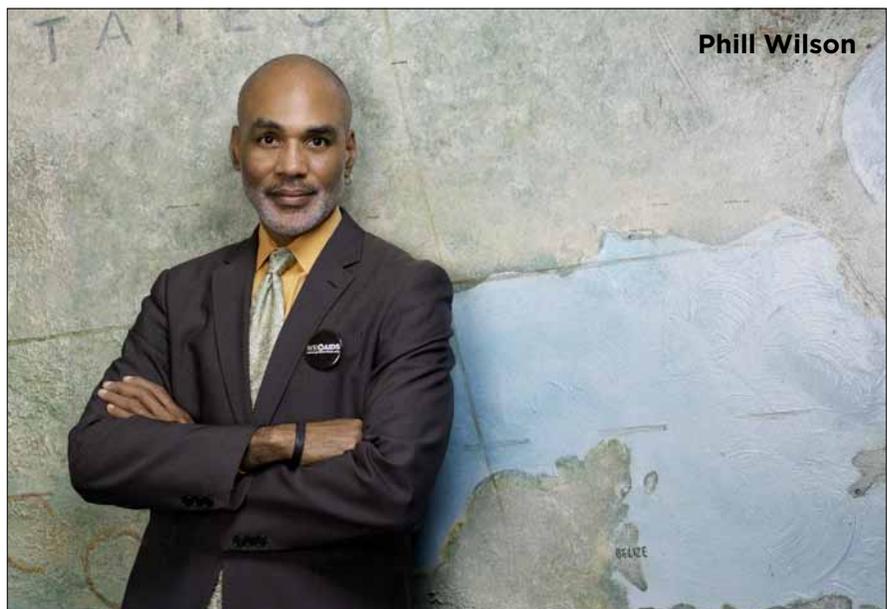
I got involved in the fight against AIDS—the GRID, (Gay Related Immune Deficiency)—shortly after the first cases were diagnosed among five white gay men at UCLA medical center in 1982.

In the beginning, like most Americans, I believed that AIDS was a white gay disease. But very quickly, I was disabused of that notion. On the ground a different story was being played out. In fact, from the very beginning of the epidemic the proportion of cases among Black gay men was more than double our share of the national population. Today, HIV prevalence among Black gay men is roughly double the prevalence among white gay men.

At a time when the LGBT community—and, indeed, American

society as a whole—has largely moved on, HIV/AIDS continues to be a leading cause of death for Black men who have sex with men. By the time a Black gay man reaches age 25, he stands a roughly one-in-four chance of being infected with HIV. By age 40, the odds reach an astonishing 60%.

Moreover, at a moment when tens of thousands of scientists, advocates, policy makers, journalists, and people living with HIV/AIDS from across the world gather in Washington, D.C., for the XIX International AIDS Conference that will focus largely on hopes of ending the AIDS epidemic, the problem among Black gay men is getting worse. Much worse. From 2006 to 2009, the rate of new infections among young Black gay men rose by 48%. While transmission rates have declined in the U.S. overall,



new infections are rapidly increasing among young Black gay men.

I wish I could report that these startling patterns have prompted newfound resolve and innovation to reverse this crisis. But nothing could be further from the truth.

First in line when it comes to need, Black gay men too often remain at the back of the line when it comes to assistance. While there are mobilization efforts going on to increase testing and access to treatment, they are often being implemented with little, if any, support from those who ought to care.

As this report explains, state and local health departments are seriously under-prioritizing prevention and treatment programs for Black gay men. And the federal government doesn't even track HIV expenditures for Black gay men. Compared to white gay men, Black gay men have more limited access to HIV testing, are more likely to lack access to care, and are less likely to receive antiretroviral therapy when they are able to obtain health care. The low-priority approach taken by many of our public health leaders would seldom lead one to conclude that Black gay men represent the only population in the U.S. in which new infections are significantly increasing.

Beyond government, the communities that are the natural

homes for Black gay men—the Black and LGBT communities—have similarly failed to prioritize the AIDS fight among Black men who have sex with men. And the philanthropic sector, once a robust presence in the AIDS fight, has withered away, with a mere handful of funders continuing to support community-based AIDS programs.

If this report were nothing more than a clarion call for action to address an unconscionably neglected issue, it would be worth publishing. But it's more than that. It's also about hope—in a future without AIDS, for all populations and in all settings.

Today, the tools are at our disposal to bring this horrible epidemic to an end. By combining new biomedical tools with strengthened prevention programs and support services that contribute to the effectiveness of biomedical interventions, we can end AIDS.

Black gay men won't gain meaningful access to breakthrough HIV tools without dramatic changes in service systems, funding patterns, and legal frameworks. The Supreme Court's validation of the Affordable Care Act in June 2012 offers an important avenue for making some of the changes needed to give Black gay men a fighting chance to get the



service they need.

But more—much more—will need to be done. Those who ought to care must care. And those in positions of leadership must lead.

This report is dedicated to a vision of a world without AIDS. It's dedicated to David, Roger, Ken, and Steven. It's dedicated to the young Black gay men who call the Black AIDS Institute almost every week who just found out they are HIV-positive. They either didn't know how to protect themselves or didn't know their lives were worth protecting. They usually know very little about the virus, don't have health care, and are often more afraid of the stigma than they are of the disease.

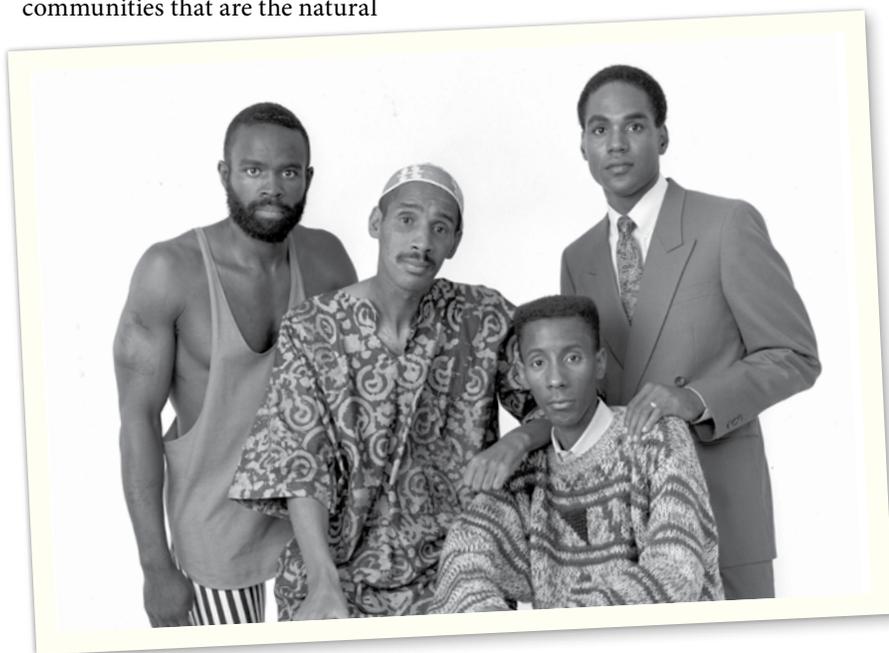
We've attempted to provide a blueprint for action, outlining urgent steps that need to be taken by government leaders, Black communities, the LGBT community, and private foundations.

This is one report that simply can't gather dust on the shelves or remain unread on a flash drive. The problem it describes is too important, and the need for action too urgent.

Let's use the release of this report to renew our commitment, reinvigorate the national AIDS response, and show through action that Black gay men are part of the American family. We are at a deciding moment. Together we are greater than AIDS.

*"I want to start an organization to save my life. If whales, snails, dogs, cats, Chrysler, and Nixon can be saved, the lives of Black men are priceless and can be saved."*

*Essex Hemphill  
For My Own Protection*



## 2

## Connecting the Dots

### The Fight Against AIDS Among Black Gay Men and the Struggle for Civil Rights

By Ernest Hopkins  
Chair, National Black Gay Men's Advocacy Coalition

When the civil rights movement gathered momentum more than a half-century ago, activists initially focused on the most basic of human rights—the right to vote, to have equal access to public accommodations, and to be free of daily indignities. The courage and perseverance of the millions of people who fought for basic civil rights resulted in the well-known landmarks of our country's long journey toward greater fairness—the Supreme Court's 1954 decision in *Brown v. Board of Education*, enactment of the Civil Rights Act of 1964, and Congressional endorsement of essential voting rights in 1965.

Although regarded by many as the culmination of decades of struggle, these milestones represented merely a continuation of efforts to realize the promise of genuine equality in the Declaration of Independence. The historic achievements of the civil rights movement moved our country forward, but it left unsolved many of the more ingrained legacies of American history—economic and social inequalities, unequal opportunity, and an unfortunate tendency to erect walls to exclude those deemed to be outsiders.

In 2012, no one can reasonably deny the progress achieved in this long struggle—a Black President, empowered Black political leaders, and vibrant civil society in cities all across our country, and a new generation that is more tolerant, more accepting of difference, less bound by the

prejudices of the past than any earlier generation.

This report focuses on one group of Americans for whom the promise of genuine equality remains unfulfilled. Today, Black gay and bisexual men are more heavily affected by HIV than any other group in the entire developed world. Indeed, it is difficult to find another population across the globe that has suffered more as a result of this epidemic than Black gay men.

Accounting for one in 500 Americans, Black gay and bisexual men represent nearly one in four new infections. Worse still, rates of new infections among Black gay men are rapidly increasing.

This report explains these shocking patterns. While Black men are at the front of the line when it comes to need, they remain at the back of the line when it comes to services. Black gay men are more likely than other gay men to have undiagnosed HIV infection, less likely to have access to life-saving HIV prevention and treatment services, and more likely to be deterred from seeking help due to the combined effects of poverty, racism, and homophobia.

The AIDS crisis among Black gay men is a problem for Black America as a whole. If this is our problem, we need to be part of the solution. We must find it within ourselves to summon the courage to confront our own prejudices; to welcome our Black gay sons and brothers into our families, communities, and churches; and to renew our commitment to the fight against AIDS, vowing to prioritize this



Ernest Hopkins

struggle until this scourge is eradicated for good.

This report needs to be read, and its recommendations heeded. With infections rapidly rising, time is of the essence. We urge all those who ought to care about this crisis—including those who are engaged in the fight, as well as those who remain on the sidelines—to incorporate the lessons in this important report and to take action. All of us have a role to play.



## 3

# Back of the Line

## The State of AIDS Among Black Gay Men in America

### EXECUTIVE SUMMARY

No population in the developed world has been as heavily affected by HIV as Black men in the U.S. who have sex with other men (MSM). Indeed, one could study the entire world and have difficulty finding another group in which the HIV burden is greater than among Black MSM.

Yet despite the epidemic's unparalleled impact among Black MSM, this grave health challenge has failed to elicit the high-priority response it warrants. Those who ought to care—government leaders at federal, state, and local levels; leaders from Black America; the lesbian, gay, bisexual, and transgender (LGBT) community; and private foundations—have largely failed to exhibit needed leadership and commitment in fighting AIDS among Black MSM.

In the absence of a meaningful national response, the health crisis among Black MSM worsens with each passing year. The number of new HIV infections among Black MSM rose by 20% from 2006 to 2009, with an especially disturbing 48% increase among young Black MSM. In comparison to their white MSM counterparts, Black MSM are significantly less likely to be alive three years after testing HIV-positive.

Research breakthroughs have electrified the AIDS field, prompting some of the world's leading scientific experts to advise that the tools now exist to end the AIDS pandemic—for all populations, and in all settings. However, without marked changes in

service systems, policy frameworks, programmatic approaches, and political leadership, it is plain that the dream of ending AIDS among Black MSM will remain beyond our achievement. Black MSM are more likely than other populations to have undiagnosed HIV infection, less likely to be linked to care, less likely to receive antiretroviral therapy, and less likely to remain engaged in care or to adhere to prescribed treatment regimens.

In short, Black MSM are at the front of the line when it comes to need, but at the very back of the line with respect to access to life-saving prevention and treatment services.

This report is animated by the belief that this state of affairs can—and must—change. It offers a blueprint for an effective, evidence-driven, appropriately prioritized national effort to end AIDS among Black MSM. And it calls on all those who ought to care to resolve to work together to make the dream of a world without AIDS a reality for Black MSM.

### **Black MSM: More Heavily Affected by HIV Than Any Population in the Developed World**

Accounting for one in 500 people living in the U.S., Black MSM make up nearly one in four new HIV infections and one in six Americans living with HIV. Black MSM represent 9% of all MSM in the U.S., but account for 38% of new infections among MSM. In

New York City, Black MSM are 325 times more likely to be diagnosed with HIV than heterosexual Black males. Nationally, HIV prevalence among Black MSM is roughly double the prevalence among white MSM. Although AIDS is a nationwide crisis for Black MSM, evidence indicates that the problem is especially severe in the South, where new cases are rising most rapidly.

HIV represents a lifetime challenge for Black MSM. Among young men ages 13-24, Black MSM are 14 times more likely to test HIV-positive than white MSM. One in four Black MSM are already infected with HIV by the time they reach age 25. By age 40, 60% of Black MSM are living with HIV.

The AIDS crisis among Black MSM isn't new. From the very earliest epidemiological reports by the Centers for Disease Control and Prevention (CDC), when the disease was still referred to as Gay-Related Immune Deficiency, it was clear that Black MSM were disproportionately affected by the disease. Over the years, reports in leading medical journals repeatedly emphasized the epidemic's unparalleled effects on Black MSM. In 2005, CDC disclosed that 46% of Black MSM surveyed in five U.S. cities were HIV-positive—a level of infection more than twice as high as was found among white MSM.

Although HIV is transmitted as a result of specific behaviors, it does not appear that behavioral patterns account for Black MSM's disproportionate risk. Studies have consistently found that Black MSM do

not engage in higher levels of sexual risk behaviors than other MSM. Indeed, some studies suggest that levels of risk behavior may actually be lower among Black MSM than among white or Latino MSM. Other suggested sources for Black MSM's disproportionate risk—below-average prevalence of circumcision among Black MSM, or the fact that Black MSM are somewhat less likely than white MSM to identify as gay—have also been disproven.

Rather, there appear to be several key reasons why Black MSM are so much more heavily affected by HIV than other populations:

- Diminished health care access and health service utilization among Black MSM, reflected in late diagnosis of HIV, sub-optimal receipt of life-prolonging and prevention-promoting antiretroviral treatment, and poorer prognosis among those who are living with HIV.

- High background prevalence of other sexually transmitted diseases, which increase by several orders of magnitude the likelihood that HIV will be transmitted or acquired during sexual intercourse.

- Sexual behavior patterns among young Black MSM, including early sexual debut and greater odds of having older (in some cases, even modestly older) sex partners, and

- A syndemic among Black MSM involving poverty, unemployment, violence, homelessness, experience of childhood sexual abuse or other trauma, experience of hostile home environments and associated disruption in education, and disproportionate risk of incarceration.

Available evidence tells us a lot about the AIDS challenge among Black MSM. Given that Black MSM's sexual behaviors don't appear to explain the profoundly higher HIV rates among Black MSM, it stands to reason that reversing the epidemic among Black MSM will require more than incremental changes in Black MSM's sexual behaviors. Instead, an effective push to end AIDS among

Black MSM will demand aggressive implementation of policies and programs that are calculated to address the root causes of Black MSM's disproportionate vulnerability to HIV. The centrality of biomedical strategies to HIV prevention indicates that access to effective HIV prevention will depend in large measure on access to essential health care services.

### **The National Response to AIDS Among Black MSM: A Failure to Respond**

Notwithstanding the increasingly alarming tenor of official reports regarding the epidemic among Black MSM, this health crisis has failed to elicit an appropriate response. Federal agencies do not currently track HIV resource allocations for Black MSM, although the limited evidence that exists indicates that Black MSM are severely under-prioritized when it comes to HIV-related spending. Although MSM overall accounted for 64% of new infections in 2009, state and local health departments allocated a mere 27% of CDC-supplied HIV prevention dollars toward prevention and testing programs for MSM. Available data indicate that Black MSM are similarly under-prioritized with respect to spending on HIV treatment, care, and research.

Government leaders are not alone in their failure to respond to the health crisis among Black MSM. Even after the release of CDC data indicating that nearly one in two Black MSM surveyed may be living with HIV and that young Black MSM are the only population in the U.S. in which new infections are significantly increasing, very few major national initiatives have emerged from the leaders of Black America to confront this rapidly escalating crisis. The organized LGBT community has also largely looked the other way, pretending that AIDS is a thing of the past even as a crisis burns among Black MSM. Few philanthropic funders remain engaged in funding

community-based AIDS programs, with a notable scarcity of foundations grounded in Black America or the LGBT community.

### **In the Midst of Failure, New Opportunities Emerge**

Although the picture is dire for Black MSM when it comes to AIDS, there is cause for hope. In 2011, researchers funded by the National Institutes of Health reported that antiretroviral therapy reduces the odds of HIV transmission by 96%. These findings come on the heels of other study results indicating the pre-exposure use of antiretroviral drugs by HIV-negative MSM substantially lowers the likelihood of HIV acquisition during anal intercourse.

These research results are inspiring, but they are unlikely to hasten the end of AIDS among Black MSM without major policy reforms and improved programmatic success. Black MSM confront multiple barriers to health care services, which in turn diminish their ability to use emerging biomedical tools to reduce the odds of HIV transmission.

A legacy of discrimination in health care settings against Black MSM, combined with an acute shortage of health care workers who have been trained to provide culturally appropriate care, deters many Black MSM from routinely seeking the services they need. Due to high rates of poverty and unemployment—as well as the fact that more than half the states exclude single, childless adults from Medicaid services—many Black MSM lack coverage for essential health care. Black MSM are more likely than white MSM to be incarcerated, which results in lifelong reductions in social acceptance, employment opportunities, and access to health and social services.

The effects of these obstacles on Black MSM's health are painfully apparent. In a CDC-sponsored 21-city survey of MSM, 59% of Black



MSM found to be HIV-positive were previously unaware of their infection, compared to only 26% of white MSM. Among MSM in care, Black MSM have fewer clinical visits than other MSM, are less likely to receive antiretroviral treatment, and are also less likely to adhere to prescribed treatment regimens. In 2008-2010, 70% of HIV-positive Black MSM on antiretroviral treatment had viral suppression, compared to 84% of white MSM.

### **Ending AIDS Among Black MSM: How Do We Move Forward?**

The National HIV/AIDS Strategy seeks to cut the number of new infections by 25% by 2015 and to generate concrete improvements in HIV testing, linkage to care, and treatment adherence. This laudable goal will be impossible to achieve without major progress toward reversing the epidemic among Black

MSM. With biomedical prevention tools taking center stage in efforts to prevent new infections, future success will depend on closing Black MSM's gaps in health care access.

The following action steps are essential:

#### **Demonstrate leadership in the fight against AIDS for Black MSM**

Every stakeholder in the AIDS response—including government leaders, Black institutions, LGBT organizations, philanthropic agencies, the private sector, and the organized AIDS establishment—must recognize the fight against AIDS among Black MSM as a central priority.

#### **Achieve saturation HIV testing among Black MSM**

CDC leadership in establishing a robust national network of testing options needs to be complemented

with targeted social marketing strategies that position knowledge of HIV status as a fundamental social norm for Black MSM. Uptake of routine HIV testing in health care settings must be improved, in part through intensive training and capacity-building support for diverse health care providers.

#### **Maximize the preventive and therapeutic benefits of antiretroviral therapy**

Gaps at each stage of the HIV treatment continuum need to be closed in order to optimize the benefits of antiretroviral therapy. Linkage to care for people who test HIV-positive must be ensured and verified, guidelines to improve retention in care and treatment adherence must be fully implemented, and enhanced efforts are needed to eliminate disparities in Black MSM's receipt of antiretroviral therapy. Timely, effective implementation of the Affordable

Care Act has the potential to ensure Black MSM's access to essential health services. Increasing the number of health care providers with the demonstrated cultural competence to care for Black MSM is an urgent necessity. Programs are also vital to increase Black MSM's HIV science and treatment literacy and demand for health services.

### **Dramatically reduce STDs among Black MSM**

An intensive national effort is required to dramatically lower rates of STDs among Black MSM. Community education and provider training are central components of a comprehensive national initiative to prevent STDs among Black MSM.

### **Introduce pre-exposure prophylaxis**

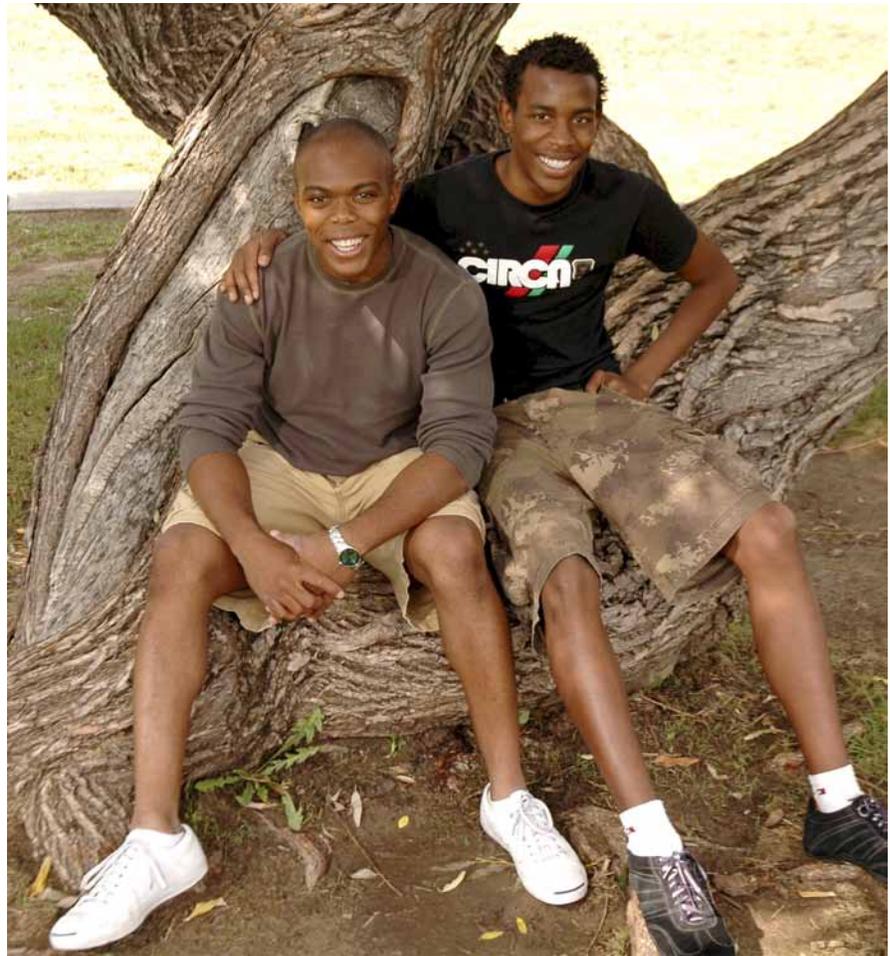
No population has greater need for effective uptake of pre-exposure prophylaxis (PrEP) than Black MSM. A major NIH-funded clinical trial is planned to obtain answers to key questions on the best strategies for introducing PrEP among Black MSM. In light of the legacy of mistrust of mainstream health systems in many Black communities, strong, consistent, and respectful community engagement and leadership are essential to the success of HPTN 073 and to future uptake of PrEP.

### **Effectively target Black MSM with high-impact prevention**

Black MSM deserve access to prevention funding commensurate with their share of the national epidemic. Prevention programs for Black MSM need to be carefully targeted, address key misconceptions that hinder effective risk reduction, and prioritize education on the risks for young MSM associated with sex with older men.

### **Build sustainable community capacity**

AIDS will not be reversed among Black MSM without robust and



sustained leadership from Black MSM themselves. Unfortunately, the community infrastructure among Black MSM is extremely weak, in part due to the failure of most funders to provide support for general operations, organizational development, and professional skills development. Black gay organizations themselves need to prepare to adapt to a changing health care marketplace, especially given the importance of biomedical strategies to the prevention of new infections among Black MSM.

### **Develop new prevention tools for Black MSM**

The historic underfunding of intervention research for Black MSM must end. Focused research is urgently needed to inform implementation of existing tools for Black MSM and to develop critical new tools, such as rectal microbicides, preventive

vaccines, and a cure for HIV.

### **Implement a national plan to reduce the vulnerability of Black MSM**

Comprehensive efforts are needed to address the root causes of Black MSM's vulnerability to HIV—poverty, lack of educational and employment opportunities, racism, homophobia, and social isolation. Such a national effort will require extensive legal reform, efforts to alter social norms, and empowerment of Black MSM to draw on their considerable sources of resilience to overcome the obstacles they face.

### **An Action Plan to End AIDS: Priority Action Steps**

To effectively deploy the tools available to end AIDS among Black MSM,

the Black AIDS Institute offers the following priority recommendations and urges their immediate adoption:

**Develop a national plan to end AIDS among Black MSM. As one of its highest priorities, Health and Human Services should immediately spearhead an inclusive process—involving relevant federal agencies (e.g., CDC, HRSA, CMS, Office of Minority Health, SAMHSA), Black MSM, Black and LGBT leaders, the philanthropic and private sectors, and state and local health departments—to develop a clear, results-driven national plan to end the epidemic among Black MSM. This plan needs to include the following elements:**

- A prioritized effort to ensure universal knowledge of HIV serostatus among Black MSM, including support for diverse, scaled-up testing strategies; intensified professional education for health care and community-based personnel; targeted, state-of-the-art social marketing to position knowledge of HIV serostatus as a fundamental social norm; and assignment by the U.S. Preventive Services Task Force of an A or B grade for risk-based HIV testing.

- A national effort to build robust, sustainable community capacity for Black MSM, with extensive support for the establishment of a national network of health centers specifically designed by Black MSM; community skills-building, general operating support, and organizational development for Black MSM community organizations; and the establishment of durable linkages with MSM-friendly health care settings.

- Intensified implementation research and support for adoption of best practices to ensure timely health care linkage and retention for Black MSM.

- Ensure Black MSM's ready access to affordable, high-quality,

culturally appropriate health and social services through full implementation of the Affordable Care Act, as well as prioritized cultural competence training for health care workers to increase their ability to provide appropriate care and treatment to Black MSM.

- Support for initiatives to increase Black MSM's demand for health services, including strong financing for targeted programs to build HIV science and treatment literacy; community education efforts to increase awareness of the availability of well-tolerated, easy-to-take HIV treatment regimens; and high-priority efforts to roll out pre-exposure prophylaxis among Black MSM.

- A nationwide campaign to dramatically reduce STDs among Black MSM, including intensive, targeted community awareness campaigns, as well as provider education.

- Ensuring that HIV prevention programs for Black MSM address misconceptions about HIV transmission and increase awareness of risks to young men from having sex with older men.

- Elimination of funding disparities in HIV prevention, treatment, care, and research that disadvantage Black MSM, including requiring all federal funders to track the share of resources dedicated to Black MSM.

- Concrete steps to ensure Black MSM's full and equal access to appropriate and affordable mental health and substance abuse services.

**Exert genuine, sustained leadership in the fight against AIDS among Black MSM. Diverse non-governmental actors must recognize both that AIDS remains a severe and worsening crisis among Black MSM and that government alone cannot turn the tide against AIDS.**

- Leading advocacy, civic,

and service organizations within the respective LGBT and Black communities—at national, state, and local levels—should immediately commit to hire a senior focal point to oversee work to support a sound and effective AIDS response for Black MSM. These same organizations must pledge to take specific steps to promote Black MSM to leadership positions within their respective agencies.

- The Congressional Black Caucus should ensure that Black MSM receive their fair share of HIV prevention and treatment services funded under the Minority AIDS Initiative.

- Philanthropic organizations—including those that focus on AIDS issues, Black communities, and the LGBT community, as well as those that serve specific states or localities—should immediately pledge to substantially increase resources for efforts to end AIDS among Black MSM. Philanthropic and corporate funders should prioritize general operating support for Black MSM organizations, as well as innovative program models for health care demand creation, HIV science and treatment literacy, and peer navigation.

**Combat homophobia and other social challenges faced by Black MSM. Governmental and non-governmental actors must join together with Black MSM to address the root causes of Black MSM's vulnerability to HIV and the factors that diminish health care access.**

- Congress should enact the Employment Non-Discrimination Act, repeal the Defense of Marriage Act, and ensure full and robust integration of LGBT service members in the armed forces.

- Black organizations at the national, state, and local levels should follow the lead of the NAACP and formally endorse both non-discrimination against LGBT people and legal recognition of same-sex marriage.



## 4

# Back of the Line

## The State of AIDS Among Black Gay Men in America

America's AIDS epidemic is no longer featured on the front page of newspapers or highlighted on TV news channels. Yet for one population—Black men who have sex with men (MSM)—AIDS hasn't gone away. On the contrary, there is every sign that the crisis is worsening.

Representing just 0.2% of the U.S. population<sup>1, 2</sup>, Black MSM accounted for nearly one in four (22.4%) new HIV infections in the U.S. in 2009.<sup>3</sup> And while medical breakthroughs have made HIV a chronic and manageable condition for some, Black MSM continue to die in disproportionate numbers. According to researchers at the Centers for Disease Control and Prevention (CDC), Black MSM are significantly less likely to be alive three years after being diagnosed with AIDS than are white or Latino MSM.<sup>4</sup> In Florida, Black MSM living with HIV are four times more likely to die than white MSM.<sup>5</sup>

One can scour the world and have difficulty finding a single population more heavily affected by HIV than Black MSM in the U.S. In an era in which Americans seem to believe that AIDS resides elsewhere, a genuine health crisis continues to burn here at home.

What is shocking is not that these disparities are occurring. The reality is that Black people from all walks of life experience more limited access to medical care and poorer health outcomes than other Americans.<sup>6, 7</sup>

Nor are these figures striking because they reflect a new

phenomenon. Black MSM have been disproportionately affected by HIV since the very beginning of the epidemic.

What *is* startling, however, is the fact that the astonishingly high rates of HIV infection, illness, and death among Black MSM have elicited precious little response from those who ought to care—from our nation's leaders, public health experts, the national media, key opinion makers in Black communities, and the lesbian, gay, bisexual, and transgender (LGBT) community.

This report is dedicated to the passionate belief that this can—and must—change.

This report explores the facts about HIV among Black MSM:

- How the disease affects Black MSM unlike any other population in the developed world, sometimes surpassing the epidemics in many developing countries,

- Why the epidemic's impact is so disproportionate among Black MSM, and

- The failure of most leaders to respond effectively to the health crisis among Black MSM.

This report, though, also reflects considerable hope. Thanks to breakthroughs in biomedical research, we now have the tools to bring AIDS to an end—for all populations, in all settings, including Black MSM here in the U.S. Capturing the promise of these medical breakthroughs constitutes the core of this report's recommendations on ways to deliver the promise of an AIDS-Free

### Different Surveys, Different Numbers

Why would one CDC-sponsored survey in 2004-2005 find 46% HIV prevalence among Black MSM, while a later survey determined that 28% were infected? Have we actually succeeded in reducing HIV prevalence among Black MSM in recent years?

Far from it, according to CDC, which reported in 2011 that HIV incidence among Black MSM has actually increased.

There are reasons why different surveys yield different estimates. First, the surveys were conducted in different settings. The 2004-2005 survey, for example, focused on five of the most heavily affected jurisdictions in the U.S.—Baltimore, Los Angeles, Miami, New York, and San Francisco. The later survey, by contrast, encompassed 21 cities, including many where overall HIV prevalence is lower than in the five high-prevalence cities surveyed in 2004-2005. In addition, different surveys use different methodologies for recruiting survey participants. Average age of participants often varies from one survey to the next.

Despite differences in HIV prevalence yielded by available serosurveys, all available studies agree on two key points. First, HIV prevalence among Black MSM is higher than for any other population in the U.S. or throughout the developed world. And second, the percentage of Black MSM living with HIV is sharply higher—twice as high or more—than among white MSM.

**1981**  
First official report of AIDS concerns unusual cluster of immune suppression among gay men in Los Angeles

**1982**  
Scientists call new disease Gay-Related Immune Suppression (GRID) although AIDS (Acquired Immune Deficiency Syndrome) is suggested and eventually endorsed by CDC

**1982**  
CDC reports that male-male sex can lead to AIDS

### A Note on Terminology

No perfect term exists to refer to Black men who have sex with men. Many Black MSM identify as gay, reflected by such groups as the National Black Gay Men's Advocacy Coalition or New York City's Gay Men of African Descent. Others regard themselves as bisexual, some prefer the term "same-gender loving," while others who have sex with men consider themselves heterosexual. Others refuse any kind of self-identity based on sex or gender. A considerable number of Black MSM, like MSM of other races, also have sex with women. As this report is designed to summarize the needs of all of these men, it has adopted an inclusive term that focuses on behavior.

### Key Messages

No population in the entire developed world has been more heavily affected by HIV/AIDS than Black MSM, who represent among the most heavily affected group in the entire world. Moreover, this problem is worsening.

HIV represents a lifelong challenge for Black MSM, with a 40-year-old Black gay man facing roughly 60% odds of being HIV-infected.

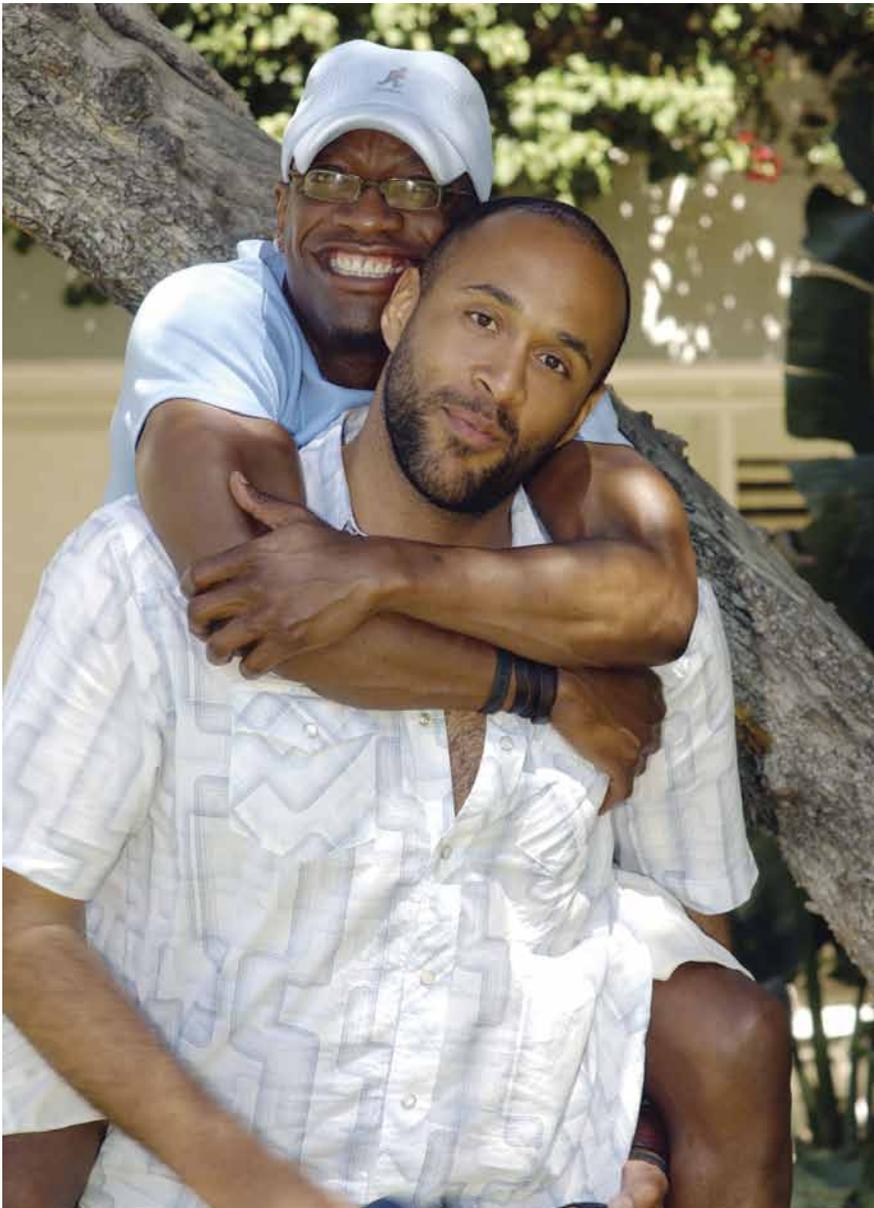
Black MSM do not engage in greater risk behaviors than other MSM. Rather, their disproportionate odds of becoming infected stem from their poor access to essential health services, high background rates of sexually transmitted diseases, early sexual patterns (including early sexual debut and the tendency of young Black MSM to have sex with older MSM), and a confluence of multiple health, social, and economic problems that increase vulnerability to HIV.

Although the HIV crisis among Black MSM represents one of our country's most serious health challenges, the national response remains wholly inadequate. Federal agencies do not monitor HIV expenditures for Black MSM, state and local governments consistently under-prioritize services for Black MSM, Black and LGBT leaders have yet to respond effectively, and few philanthropic funders emphasize support for Black MSM.

Today, there is greater hope than ever for progress against AIDS, as antiretroviral therapy reduces the odds of HIV transmission by 96%. By reducing community viral load, we can sharply lower rates of new infections. Indeed, with recent biomedical breakthroughs, we now have the means to end the AIDS pandemic—for all populations and in all settings, including among Black MSM here in the U.S.

Without a major change of direction, however, Black MSM will not benefit from recent research breakthroughs. Black MSM are more likely than other MSM to have undiagnosed infection, less likely to be linked to care once they test HIV-positive, less likely to receive antiretroviral therapy, and less likely to remain engaged in care. HIV-positive Black MSM are considerably more likely to die than other MSM living with HIV.

A high-priority, multi-faceted, multi-stakeholder national plan is urgently needed to address the spiraling HIV crisis among Black MSM. This plan needs to ensure Black MSM's full and equitable access to essential services, correct imbalances in resource allocation, and combat homophobia and other social and economic issues that increase vulnerability and reduce health care access. Such a plan can only succeed if dramatically greater leadership and commitment are demonstrated in the fight against AIDS among Black MSM.



## The AIDS Alphabet Soup A Glossary of Acronyms

Here are a few of the abbreviations you'll see in this report:

### **CDC**

Centers for Disease Control and Prevention

### **CMS**

Center for Medicare & Medicaid Services

### **FDA**

Food and Drug Administration

### **HAART**

Highly Active Antiretroviral Treatment

### **HRSA**

Health Resources and Services Administration

### **NBGMAC**

National Black Gay Men's Advocacy Coalition

### **NIH**

National Institutes of Health

### **ONAP**

White House Office of National AIDS Policy

### **PrEP**

Pre-Exposure Antiretroviral Prophylaxis

### **SAMHSA**

Substance Abuse and Mental Health Services Administration

Generation—for Black MSM, as well as for all other people affected by HIV.

“Business as usual” will not get the job done. Black MSM may be at the front of the line when it comes to risk for HIV, but they remain at the back of the line for access to medical breakthroughs and other HIV services. To translate research breakthroughs into concrete gains against HIV for Black MSM:

■ Leaders across sectors—government, community, scientific, and MSM themselves—will need to *lead* by squarely addressing HIV among Black MSM,

■ Systems for the delivery of high-quality, culturally relevant HIV medical care and other HIV services will need to be reconfigured to work for Black MSM, and

■ Major new national initiatives will be required to prevent and treat sexually transmitted infections among Black MSM, to help Black MSM navigate health and social service systems, to build robust and durable community infrastructure in Black gay communities, and to combat the related challenges of homophobia, racism, and poverty.



## 5

## Worse Than Any Other

More Heavily Affected by HIV Than Any Population in the Developed World

It is possible to analyze America's HIV epidemic from multiple angles. Yet no matter how HIV in the U.S. is studied, the epidemic's burden on Black MSM is striking:

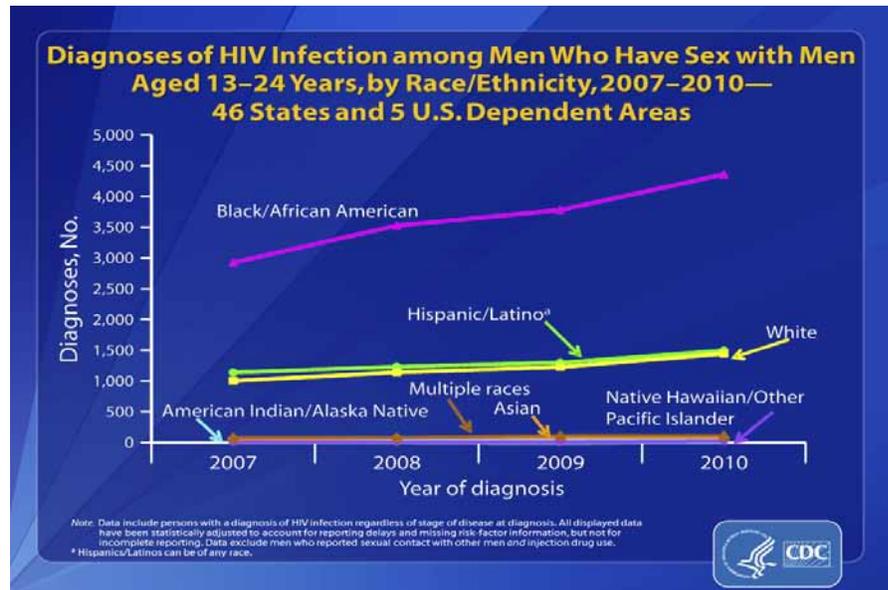
■ Although Black people represent 13% of the U.S. population<sup>8</sup> and an estimated 9% of all MSM<sup>9</sup>, Black MSM accounted for nearly 38% of new HIV diagnoses among MSM in the U.S. in 2010.<sup>10</sup> Of all new HIV diagnoses among Black males in 2010, MSM accounted for 70%.<sup>11</sup>

■ Representing one in 500 people in the U.S., Black MSM make up nearly one in six (15%) of all people living with a diagnosis of HIV.<sup>12</sup> Extrapolating Black MSM's share of diagnosed HIV infections across the total estimated population of people living with HIV<sup>13</sup>, it appears that nearly 177,000 Black MSM were living with HIV as of December 2008.

■ In 2009 alone, 10,800 Black MSM were newly infected with HIV.<sup>14</sup>

■ Gay and bisexual men are 44 times more likely to be diagnosed with HIV than other males<sup>15</sup>, and the odds are considerably greater that Black MSM will be newly infected than white MSM. In New York City, Black MSM are 488 times more likely than males generally—and 325 times more likely than Black heterosexual males—to be diagnosed with HIV.<sup>16</sup>

■ Altogether, Black MSM experience an unparalleled HIV burden in the U.S. In 2004-2005, surveys of MSM in five cities found that 46% of Black MSM surveyed were living with HIV—a level more than twice as high as among white



MSM (21%).<sup>17</sup> Subsequent studies have confirmed that Black MSM are substantially more likely than white MSM to be infected with HIV.<sup>18</sup> In New York City, for example, one study found that HIV prevalence was six times higher among young Black MSM than among young white MSM.<sup>19</sup> A national survey of MSM in 21 cities detected HIV prevalence of 28% among Black men, nearly twice the level found among whites.<sup>20</sup>

■ While the health crisis among Black MSM is a nationwide phenomenon, the challenge is especially acute in the South. In 2006, for example, more new AIDS cases were diagnosed among Black MSM in the South than in all other regions combined.<sup>21</sup>

■ Moreover, the impact of HIV on Black MSM is increasing over

time. From 2006 to 2009, the annual number of Black MSM newly infected with HIV rose by 20%.<sup>22</sup> Among young Black MSM (ages 13-29), new infections soared by 48% from 2006 to 2009.<sup>23</sup>

## 6

# A Physician Speaks: Health Care Barriers for Black MSM

An Interview with Dr. David Malebranche

Dr. David Malebranche is an Associate Professor of Medicine at Emory University School of Medicine and an HIV specialist at Grady Hospital's Ponce de Leon Clinic in Atlanta.

**As a clinician who treats large numbers of Black MSM living with HIV, what have you learned about how poverty affects the ability of HIV-positive Black MSM to obtain the services they need?**

It has always been curious to me how people somehow erase the notion of Black gay men and Black MSM being part of a broader Black community. The focus for a long time when it comes to Black MSM has been on sexual orientation, bullying, homophobia, and such. But Black MSM emerge from Black communities and Black families, and to ignore that reality is a huge mistake. To understand the HIV-related challenges of Black MSM, we need to understand how racism intersects with poverty. Being in poverty influences your access to health care and your ability to get information and education, and it also sometimes puts you in desperate circumstances in terms of situational sex or living in geographic areas under duress due to economic distress, criminal behavior, or substance abuse. All those issues have been linked to zip codes with high HIV rates. It's no coincidence that where you see high rates of HIV and STDs you are also going to see high rates of poverty. And all of that is even

before you get to issues of sexual orientation. All of these issues form the lives of Black MSM before they become sexual beings.

**You live and work in Atlanta, which is sometimes regarded as the capital of Black America. What are some of the challenges you've seen for Black men in Atlanta in dealing with the health care system?**

I can give you my perspective based on my experience at Grady Hospital. In recent years, we've had a reversal of white flight and the departure of more affluent people from Atlanta. Inside the perimeter in Atlanta, we are seeing major changes. More affluent white people are moving back in, and many people who are not white and are less affluent are being pushed out. This leads to physical and psychological trauma among people who are being displaced.

Grady is a level one trauma center that gets most of its funding through the State and local governments. Georgia is a very conservative, Bible Belt state, and taking care of the uninsured and the poor is not a high political priority. Over the last 10-15 years, funding for Grady has been flatlined. We've even seen reduced funding for Grady in the last few years, even though the number of uninsured is skyrocketing. We have had three or four different CEOs take the helm of Grady in the last 6-10 years. They've

instituted a number of changes, including \$2 co-pays for medication, co-pays for provider visits, and other things as well.

Fulton and Dekalb counties contribute funding to Grady. Previously, a lot of surrounding counties contributed funding to Grady because their uninsured residents relied on Grady for care. Over time, though, these counties have cut their contributions to Grady but have continued sending their residents to us for medical services. As a result, Grady has instituted a rule that if you are uninsured and impoverished, your co-pay will be much less if you are a resident of Fulton or DeKalb counties, since these are the only two counties contributing funding for services. This actually makes sense from a fiscal point of view, but the reality is that the uninsured exist outside Fulton and Dekalb counties. And, of course, sexual networks cross these geographic boundaries.

Getting care at Grady isn't easy. There are lots of hoops people need to jump through to get that card. And you have to be prepared to wait for a long time to get a clinic visit or get care at the emergency room.

**What is the role of Medicaid and other third-party payers in supporting HIV care for Black gay men in Atlanta?**

Clinic visits and labs may be covered by Medicaid, but there is very poor reimbursement for clinic visits.

Dr. David Malebranche



Compensation for a clinic visit from Medicaid is \$60, which is absolutely nothing. So people in private practice aren't going to take Medicaid. As a result, everything is run through Grady's system when it comes to taking care of low-income people living with HIV, and that system gets plugged up.

There are a lot of problems in getting health care for someone on Medicaid who is diagnosed positive with HIV. Medicaid issues a lot of denials of coverage. Medicaid has its own drug formulary, and the program will change it at the drop of a dime and won't tell providers the formulary has changed. It's always about saving money. To make sure patients get the drugs they need, providers have

to write lots of letters and sign prior authorization forms.

The AIDS Drug Assistance Program (ADAP) is a state-administered program that provides drugs for people living with HIV, but the program has a waiting list here in Georgia. It can take a while for people to get plugged into ADAP.

**Finding a way to pay for your medical care is, of course, only part of getting the treatment and care you need if you are HIV-positive. You also need to find a qualified health care provider with whom you are comfortable. Can you talk a**

### **bit about cultural competence and its role in addressing the HIV care needs of Black MSM?**

When you look at medical education and how cultural competency is defined, the tacit assumption is there is going to be a white provider who is dealing with someone from another culture. Usually people think about patients who speak another language.

The cultural competence literature doesn't focus much on class differences, race differences within the same country, sexual orientation differences. Those issues get swept under the carpet and, unfortunately, those are the components that often

play into the lives of Black gay men.

We did a study about eight or nine years ago looking at the health care experiences of Black gay men. We asked these men whether it matters to them that the provider is white, Black, male, female, gay, or straight. The most common response we got is that Black gay men just want their provider to be good. They wanted the person to be able to communicate, not be racist or homophobic, to take their needs seriously.

### **How would you characterize the community-based infrastructure for Black gay men in Atlanta?**

There are several community organizations to help people navigate the health care system. Some of these organizations have special services for Black gay men, but a lot of these services are HIV-focused. If you are a community organization, you are not going to get a lot of funding to address the general life issues of Black gay men.

### **As a treating clinician, are you hopeful that health care reform can help improve the ability of Black MSM to get the HIV services they need?**

Unless we have a national health care system, we won't make even the remotest dent in racial and economic disparities. The current health care system is based in capitalism, and the business models just won't work. I didn't expect us to get to a national health care system overnight, so we need to see this as part of a long process. But the sad fact is that so many people are making a killing off the health care system at the cost of a lot of lives.

### **What needs to happen to turn the epidemic around among Black MSM?**

That's a difficult question. Personally, I'm not as excited about PrEP and some of the other biomedical stuff as a lot of people are. We haven't done anything about the social context of this disease and what is going on with Black gay men. Thinking of PrEP as a the main solution to AIDS among Black gay men is trying to put a bow on something that is broken. There is still a huge question about who is going to pay for PrEP and who is going to benefit from it. We haven't really talked much about the possibility of developing resistance to or of toxicities from PrEP. The study results were not derived primarily

from the United States, and there were a lot of issues with adherence in the controlled environment of the study. Have we really approached this in an intersectional way that integrates the biomedical with the behavioral?

I do believe in ART as prevention. That should be our focus. Our focus has to be on getting people who are positive on treatment that is affordable, reasonable, and of acceptable quality so they can get their viral load down. We can't achieve that without addressing the health care system. HIV isn't in a compartmentalized box that is unaffected by the broader system. You have to have a provider that is able to communicate with the patient and follow up regularly. Here in Georgia, we still see people who are being referred to us from rural areas and are on HIV regimens that don't even include three working medications!

One thing we need to do is get more medical students involved in HIV care. But HIV care isn't reimbursed well, and most medical students are leaving school with a debt of \$200,000 or more. It's no shock that most people want to go into a sub-specialty where they can make a lot more money.





# 7

## At Risk No Matter the Age A Lifetime Challenge

**H**IV transmission patterns differ among racial and ethnic groups. Whereas more than two-thirds of new infections among white MSM occur in men in their 30s and 40s, a majority of newly infected Black MSM are ages 13-29.<sup>24 25</sup>

Due to exceptionally high rates of new infections among young Black MSM, many Black MSM enter adulthood already infected with HIV. Among 13-24-year-olds, Black men are nearly 14 times more likely to be diagnosed with HIV than white men, with MSM accounting for more than 90% of new diagnoses among young males.<sup>26</sup> Although Black people account for a mere 9% of all MSM in the U.S., Blacks comprise more than 62% of new diagnoses among young MSM in 2008.<sup>27</sup> Due to a

surge in new infections among Black MSM, the disparity in HIV diagnosis rates among Black and white males increased by 257% from 2005 to 2008.<sup>28</sup>

But the challenge posed by HIV extends across the lifetime for Black MSM. According to modeling derived from CDC estimates of HIV incidence, Black MSM face startling, progressively serious risks of contracting HIV as they age.

The odds that a Black MSM will become infected with HIV increases as he ages—rising from a 7.8% chance of infection at 20 years old to a 59.3% chance of infection by the time he reaches 40 years old:

- By age 20, 7.8%
- By age 25, 24.9%
- By age 30, 38.7%
- By age 35, 50%
- By age 40, 59.3%<sup>29</sup>

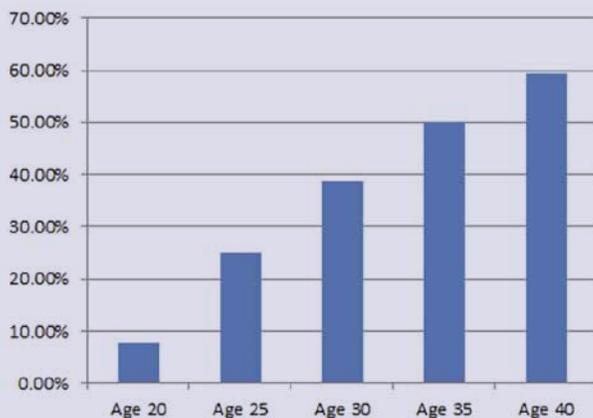
### HIV and Black MSM: A Problem That Isn't New

Black MSM have been at elevated risk since the beginning of the epidemic, although their disproportionate risk was obscured by the prevailing view of AIDS as a “white gay disease” in the 1980s and through much of the 1990s. From 1981-1985, when MSM represented three out of four reported cases, Black people accounted for less than 12% of the U.S. population<sup>30</sup> but for 25% of all AIDS cases.<sup>31</sup> As early as 1986, the disproportionate HIV prevalence among Black MSM was observed in the pages of the *New England Journal of Medicine*.<sup>32</sup> In 1987, researchers reported in the *Journal of the American Medical Association* that Black MSM appeared to experience higher HIV prevalence and incidence than other groups of MSM.<sup>33</sup> In 1988 in California, where Black people made up less than 8% of the population, Black people accounted for more than 13% of AIDS cases, with gay and bisexual men making up three out of four cases among Black Californians at the time.<sup>34</sup>

In short, the signs were plain from the epidemic's early years that Black MSM confronted a severe and potentially unparalleled health crisis. Yet relatively few people noticed the above-average HIV rates among Black MSM in the epidemic's early years—and even fewer responded.

Yet Black MSM themselves took notice. In 1985, an AIDS Task Force was created by the National Association of Black and White Men

**Odds of HIV Infection Among Black MSM, Ages 20-40**



Source: Running in Place: Implications of HIV Incidence Estimates Among Urban Men Who Have Sex with Men in the United States and Other Industrialized Countries. *AIDS Behav* 13:615-629.

## The AIDS Challenge In Black Transgender Communities

An issue beyond the scope of this report—but one that warrants a substantially stronger national effort—is HIV among transgender persons.

Due to the lack of routine HIV surveillance among transgender communities, a clear understanding of the severity and extent of the AIDS challenge is lacking. A 2011 study by researchers from the University of California at Los Angeles found that 0.3% of the U.S. population qualifies as transgender.<sup>1</sup> According to a meta-analysis of HIV-related studies in transgender communities, CDC researchers report that Black transgender people are at much greater risk of HIV, with an estimated 56% of Black male-to-female transgender persons living with HIV.<sup>2</sup>

In New York City, 183 transgender individuals were diagnosed with HIV from 2006-2010.<sup>3</sup> Male-to-female transgender individuals account for 94% of all transgender HIV cases in New York during the five-year period, with Black and Latino people accounting for more than 90% of such cases. Among newly diagnosed transgender individuals, 28% report having been incarcerated, 11% have been homeless, 8% have engaged in sex work, and 5% have been sexually abused.

### Notes

1. Gates GJ, How many people are lesbian, gay, bisexual and transgender? 2011: <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf>.

2. Herbst JH et al., *AIDS Behav* 12:1-17.

3. New York City Department of Health and Mental Hygiene, 2010: [http://www.nyc.gov/html/doh/html/dires/epi\\_surveillance.shtml](http://www.nyc.gov/html/doh/html/dires/epi_surveillance.shtml).

Together (NABWMT), eventually becoming the National Task Force on AIDS Prevention, to focus specifically on the need for Black gay men to have access to HIV prevention services. Across the country, Black MSM joined together in an effort to address the growing health crisis, alerting their peers to the dangers associated with unprotected sex and working to care for those who were living with HIV. In New York City, for example, Gay Men of African Descent was established in 1986, to provide a home for Black gay men and to address their health and social service needs. Similar organizations sprung up in Chicago, Dallas, Detroit, Houston, Seattle, St Louis, and other cities.

As the years progressed, the evidence would become overwhelming that Black MSM were being affected more severely than any other part of the LGBT community. In 1994, researchers conducting a serosurvey in San Francisco reported that HIV prevalence among young Black gay and bisexual men (21.2%) was more than twice as high as for gay and bisexual men generally.<sup>35</sup> According to results from venue-based surveys in five U.S. cities in 1994-1998, young Black MSM were found to be more than six times more likely than young white MSM to be HIV-infected.<sup>36</sup>

By the time that CDC reported in 2005 that a five-city study had found 46% of Black MSM surveyed to be living with HIV infection<sup>37</sup>, the evidence was irrefutable that HIV among Black MSM was a genuine health crisis. With rates of new infections among Black MSM now rising faster than in any other population, no one can claim to have been caught off guard. This news has long been there for all to see, although it has yet to elicit a commensurate response.

## The National Response to the Health Crisis Among Black MSM: A Record of Failure

Acknowledging that Black MSM are at disproportionate risk, the National HIV/AIDS Strategy calls for concerted efforts to reduce the number of new HIV infections by 25% by 2015 (from a 2010 baseline).<sup>38</sup> Development of a National HIV/AIDS Strategy represents a momentous step forward in our national response and has served to reinvigorate domestic efforts to combat HIV/AIDS. As part of the implementation of the National HIV/AIDS Strategy, the Department of Health and Human Services now tracks use of federal HIV funding by race/ethnicity, gender, and exposure category—a major improvement that for the first time allows transparent reporting on the use of federal dollars for HIV.

It is clear, though, that the goal of cutting new infections by 25% is unlikely to be achieved without reversing the epidemic among Black MSM. What is equally clear, unfortunately, is that current efforts are woefully short of what is needed to meet the AIDS challenge among Black MSM. Indeed, a review of how available HIV resources are spent reflects our failure to take seriously the HIV crisis among Black MSM.<sup>39</sup>

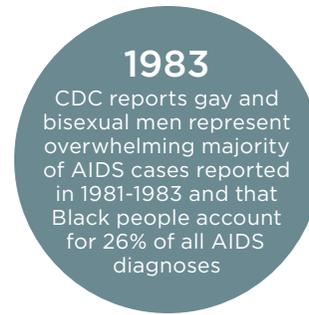
Although federal innovations in tracking HIV expenditures represents important progress, resource tracking is still not conducted in a manner that permits assessment of allocations specifically for Black MSM. In 2009, when MSM of all races and ethnicities accounted for 64% of all new infections<sup>40</sup>, state and local health departments focused only 27% of CDC-supplied risk-reduction funding toward MSM.<sup>41</sup> Allocation of dollars for HIV testing services at the state and local level was even more skewed, with MSM attracting only 10% of funding for targeted HIV testing programs.<sup>42</sup> A recent survey found state and local health departments woefully unprepared to

undertake a meaningful strategy to reduce HIV incidence among Black MSM, with survey participants citing a lack of culturally competent staff and a shortage of appropriate prevention interventions for Black MSM.<sup>43</sup>

The state of Wisconsin, one of the recipients of CDC HIV prevention funding, has shed further light on the mismatch between demonstrated need and HIV prevention programming. With the aim of assessing the fit between need and service access, Wisconsin undertook a careful analysis of its prevention funding. In 2009, although MSM accounted for 58% of all HIV diagnoses among Black people in the state, Black MSM received only 19% of targeted HIV tests in Wisconsin and represented a mere 11% of HIV prevention clients.<sup>44</sup> While Wisconsin deserves praise for its leadership in tracking actual service access among Black MSM, its findings underscore the urgent need for greater accountability nationwide in how limited prevention dollars are allocated.

The Health Resources and Service Administration (HRSA) also fails to track utilization of Ryan White CARE funding by Black MSM.<sup>45</sup> However, the limited evidence that exists suggests that Black MSM may be as under-prioritized in care funding as they are with respect to HIV prevention resources. In New York City, for example—which accounts for roughly one-tenth of the U.S. epidemic and where MSM represent 34% of people living with HIV<sup>46</sup>—young MSM of color represented for only 0.6% of services supported through Ryan White Part A base funding in 2008-2010, while LGBT clients of any race or ethnicity made up only about 9% of Ryan White clients.<sup>47</sup> Although HRSA displayed important leadership in sponsoring a five-year project to identify best practices for engaging HIV-positive young MSM of color, no new resources have been allocated to implement the best practices generated by this important study.

HIV intervention research is also failing Black MSM. After more than



## Conspiracy Theories and HIV

There is little question that AIDS awareness is higher in Black America—perhaps higher than in any other segment of the American population. According to a 2011 survey by the Henry J. Kaiser Family Foundation, Black people are more than twice as likely as whites to regard AIDS as a serious problem, and they want the government to do more to fight AIDS, with 63% of 18-29-year-old Black people believing that too little money is being spent on AIDS.

But this high level of awareness about AIDS also co-exists with conspiracy theories about AIDS among a sizable segment of the Black population. According to a survey of HIV-positive Black people in rural Alabama, 31% said AIDS was a form of genocide against Black people, while a majority (56%) believed the government was withholding a cure.<sup>1</sup>

The persistence of conspiracy theories has potentially damaging consequences for the fight against AIDS—both with respect to the spread of HIV and for efforts to treat the disease. Black men who harbor conspiracy beliefs about AIDS are notably more likely than those who disbelieve such theories to have unprotected sex.<sup>2</sup> In a separate study involving Black men, those who believed that recipients of antiretroviral therapy were serving as guinea pigs for government experiments were less likely to adhere to HIV treatment than other patients.<sup>3</sup>

### Notes

1. Zekeri AA et al. (2009) *Psychol Rep* 104:388-394.
2. Bogart LM et al. (2011) *AIDS Behav* 15:1180-1186.
3. Bogart LM et al. (2010) *J Acquir Immune Defic Syndr* 53:648-655.

**Teens:  
Christopher Barnhill**

Chris Barnhill was a newborn when he was infected, although he didn't learn he was infected until 2004, when he was 16 years old.

"I was at a health fair," he recalls. "And three people—three random people—within a few minutes asked me to get an HIV test. I didn't fit the profile in my head of a person with HIV—you know, like Tom Hanks in Philadelphia. But, still, I believe in the power of three, and because three people asked me about getting testing, I thought I might as well do that. So I did. And 20 minutes later I received the result, and I was positive."

Barnhill recalls that the news that he was HIV-positive "confused the mess out of me." He wasn't a virgin at age 16, but he quickly learned that everyone he had had sex with was HIV-negative. So he asked his grandmother and learned that he was born with HIV. His aunt told him his deceased mother had been diagnosed with HIV.

This startling news changed his life. "We all have a gift to the world," he says. "It wasn't until I became positive that I discovered why I was put on this earth. I had thought the whole time that I was put on this earth to make music or to be an actor. But it wasn't until I learned my HIV status that I found that what makes my soul dance is to talk publicly and openly about being positive—in any arena, in any setting that will give me the voice to do so."

Barnhill began working with an organization called Metro TeenAIDS, a



Washington group that engages young people on issues of HIV, pregnancy, and other health concerns.

He is also a youth minister at the Community Church in Washington, D.C. Although it is theoretically a "weekend job," it occupies him seven days a week. "I think sometimes I have Saturdays off," he jokes.

Although he is only 25 years old, he has already lost two close friends to AIDS. In one case, Barnhill spoke to his close hospitalized friend by phone. Thirty minutes later, his friend died. "The last day I spoke to him he told me not to come to the hospital because he was tired. That really affected me when he died, because it was 30 minutes after I spoke to him. But I was blessed to have the opportunity to have one more conversation with him."

Barnhill believes the search for connection, for belonging, is what often prompts young Black gay men to

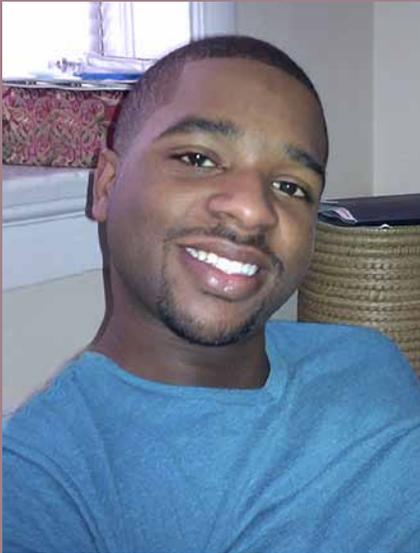
take sexual risks. "Being young, black, and gay—when you add up all three components, that's a lot to deal with," he says. "When you are young you're trying to be accepted. The late-night partying, the multiple partners, dating somebody for two months and that's it, or random sex partners—I think that's an outlet to escape from day-to-day life. But I guess that's not healthy."

"With gay people, mental health is definitely important. I think what's often missing is connection, and I think sex is a connection for people—just to have two minutes of this, or 15 minutes of feeling love. Sometimes it's just that feeling of love, that need to feel loved and cared for. I don't want him to leave me, so I don't mind not protecting myself."

In Barnhill's view, building community is an important strategy for improving the mental health of gay men. "Building community makes me feel good," he says. "I have friends who do similar work. They may not be engrossed in HIV, but they are doing something that promotes a healthy lifestyle for Black gay men. And, because we do the same kind of work, it builds community amongst us."

Barnhill is worried that HIV treatments have given people a false sense of invulnerability to HIV. "HIV is more than just a blue and an orange pill that you take and you'll be fine," he says. "I think that's the perception of HIV today. But that pill comes with a lot of responsibility. That orange and blue pill comes with hurt. That orange and blue pill comes with discrimination and stigma. And it can come with death, too."

# 20s



## **Twenties: Lawrence Stallworth**

At the age of 20, Lawrence Stallworth is only three years removed from testing HIV-positive. “It only took one mistake for the virus to become a personal reality for me,” he says.

“I was sitting on the edge of the bed, and the doctor told me I was positive. I was devastated. I had known so much about taking the proper precautions, so when I found out that I had HIV it was so shocking. No one is ready to hear that kind of news. The minute the doctor told me, I burst into tears.”

After testing positive, Stallworth had to navigate the complicated feelings of his friends and family. “The first I told was auntie,” he recalls. “She’s actually a nurse in Cleveland where I’m from. She’s been my rock for as long as I can remember, almost my surrogate mother. After I told her the news she rushed right over.

“My mom and dad were there, but not like I needed them. . . . When my father found out, he went to the bathroom and closed the door. I had just come out, so it was already a lot for him to take in. My siblings took the news hard, but they saw my strength, so they were able to stay strong to a certain extent.”

He lost a number of friends after testing HIV-positive, but he also learned who his true friends were. “[My best girlfriend and I] had just got off summer break, and we were in class together. I looked over at her, and she just started crying. I took her out

into the hallway and said, ‘Look here girl, you gotta stop crying!’ I made her laugh and said, ‘You gotta suck this up!’”

Two months after testing positive, Stallworth began taking HIV medications. “I knew the only way to remain healthy was to be proactive in the fight and not sit around and be defeated,” he says. “I take three pills a day—once a day, every day. I try to eat as healthy as I can, always on the go. I exercise regularly, take my meds and do what the doctors tell me to.”

Stallworth says community awareness and education is key to fighting AIDS among Black gay men. “We need to be aware of what is really going on,” he advises. “We need to be read and be community-minded. HIV affects all of us, and it needs to be something that isn’t dealt with individually. Community viral load comes down when you get people in treatment. If we can help people be safe, help keep them in care and consistent treatment, we help not only ourselves but our entire community.”

Unfortunately, Stallworth says that too many Black gay men are not effectively engaged in the AIDS response, often because they don’t know about the availability of non-judgmental services. “Before I became infected, I didn’t even know there was a place that young Black gay people could come and be free from ridicule and persecution,” he recalls. “I found an AIDS task force in Cleveland [after testing HIV-positive], and it really opened my eyes. When I found out I had HIV, I had two options—either to get involved or not to get involved, and I chose the first one. It’s a collective fight to combat and prevent HIV/AIDS.”

### Thirties: Cornelius Jones Jr.

Cornelius Jones Jr. is a 34-year-old artist living in Los Angeles. Art not only led Jones to learn his HIV status, but he also sees art as a way to transcend AIDS.

“I was in college and . . . to make a long story short, there was this young lady there performing a performing art dance piece, and the piece was about her father dying of AIDS,” he recalls. “I decided it was time for me to get tested because a year prior to that I had heard rumors that someone I was involved with was HIV-positive . . . [W]hen I saw this performance it was a spiritual calling to go and find out what’s going on with me.”

Jones believes art has a special power to communicate important messages. “I went to a comedy show here in LA not too long ago, and this woman was freaking hilarious the whole time. But right before she ended her set she spoke about some really socially charged issues—about women taking care of themselves, you know, health and wellness, HIV and AIDS, relating to Black women. That was a powerful medium to get the socially important information across.”

Jones is open as an HIV-positive gay man as a performer. “I speak to specific experiences of me as a young gay Black man growing up and being HIV-positive,” he says. “I am out in my work to educate and help have this conversation to erase the stigma, to help have dialogue and conversation around HIV and AIDS.” He was featured in a AIDS awareness public service announcement that went national under the MTV logo.

“AIDS is a part of our culture in Black America,” he believes. “Back in earlier days there was slavery, and there was jazz, R&B, those things that made us, our soul food cooking—all of that was part of Black culture. Now, it is HIV/AIDS. That’s now a part of our culture, and we need to embrace and educate ourselves just like we did with slavery and with jazz, R&B, hip-hop.



It’s everyone’s responsibility to talk about this in some degree.”

Being open about his HIV status within his family is important. “Within my family, who I don’t see often, they are aware of my status, and I am very adamant about having the conversation with my nieces and my nephews who are young . . . I know how it is back in Virginia. I was young once, and your hormones are racing at an early age! I want my nieces and nephews to know that, hey, this is your uncle’s life, this is what happened, this is how he is dealing with it. Do you have any questions? Do you need to know something? Talk to me.”

Jones finds disclosure sometimes to be more challenging with potential romantic partners than with family and professional colleagues. “Sometimes I disclose right away at the beginning of the relationship,” he says. “Sometimes I need to wait for the

second or third date or conversation. It is easier now than it used to be.

“I thought at one point it would be easier to date somebody who is positive, so I even attended poz dating events and went to all poz-specific groups and everything. And I found that it’s really about the person, you know, it’s not necessarily about the person being negative.”

He’s bothered by some of the attitudes he encounters on online dating sites. “This thing of when you make your profile and you write that, ‘I am disease free, that I am clean,’ that really bothers me. It’s as if you’re saying that because you are HIV-negative you are clean, and because I am positive, I am dirty.”

While he finds his 30s to be “a great place to be,” he admits to struggling for a time after testing HIV-positive. In particular, he struggled with depression, which stemmed he believed from a combination of challenges—as someone newly diagnosed with HIV, as a Black gay man, and as a struggling, young artist.

Health-wise, he feels fortunate. Because his CD4 and viral load numbers have remained good, he hasn’t had to initiate treatments. He sees his doctor regularly for follow-up and monitoring.

# 40s

## **Forties: Chris Bland**

Chris Bland was 21 years old, in graduate school, and in the midst of getting two master's degrees when he tested HIV-positive in 1985. He thought his life was over and that he'd be dead before he was 25, but he's still here and is now 48 years old.

"HIV hasn't always been my life, but it has definitely shaped and defined my life and career more than anything else," Bland said. "Even being Black has not impacted me as much."

One of Bland's degrees was in Public Health, and he has worked in the HIV/AIDS field for most of his professional career. He has experienced HIV/AIDS on a personal, professional, and academic level.

Bland grew up in a small town in Virginia and moved in the 1990s to San Francisco. He missed out on the horrifying and almost daily deaths of friends and colleagues in the 1980s, but he vividly remembers the week in 1997 when the *Bay Area Reporter*, the main local gay newspaper, ran the headline "No Obits." The first-ever absence of obituaries since the epidemic's beginning followed the approval of protease inhibitors, signaling a change in the epidemic for many, but not for all.

Personally, Bland has been fortunate to avoid progressing to AIDS, although the disease has definitely taken its toll spiritually and mentally. "Being HIV-positive caused me to have a bit of a mid-life crisis when I turned 40 and was still alive,

yet alone and hadn't planned for the future," he recalls. Today the outlook is not as bleak, but aging with HIV presents its own challenges. "Now I have to worry about my cholesterol, diabetes, and cancer."

Developing Black gay organizations represents an important area of personal and professional interest for Bland. "I have provided technical assistance to many Black gay organizations and advocates around the U.S., and I'm concerned about the shrinking numbers of those organizations. We saw the white gay community organize and establish institutions that are still here and on the forefront of the epidemic, while in the Black gay community we have regressed back to having only a few, underfunded organizations." Bland feels that the fault for this is shared across the board, including foundations, government agencies, and the community itself. "We are the victims of homophobia, institutionalized racism, and our own community culture of desire that would rather focus on creating Black gay circuit parties rather than saving the lives of young Black gay men."

Bland is most alarmed by what is happening to young Black gay men—a pattern he refers to as "genocide." "Young Black gay men are being treated as disposable objects and not as the future of our movement and as our salvation. They are preyed upon instead of praised, supported, and nurtured. Part of the reason is that we lost a generation of elders to the epidemic, so the intergenerational



balance is askew."

Moving forward, there is hope. "We are a resilient people and it is encouraging that through my 'six degrees of separation' I am connected to the White House and other powerful structures." But there is still much work that needs to be done. Organizations and individuals—Black, white, gay, faith-based, must all be held accountable and supported in addressing the needs of young black gay men. HIV affects us as individuals but the response must be a collective one."



**Fifties:  
Cornelius Baker**

Cornelius Baker tested HIV-positive in 1986. “In the early 80s there was the perspective that everyone would die,” he said.

Living with HIV and experiencing the epidemic’s extraordinary impact on Black gay men has altered Baker’s life in a number of ways. “Living in a time of great challenge like this epidemic, and at an early age witnessing so many people die, it created a very different perspective on life,” he said. “In some ways a maturity of soberness and impatience. You recognize that both time and life are short. And you just don’t really have a lot of patience for foolishness.”

Baker’s impatience for change led him to AIDS advocacy. Baker formerly led the National Association of People with AIDS and the Whitman-Walker Clinic in Washington DC, is currently senior policy advisor for the National Black Gay Men’s Advocacy Coalition, and is a member of the Presidential Advisory Council on HIV/AIDS.

Over more than two decades of work in AIDS, Baker has seen a lot of problems but also encountered considerable frustrations. “On the scientific side we’ve made a lot of progress,” he notes. “We have treatments for HIV . . . and we are making progress scientifically almost every day. Where we’ve not done so good a job is in implementing everything that we know.”

“I’ve been very fortunate in that I’ve generally had very good health care

from my employer,” he says. “I know the challenges of being in continuous care with a provider you can relate to, but on the whole I’ve had enormously good care and good providers and a wonderful relationship with my physicians. But I’m also demanding of them, and I think that’s a critical piece. Proper care isn’t a gift that someone gives you; it has to be a gift you give yourself. When we go to a physician there’s a tendency to just be very passive and accept their direction, but it’s a service we’re paying for and should be a partnership. One has to be prepared to ask questions, prepared to get the best possible care, and to accept that this is really about your life.”

# 60s

## **Sixties: Ron Simmons**

In 1989, at age 39, Ron Simmons was diagnosed as HIV-positive.

When the doctor asked Simmons about his sexual behaviors, his instinctive reply was authentic. HIV was not going to stop him from living an informed, holistic, and involved life.

“AZT [the most common antiretroviral medication when he was diagnosed] gave you two more years of life,” Simmons recalls. “I wanted 30-40!”

He decided to take more holistic methods of treatment, combining mental, spiritual, and emotional approaches with physical wellness. In 1991, Simmons joined a support group for Black gay men that focused on the idea of “Living with the disease, not dying because of it”. This approach aligned with his own mindset about HIV, so he completed the 12-week program. In 1992, he volunteered as the organization’s executive director, and in 2003 he became the President and Chief Executive Officer of what we know today as Us Helping Us, People into Living Inc. (UHU).

Simmons’ experience as an HIV-positive Black gay man running a major service organization has given him insight about the many challenges faced by gay men of color. In particular, he emphasizes the need for Black gay men to pursue holistic health, in addition to taking life-preserving medications. This holistic approach, Simmons says, has to start from within. Black gay men, Simmons

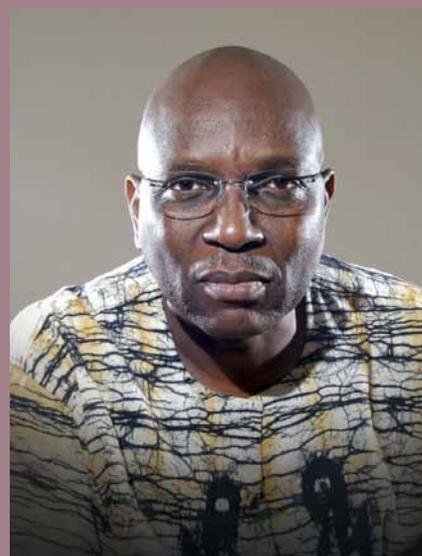
believes, need spiritual, mental, and emotional affirmation through group- and community-centered programs that enables men to address what he calls “a lack of self-definition of identity.”

“Black gay men are not white gay men with black faces,” he insists. “We are different and need to embrace and explore those aspects of us.”

When asked about his experience running a service organization that caters to Black gay men, Simmons cites two. The first involves finding the funding needed to support programs for Black gay men. In particular, UHU has struggled to obtain corporate sponsorship and hire the staff needed to address the enormous needs of Black gay men in Washington, D.C.

Second, navigating the culture of Black gay men is not always simple. As one would expect for a marginalized population that is itself highly diverse, ensuring cultural relevance to the many Black gay men in Washington is a challenge.

Seizing new opportunities and meeting new challenges head-on are organizational attributes of UHU. In response to dramatic breakthroughs in new biomedical strategies for HIV prevention, UHU in 2012 was awarded a grant to increase public awareness of biomedical HIV prevention and vaccine research among Black gay men, white gay men, and Black heterosexuals. In conducting the project, UHU is collaborating with Heart to Hand, Inc. in Prince Georges County, Maryland, and the INOVA program at Fairfax Hospital in



northern Virginia.

Simmons lives the principles reflected in UHU’s programs, serving as a real-life example of human perseverance in the face of immense challenges. “Do not be paralyzed by fear,” he advises. “You are not alone. Get into care and know where you stand.”

1985

CDC reports that Black people (who represent less than 12% of the U.S. population at the time) account for 25% of AIDS cases reported from 1981-1985

1986

A letter in the *New England Journal of Medicine* notes the disproportionately high HIV prevalence among Black MSM

## Prisons, Sex, and HIV

Black MSM are more than twice as likely to have been incarcerated in the previous year than white MSM.<sup>1</sup>

The risks of HIV transmission in correctional settings is hotly debated. While CDC advises that there is little evidence that substantial transmission occurs in prison settings—with most HIV-positive prisoners having been infected prior to becoming an inmate—the agency has documented that transmission sometimes does occur.<sup>2</sup> Others, though, are more skeptical of the supposed rarity of sexual transmission within prisons.

What is apparent is that few prison settings take meaningful steps to protect inmates from HIV. Federal prisons prohibit condom distribution, and as of 2007 only two state systems and five municipal prisons systems made condoms available.<sup>3</sup> Methadone maintenance or needle exchange is even scarcer.

Regardless of whether an individual contracts HIV within the prison walls, an HIV-positive man who has been incarcerated leaves prison with a mind-boggling array of handicaps that increases vulnerability for HIV-negative men and reduces the odds of health care access regardless of serostatus. A Black man released from prison is less likely than individuals without a criminal record to get a job, is less likely to obtain safe housing or get access to public benefits, and is often prevented from voting or otherwise participating as a full and equal citizen in the life of his community. These disabilities are especially acute for Black men. According to an exhaustive study of incarceration in America, “The United States imprisons a larger percentage of its black population than South Africa did at the height of apartheid.”<sup>4</sup> In Washington, D.C., our nation’s capital, three out of four Black men will serve time in prison sometime in their lives.

### Notes

1. Millett GA et al. (2012) CROI Paper #1094.
2. CDC (2006) MMWR 55:421-426.
3. Okie S (2007) *New Eng J Med* 356:105-108.
4. Alexander M (2010) *The New Jim Crow*.

two decades’ investment by U.S. taxpayers in the development of scores of evidence-based HIV prevention programs, precious few interventions have been developed specifically for or validated for use among Black MSM.<sup>48-49</sup> Numerous studies tracking sexual behaviors of Black MSM have been undertaken, but extremely few focused research efforts have evaluated strategies to prevent new infections and improve health outcomes for Black MSM. Although NIH, like other arms of the federal HIV response, does not track resource allocations for Black MSM, it is apparent from a review of the NIH research portfolio that Black MSM are badly under-prioritized. This lack of research support for Black MSM’s health needs is consistent with recent research indicating that Black investigators are 13% less likely to receive NIH research funding compared to white investigators.<sup>50</sup>

Apathy about the HIV crisis among Black MSM extends beyond the government and encompasses the news media and community leaders. Even after the release of CDC data indicating that nearly one in two Black MSM surveyed may be living with HIV and that young Black MSM are the only population in the U.S. in which new infections are significantly increasing, very few major national initiatives have emerged from the leaders of Black America to confront this rapidly escalating crisis.

A similarly tepid response is evident from the organized LGBT community. In large measure, the LGBT community has moved on from AIDS, even as HIV infection rates and AIDS deaths among Black MSM have skyrocketed.<sup>51</sup> Illustrative of this pattern is a landmark 2012 report by Human Rights Campaign that surveys the challenges confronting LGBT youth without mentioning that one in 12 Black gay men will be living with HIV by age 20.<sup>52</sup> Although Black MSM are at the center of a major health crisis in the LGBT community, with the exception of Chicago’s Howard Brown Health Center, which is headed

1987

Researchers observe in the Journal of the American Medical Association that Black MSM have higher HIV prevalence and HIV incidence than other MSM

1987

Blacks surpass whites among new HIV infections in the U.S.

1987

National Task Force on AIDS Prevention is formed with the goal of improving Black MSM's access to HIV prevention services

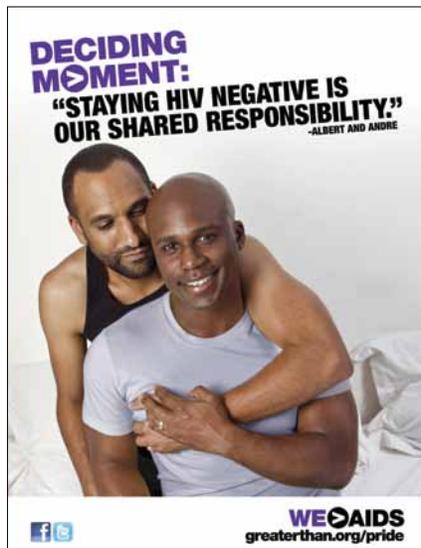


### Black MSM Respond

After CDC's 2005 report found that nearly half of all Black MSM surveyed were HIV-infected, Black MSM petitioned CDC and demanded a plan of action. Following a CDC consultation in August 2005, the National Black Gay Men's Advocacy Coalition was formed.

by Jamal Edwards, none of the nation's leading gay health centers or AIDS service organizations are currently led by a Black gay man.

The philanthropic sector is also indicative of this failure of leadership. At a moment when new infections among young Black MSM are rapidly rising, philanthropic funding for HIV activities of any kind in the U.S. declined by 10% in 2010.<sup>53</sup> Today, only a handful of foundations remain engaged in supporting HIV-related programming. Notably missing from the list of the top funders for domestic AIDS activities in the U.S. are any foundations specifically grounded in Black America or expressly focused on addressing health or social issues in Black communities. LGBT-focused foundations are similarly absent from



the list of top funders, notwithstanding the spiraling rates of HIV among Black MSM.

1989

The Balm in Gilead is founded to engage Black churches in the fight against AIDS

1990

Ryan White CARE Act enacted to support HIV care and treatment

1990

Americans With Disabilities Act is passed, prohibiting HIV-related discrimination

### The Limitations of Behavior Change Programs for Black MSM

Although sexual risk reduction will remain critical to long-term efforts to reduce HIV infection rates among Black MSM, there are several reasons why behavior change alone will not reverse the epidemic in this population. Apart from the fact that few validated behavioral interventions have been tested in Black MSM, it is difficult—and probably impossible—to bring behavior change programs to sufficient scale, as only a small minority of MSM are reached by behavioral interventions.<sup>1</sup> It is challenging, especially for small community-based organizations, to translate evidence-based behavioral interventions in the real world; many interventions require psychologists or other trained staff, and most require participants to attend multiple sessions (sometimes as many as 12). Staff turnover at small community organizations is often high, underscoring the challenge of translating efficacious interventions into effective programs in the community.<sup>2</sup>

#### Notes

1. CDC (2006) *MMWR* 55:1-16.
2. Stall R, The Evolving HIV/AIDS Epidemic Among MSM, 2010.

### Reasons for the Disproportionate Impact of HIV Among Black MSM

Over the years, various theories have been floated to explain why Black MSM are at much higher risk of contracting HIV. It has been suggested that Black MSM must engage in higher levels of risk behavior to have such disproportionate HIV risks, that Black males' lower rates of circumcision in comparison to whites increase the risk of transmission<sup>54</sup>, and that the fact that Black MSM are less likely than white MSM to identify as gay must somehow explain disparities in rates of HIV infection.

Over time, each of these theories has been disproven. Studies consistently demonstrate that Black MSM are no more likely to engage in HIV-related risk behaviors than other MSM.<sup>55 56 57</sup> Indeed, some studies even suggest that sexual risk behaviors are less frequent among Black MSM.<sup>58</sup> For example, a CDC-sponsored survey of MSM in 21 cities found that Black MSM were notably less likely than white or Latino MSM to have used cocaine, poppers, or methamphetamine in the past 12 months.<sup>59</sup> A recent meta-analysis of more than 145 studies that collectively enrolled nearly 155,000 Black MSM found that Black MSM were more likely than other MSM to take steps to reduce their risk of HIV, but twice as likely to become infected with the virus.<sup>60</sup> Differential circumcision rates also appear not to explain disparities in HIV prevalence between Black

and white MSM.<sup>61</sup> Nor, according to the evidence, can differences in HIV prevalence be tied to the somewhat lesser likelihood that Black MSM will self-identify as gay.<sup>62</sup>

While available evidence has debunked a number of prior theories, accumulated research has identified several factors that are consistently and strongly associated with elevated HIV risk among Black MSM:

- Diminished health care access and health service utilization among Black MSM, reflected in late diagnosis of HIV, sub-optimal receipt of life-prolonging and prevention-promoting antiretroviral treatment, and poorer prognosis among those who are living with HIV.<sup>63</sup>

- High background prevalence of other sexually transmitted diseases, which increase by several orders of magnitude the likelihood that HIV will be transmitted or acquired during sexual intercourse.<sup>64 65</sup>

- Sexual behavior patterns among young Black MSM, including early sexual debut and a greater odds of having older (in some cases, even modestly older) sex partners<sup>66</sup>, and

- A syndemic among Black MSM involving poverty, unemployment, violence, homelessness, experience of childhood sexual abuse or other trauma, experience of hostile home environments and associated disruption in education, and disproportionate risk of incarceration.<sup>67 68</sup>

What does available evidence tell us about how best to move forward to reverse the epidemic among Black

1994

Landmark study of gay/bisexual men in San Francisco finds that Black MSM are more than twice as likely to be living with HIV than whites or Latinos

1995

FDA approves first protease inhibitor

1996

Studies confirm that Highly Active Antiretroviral Therapy reduces HIV-related sickness and death

1998

Minority AIDS Initiative created

MSM? Two clear lessons emerge

First, given the fact that differences in risks behaviors do not appear to be driving the extraordinarily high HIV rates among Black MSM, it is evident that efforts to produce incremental changes in Black MSM's risk behaviors are, on their own, unlikely to be sufficient. In communities where a 40-year-old Black MSM has a roughly 60% chance of being infected with HIV—and even a 25-year-old Black MSM has a roughly one-in-four chance—even extremely low levels of sexual risk behavior carry exceptionally grave risks of HIV transmission. While HIV education and condom promotion will remain central to HIV prevention efforts among Black MSM, much more will be needed to reduce HIV incidence and improve the health and well being of Black MSM.

Second, no strategy is likely to alter the HIV dynamic among Black MSM unless it addresses the root causes of Black MSM's disproportionate risk. New approaches are urgently needed to eliminate health disparities for Black MSM. In addition to policy and program reforms to expand access to care, considerable efforts are also needed to increase demand for and uptake of HIV treatment within Black MSM communities. It is also vital to dramatically lower rates of STDs, forge new sexual norms among Black MSM (with particular attention to the needs of young men), and combat the many economic, social, and health deficiencies that combine to render Black MSM especially vulnerable to HIV.

## Treating HIV How Things Have Changed

We are not in the same world as when AIDS first appeared in the 1980s, or in comparison to the mid-1990s, when the first effective HIV treatments became available. Today, most people newly diagnosed with HIV can be effectively treated with a once-a-day pill, experience few side effects, and expect to live a normal lifespan.

The first drug approved for the treatment of HIV infection was AZT, an antiretroviral endorsed by the Food and Drug Administration (FDA) in 1987. Although approval of AZT raised hopes, it soon became clear that the virus rapidly developed resistance to the drug. In 1993, results from a large multinational trial found that early initiation of AZT did not extend life. Subsequent approval of additional drugs similar to AZT allowed physicians to prescribe dual therapy, but this too achieved only limited clinical results.

In 1995, the FDA approved the first of a new class of antiretroviral drugs, known as protease inhibitors. By combining at least three drugs from multiple classes, doctors for the first time were able to stop HIV in its tracks in many patients. As a result, rates of HIV-related hospitalization and mortality sharply fell beginning in the mid-1990s.

While combination antiretroviral therapy was a godsend for hundreds of thousands of HIV-positive people here in the U.S., the early combinations often had considerable side effects. As new drugs have been developed and new combination regimens devised, antiretroviral drugs are now much easier to tolerate and associated with fewer side effects. The most popular regimen for newly diagnosed individuals is a single, once-a-day pill that combines three different antiretroviral drugs.

One thing that hasn't changed over the years is that HIV drugs are extremely expensive here in the U.S., where drug prices are the highest in the world. Prices are especially high for the newer classes of antiretroviral drugs, such as protease inhibitors, integrase inhibitors, and fusion inhibitors.<sup>1</sup> Today, it is estimated that lifetime treatment costs for a person living with HIV in the U.S. exceed \$600,000.

### Notes

1. NIH, <http://www.aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/276/appendix-c—monthly-average-wholesale-price-of-antiretroviral-drugs>.



## 9

# The Best and Worst

## U.S. Cities Ranked

**A**IDS is a crisis for Black MSM from coast to coast. In a federal system of government like ours, however, states and municipalities have the leeway to pursue different approaches to public health challenges. As a result, some settings are likely to have policies and programs in place that make them friendlier terrain for Black MSM.

Ideally, all Black MSM will live in a city in which they have equitable access to robust support for HIV prevention and treatment services. Their rights ought to be recognized and protected and they should be free from discrimination, state and local leaders should actively promote knowledge of HIV status and utilization of life-saving services, and the health care safety net should be strong and comprehensive.

The Black AIDS Institute set out to determine the degree to which Black MSM living in different parts of the country have access to these prerequisites for a sound AIDS response. Using an objective scoring system, the Institute ranked 25 cities that were chosen on the basis of several considerations, including the presence of a substantial Black population, a heavy HIV burden among Black residents, notable Black political leadership in local affairs, a meaningful Black civil society (e.g., civil rights organizations, churches, Black radio stations), and engagement of Black community organizations in the delivery of HIV services.

The Institute created a scoring

system that took into account 12 factors relevant to a sound AIDS response for Black MSM. These factors generally addressed comparative funding for HIV prevention and treatment services, the comprehensiveness of the safety net for HIV prevention and treatment, and legal protections for Black MSM.

The Institute's scoring system used published data sources to assign scores. However, the system has limitations. Due to the lack of city-specific information on some measures, for example, the Institute in several instances used statewide data to assess criteria for individual cities. In addition, while the Institute's methodology took into account the magnitude of HIV-related funding available in different jurisdictions, it was unable to determine whether cities made effective use of this funding to prioritize prevention and treatment programs for Black MSM.

The Institute does not suggest that its criteria reflect the optimal means for ranking different cities. Due to the lack of available evidence, for example, the Institute's scoring system cannot assess the degree to which Black MSM are integrated into broader Black or LGBT community institutions. Nor do the Institute's criteria address other cultural or quality-of-life issues that affect Black MSM. Rather, the Institute offers its methodology as an example of how key issues may affect Black MSM and how the health and well-being of Black MSM are affected by policy and programmatic choices made in different settings.

### Leadership on Gay Rights in Black America

In May 2012, the board of directors of the NAACP made history when it endorsed same-sex marriage, asserting that "civil marriage is a civil right and a matter of civil law." The NAACP linked the fight for marriage equality with the broader struggle for civil rights in the U.S., with NAACP President and CEO Benjamin Todd Jealous stating, "The NAACP's support for marriage equality is deeply rooted in the Fourteenth Amendment of the United States Constitution and equal protection of all people." The NAACP's endorsement of same-sex marriage followed President Obama's own embrace of legal reform to permit couples of the same sex to be married.

## Factors Taken Into Account in Ranking U.S. Cities

The Institute assigned scores for the following factors:

### Total HIV Federal Grant Dollars Per Individual Living with HIV

The Institute relied on statewide data used by the Henry J. Kaiser Family Foundation to rank states in four categories, from low to high.

### CDC Funding for HIV Prevention

The percentage of HIV prevention funding was compared to the percentage of diagnosed HIV cases in each state, with points added or subtracted depending on whether prevention funding exceeded or fell short of a state's contribution to the national epidemic.

### 12 Cities Initiative

The federal government provides focused support for HIV service enhancement and coordination in 12 cities that collectively account for nearly half of all reported HIV/AIDS cases. Each of the 12 cities received additional points to take account of the additional federal support available.

### Testing Rate

The scoring system used the four-part categorization used by the Henry J. Kaiser Family Foundation based on the percentage of state residents tested in the last 12 months.

### Ryan White Part A Funding

Additional points were provided for all cities that receive Ryan White Part A funding, which is allocated based on service priorities agreed to by local community planning bodies.

### ADAP Funding

The Institute assumed that total ADAP spending per client reflects the strength and comprehensiveness of state ADAP programs. Using data

collected by the Henry J. Kaiser Family Foundation, the Institute ranked states from low to high based on average ADAP spending. In large measure, ADAP spending represents state policy choices, as states where legislative leaders have made minimal financial contributions to the program are most likely to have low per-client spending or waiting lists for ADAP services.

### ADAP Waiting List

Any city in a state with an ADAP waiting list as of June 2012 had points deducted.

### Medicaid Spending

Similar to the approach adopted with respect to ADAP, the Institute relied on data collected by the Henry J. Kaiser Family Foundation to score states based on total Medicaid outlays per HIV-positive beneficiary.

### Medicaid Exclusion

Most states do not allow single, childless adults to receive Medicaid, which serves as a major service barrier for many Black MSM. Any state with such an exclusion in place had points deducted. (The Affordable Care Act, as originally drafted, would have resolved this gap by providing coverage for income-eligible, single, childless adults, but the Supreme Court held in June 2012 that Congress overreached its authority by mandating that states expand their Medicaid programs. It remains to be seen how many states will expand Medicaid services to cover single, childless adults.)

### Anti-Discrimination Provisions

The Institute consulted online information regarding existing state and local laws to determine whether Black MSM in different cities were protected from discrimination based on sexual orientation. Cities

in which either a state or local anti-discrimination law was in place received additional points.

### HIV Criminalization

Cities in states with HIV-specific statutes criminalizing HIV non-disclosure, exposure or transmission had points deducted. Somewhat fewer points were deducted in states where no HIV-specific criminal statute was in place but where prosecutions of people living with HIV have occurred based on other laws (e.g., assault and battery). States in which five or more such prosecutions have occurred in the past two years had extra points deducted.

### LGBT Relationships

Cities in states recognizing same-sex marriages received additional points, with lesser additional points awarded in jurisdictions recognizing same-sex civil unions but not gay marriages. Jurisdictions in states that have passed laws specifically outlawing recognition of same-sex relationships had points deducted.

## The Three Best Cities for Black MSM

Based on the Institute's scoring systems, three cities scored at the top:



### 1. New York City

Black gay New Yorkers benefit from living in a jurisdiction with among the highest per capita funding for HIV prevention and treatment. New York's Medicaid program is among the country's most expansive, offering comprehensive coverage for single, childless adults below 100% of the poverty line. Due to substantial state contributions, as well as allocations from Ryan White Part A, New York also has perhaps the most generous ADAP in the country. New York is one of the 12 cities receiving focused federal support for HIV service enhancement.

New Yorkers are broadly protected from discrimination based on sexual orientation, and in 2011 state legislators formally recognized same-sex marriage. The state government complements federal funding with focused HIV prevention and treatment services, and the city's Congressional delegation is politically active in supporting robust federal support for HIV services.



### 2. Washington, D.C.

Although the nation's capital has garnered major headlines regarding the seriousness of its epidemic, it has also proven to be among the most energetic of jurisdictions in mounting an aggressive response. Like New York, Washington is one of federal government's 12 focus cities for HIV service enhancement and has a generous ADAP, although its Medicaid spending per HIV-positive beneficiary is somewhat lower than in New York.

Washington is also home to a vibrant community response among Black MSM, and its public health leaders have implemented innovative HIV programs, including the routine offer of HIV testing in many government offices, such as the motor vehicles department.



### 3. Los Angeles

Although HIV grant dollars are somewhat lower per capita in California than in New York and the District of Columbia, spending on Medicaid and ADAP per HIV-positive enrollee is among the highest in the country. Los Angeles scores behind New York and Washington, in part due to the fact that California's Medicaid program (Medi-Cal) does not cover single, childless adults. The fact that prosecutions of people living with HIV have occurred under California law also lowered LA's score.

Other cities that had high scores were Chicago and Oakland. Chicago had generally impressive scores but missed making the top three primarily due to Medicaid's failure in Illinois to provide coverage for single, childless adults. Oakland also had favorable scores but missed the top three primarily due to the fact that it is not one of the federal government's 12 focus cities for HIV service enhancement.

## The Worst Cities for Black MSM

If some cities score better when it comes to addressing the HIV-related needs of Black MSM, it stands to reason that some do worse. Based on the Institute's scoring method, three cities scored at the bottom:



### 1. Gary

Gary, Indiana, was the first city in the U.S. to elect a Black mayor, but today it qualifies as the worst city for Black MSM, according to the Institute's scoring system. The city's low score primarily stems from policy choices made at the state level. Indiana ranks in the very bottom category with respect to federal HIV grant dollars per person living with HIV, and the state's ADAP program is also below average in spending per beneficiary.

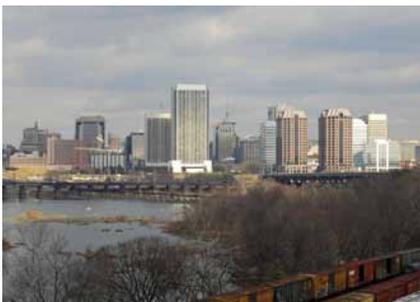
The state Medicaid program excludes single, childless adults, Indiana has enacted a law banning recognition of same-sex unions, and the state also has a record of prosecuting people living with HIV. Suffering from the loss of key industrial capacity and having an unemployment rate higher than the national average, Gary itself has limited ability to support a robust AIDS response for Black MSM, making it dependent on the state, which has proven itself unwilling to rise to the challenge.



### 2. Memphis

Memphis may have given birth to some of the greatest Black music in history, but it falls short when it comes to caring for the HIV-related needs of Black MSM. Tennessee is below average with respect to federal grant dollars per case of HIV infection, including CDC prevention funding.

Single, childless adults are ineligible for Medicaid, which in any event provides funding for HIV care that is below the national average. The state is near the very bottom of per-beneficiary spending on ADAP. And the state legislature has enacted legislation prohibiting recognition of same-sex unions.



### 3. Richmond

Richmond shares many characteristics of Gary and Memphis—below-average access to federal HIV grants, below-average Medicaid spending for HIV, and exclusion of single, childless adults from Medicaid. HIV-positive Black MSM in Richmond are further disadvantaged by the state's ADAP. As of June 21, 2012, nearly 600 people living with HIV in Virginia had been placed on a waiting list for ADAP services. Indeed, Virginia alone accounted for 28% of all people nationwide on ADAP waiting lists in June 2012.

Several other cities vied for inclusion in the list of the worst cities for Black MSM, notably Jackson MS, Durham NC, and three cities in Ohio (Cincinnati, Cleveland, and Columbus). Indeed, Durham had the same score as Richmond, avoiding the bottom three solely by virtue of the fact that North Carolina's ADAP waiting list is slightly less severe than Virginia's.

## What Do The Rankings Tell Us?

The Institute's ranking of cities generates a number of important insights. The cities at the very top of the rankings are all urban powerhouses, in which the Black community is politically empowered and has long been mobilized to fight for its rights. New York and Washington are universally recognized as two of the political and cultural capitals of Black America, with a history of Black political leadership at City Hall and (in the case of New York) in its Congressional delegation. Although the Black population is less prominent in Los Angeles, the city was the first of the most populous metropolitan areas to elect a Black mayor, and its Congressional delegation includes some of the country's most visible AIDS champions.

Four of the five cities with the lowest ranking are south of the Mason-Dixon line. This is cause for concern, as cases among Black MSM are rising the fastest in the South. Although Southern states are hardly alone in skimping on support for health care safety nets—the major Ohio cities, for example, also rank near the bottom—Southern states have generally adopted much more restrictive Medicaid policies than other states and are disproportionately represented among states with ADAP waiting lists.

Significantly, the bottom five cities (Gary, Memphis, Richmond, Jackson, and Durham) are found in states in which urban interests have limited political clout. This pattern highlights an additional feature of importance in the AIDS response for Black MSM. While all Black MSM struggle to obtain the services and support they need, regardless of where they live, urban-dwelling men are often better equipped to obtain community-based services or access to a spiritual home that is more accepting of diversity. By contrast, Black MSM residing in small towns and rural areas are most isolated and disenfranchised.

## Mobilizing to Make a Difference: Us Helping Us in Washington

Although Black MSM need and deserve the support of government, the Black and LGBT communities, and private foundations, Black MSM themselves will need to lead the fight if AIDS is to be reversed. While Black MSM experience multiple challenges in their efforts to overcome AIDS—homophobia, racism, social exclusion, and limited economic and educational opportunities—they also possess enormous reservoirs of resilience on which to build a durable and effective response.

Us Helping Us (UHU) is an example of Black gay leadership in the fight against AIDS. Founded as a support group for HIV-positive Black gay men in 1985, when no effective treatment existed for HIV infection, UHU focused on holistic health promotion and mutual support as means to promote Black gay men's well being in the midst of a new epidemic that was spiraling out of control.

From its inception, UHU has understood the mind, body, and spirit as integral components of a holistic approach to health. Its early health promotion programs provided support and guidance to Black gay men on such issues as diet and nutrition, exercise, anger management, and a dialogue between mind and body.

Over the more than 25 years that UHU has been in existence, the AIDS landscape has dramatically changed. While treatments now make it possible to live a long and healthy life with HIV, many Black gay men struggle finding culturally relevant health services. And the rate of new infections among Black gay men continues to escalate.

Through all of these changes, UHU has formulated and implemented model programs through a process of continuous innovation and adaptation. While its roots were in alternative therapies, today UHU embraces advances in biomedical research and is a partner in the National Institute of Allergy and Infectious Diseases (NIAID) Be the Generation Bridge Project ([www.bethegeneration.nih.gov](http://www.bethegeneration.nih.gov)). Through this program UHU uses trainings, updates, social networks, and viral media to disseminate biomedical prevention research information. According to Ron Simmons, UHU's executive director for more than 20 years, "Given the disproportionate rate of HIV infection among Black gay men, it is imperative for Black gay and same-gender-loving men to be aware of biomedical HIV prevention research, and become involved in clinical trials for biomedical prevention and vaccine research."

Another example of UHU's impact on HIV/AIDS was a recent initiative to spark a national dialogue on the need for a "paradigm shift" in understanding and addressing HIV infection among black gay men. Responding to studies indicating that Black gay men are more likely to use condoms and less likely to engage in risky sexual behavior than white or Latino men yet are at greater risk of HIV infection, UHU has worked to promote a public dialogue to increase awareness of these patterns and to debunk notions that Black gay men engaged in riskier behaviors. This year-long collaboration with leading Black gay researchers and scholars worked to place the paradigm shift on the agenda of every major HIV/AIDS conference and to engage leading government officials and funders on ways to reconceptualize HIV prevention for Black gay men.



# 10 New Hope, New Opportunities But Will Black MSM Benefit?

The last two years have witnessed historic breakthroughs in efforts to develop more effective weapons with which to combat HIV/AIDS. Indeed, every sign suggests we have entered a new phase of our national response—one that potentially points toward the feasibility of bringing AIDS to an end.

Most significantly, study results in 2011 found that antiretroviral therapy reduces the odds that a person living with HIV will transmit the virus to an uninfected sexual partner by 96%.<sup>69</sup> With the odds of HIV transmission clearly correlated with the viral load (i.e., magnitude of virus circulating in plasma) of the infected partner<sup>70</sup>, antiretroviral therapy helps reduce the risk of transmission by lowering viral load (typically to undetectable levels). The HPTN 052 results, which confirmed observational studies in several parts of the world, led Dr. Anthony Fauci, leader of the federal HIV research effort, to declare that the tools now exist to end the AIDS epidemic.<sup>71</sup>

These findings followed earlier study results demonstrating that the same antiretroviral drugs used to treat HIV may also be taken by HIV-uninfected individuals to reduce their risk of acquiring the virus. According to a multi-country study of MSM, pre-exposure prophylactic use of antiretrovirals reduced the odds of HIV acquisition by 44%, with a more than 90% reduction in new infections among individuals confirmed by blood tests to have regularly adhered to the

daily prophylactic regimen.<sup>72</sup>

Whereas behavior change has traditionally been the centerpiece of HIV prevention efforts, these study results indicate that biomedical interventions are likely to be the most critical channel for stemming the spread of HIV in future years. To translate the study results on antiretroviral therapy as HIV prevention to the real world, the goal is to achieve sharp reductions in community viral load, or the overall amount of virus circulating within any neighborhood, population, or sexual network. According to HIV surveillance data in San Francisco, a 40% reduction in community viral load in the previous decade was associated with a 45% decline in new infections.<sup>73</sup>

While health care settings now take center stage in the effort to prevent new infections, it is clear that health care workers cannot on their own accomplish all that needs to be done to reverse the epidemic among Black MSM. In addition to obtaining timely and ongoing access to health services, HIV-positive Black MSM must also rigorously adhere to prescribed regimens in order to prevent treatment failure and related viral rebound. Available evidence suggests that peer-based interventions, as well as ready access to supportive social services, are critical to ensuring strong treatment adherence and promoting the success of clinical services.<sup>74</sup>

Although pre-exposure prophylaxis (PrEP) is unlikely to have the same population-level potential to reduce

HIV incidence as antiretroviral therapy, it also represents a potentially important new tool to reduce the spread of infection among those who are at especially high risk. In the U.S., no population warrants more intensive support for the implementation of PrEP than Black MSM.

While these and other prevention breakthroughs have generated renewed hope and optimism, major steps will be needed if they are to benefit Black MSM. These new breakthrough tools will need to be delivered in health care settings, where Black MSM confront substantial obstacles to timely, high-quality, non-judgmental, and culturally competent care.

A legacy of discrimination in health care settings against Black MSM, combined with an acute shortage of health care workers who have been trained to provide culturally appropriate care, deters many Black MSM from routinely seeking the services they need.<sup>75 76</sup> Black MSM typically confront not one, not two, but a host of factors that impede their ability or desire to access needed services. Socialized as Black men, Black MSM confront the everyday reality of racism. They may be ostracized from their families or communities of birth as a result of their same-sex attraction. Within the mainstream LGBT community, Black men often perceive themselves as unwelcome; according to a large, multi-ethnic survey of Black MSM in San Francisco, Black men were the least preferred sexual partners, less likely to be considered friends, and

1999

Black AIDS Institute  
founded

2000

CDC reports that  
surveys of MSM in  
five cities indicates  
that Black MSM are  
six times more likely  
than whites to be  
infected

2002

FDA approves  
OraQuick rapid HIV  
test

less welcome in gay venues, and also regarded as presenting the highest risks for HIV transmission.<sup>77</sup> Black MSM are also more likely than other MSM to have been incarcerated in the past year<sup>78</sup>, which in turn results in lifelong diminishment of employment opportunities, social acceptability, and ability to vote or otherwise participate fully in society.<sup>79</sup>

Altogether, these factors reduce Black MSM's trust in mainstream service systems and slow uptake of essential health services. For example, Black MSM are seven times more likely than other MSM to have undiagnosed HIV infection.<sup>80</sup> In CDC's 21-city survey of MSM, 59% of Black MSM found to be HIV-positive were previously unaware of their infection, compared to only 26% of white MSM.<sup>81</sup>

Once in care, Black patients living with HIV are less likely than white patients to receive antiretroviral therapy<sup>82</sup>—a pattern that holds for Black MSM as well as for Black heterosexuals.<sup>83 84</sup> Among MSM in care, Black MSM have fewer clinical visits than other MSM and are also less likely to adhere to prescribed treatment regimens.<sup>85 86</sup> In the largest cohort of young MSM of color ever studied, a five-year federally sponsored project found that only half of treatment-eligible study participants were receiving antiretroviral therapy.<sup>87</sup>

Significantly, given the powerful potential of antiretroviral treatment to slow the spread of infection by lowering viral load, Black MSM on antiretroviral therapy are significantly less likely to have viral suppression

than other MSM receiving HIV treatment. In 2008-2010, 70% of HIV-positive Black MSM on antiretroviral treatment had viral suppression, compared to 84% of white MSM.<sup>88</sup>

In addition to the deterrent effects of homophobia and racism on health care utilization, Black MSM also confront substantial systemic obstacles to timely and appropriate care. Gay and bisexual men are less likely than heterosexual males to have health insurance coverage<sup>89 90</sup>, and Black people generally are nearly twice as likely as whites to lack health insurance (20.8% vs. 11.7% in 2010).<sup>91</sup> Among more than 1,500 Black MSM enrolled in an ongoing NIH-supported intervention trial, a majority are unemployed, lacking access to the typical route Americans use to obtain health coverage. Lack of insurance is associated with reduced likelihood of having ever been tested<sup>92</sup> and with lower utilization of needed health services.<sup>93 94</sup>

In short, business as usual will ensure continued failure in the AIDS response for Black MSM. Even with potent new biomedical weapons capable of breaking the epidemic's back, Black MSM will fail to benefit unless major changes are implemented to their ensure full and equitable access. In the absence of the concerted national action recommended in the National HIV/AIDS Strategy, Black MSM will remain at the front of the line with respect to need, but at the back of line when it comes to access.

### Leadership on HIV and Black MSM

Although the overall picture of leadership on HIV and Black MSM is rather dismal, there are noteworthy bright spots. For example, CDC's Act Against AIDS Leadership Initiative has supported two Black MSM organizations. CDC has also launched a nationwide testing campaign for Black MSM, Testing Makes Us Stronger, which is focusing initially on six high-burden cities (Atlanta, Baltimore, Houston, New York, Oakland and Washington, D.C.).

Greater Than AIDS—a collaborative national campaign by the Henry J. Kaiser Family Foundation, the Black AIDS Institute, and several other foundations—promotes HIV awareness and combats HIV-related stigma, with the aim of connecting the AIDS response to Black America's historic struggle against other challenges. Since its inception, Greater Than AIDS has focused particular attention on Black MSM, including developing a targeted campaign that specifically addresses Black MSM.



## 11

# An HIV Prevention Leader Speaks: Growing AIDS Crisis Among Black MSM

An Interview with Dr. Kevin Fenton

Dr. Kevin Fenton is director of the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention at the Centers for Disease Control and Prevention.

## Why are Black MSM so much more heavily affected by HIV than other populations?

There are many reasons why we are seeing the high rates of HIV among Black MSM. You have to take into account individual-level factors, factors relating to the high background prevalence of disease within the community, and also societal and broader community-level factors, such as stigma, homophobia,

discrimination, and poor access to health care. These factors are operating at multiple levels and interacting with each other.

With regard to individual-level factors, we have seen increases in risk behavior across many MSM communities. In part, these changes are occurring because we are 30 years into the epidemic, perhaps leading to a certain complacency about HIV, a lack of urgency, a lack of fear about the seriousness of the disease, or ignorance about the epidemic and its impact. These factors may be resulting in less vigilance at the individual level to practice safer sex.

We know that men are making a lot of assumptions about their partners. Certain practices, such as

serosorting and strategic positioning, are becoming more prevalent within the community. At the individual level, we also know that sexually transmitted diseases facilitate both acquiring and transmitting HIV. For MSM, with high background prevalence of STDs, this can in turn increase the risk of acquiring HIV.

Another factor is the high prevalence of disease among Black MSM. High HIV incidence results in high HIV prevalence, especially as people are living longer with the disease. If there are more people in your community who are living with HIV, the likelihood of coming into contact with the virus with each episode of unsafe sex is much higher.

Partnership issues also come into play. We know that most infections are occurring in the context of stable relationships. People may use a condom initially, but as they get to know one another they stop using condoms without getting tested and ensuring that is a safe thing to do. This can result in transmission of HIV. Issues of disclosure, couples testing, and other partnership issues become incredibly important for all gay men, especially Black gay men.

Societal factors also help explain why Black MSM are at much higher risk of HIV. Extensive research within minority communities has revealed a high prevalence of stigma and homophobia, which may have negative effects on the ability of gay men to disclose they are homosexually active. These issues are not unique to Black men, but they have to be taken into



Dr. Kevin Fenton

account in understanding the problem in this community.

No discussion about Black MSM would be complete without taking faith communities into account. When churches add their voices to an effective response, it is truly powerful. But churches can also negatively impact the lives of Black gay men by reinforcing some of the societal factors I've mentioned. So we are working with faith communities to make sure they can be even stronger partners in response to HIV.

In short, there is no one single driver of the disproportionately high infection rates among Black MSM, and there is no one single solution.

### **If Black MSM don't appear to engage in higher levels of risk behavior, is it reasonable to expect behavior change alone to solve this crisis?**

Studies consistently indicate that Black gay men are no more likely to have higher rates of partner change or unprotected sex than men of other races. What are other factors that may be putting individuals at risk? Higher rates of STDs may partly explain the inequities. In addition, young Black MSM are more likely to report having partners that are older gay men. In an environment where incidence and prevalence are high, especially among older men, having older partners can increase young men's risk of becoming infected. In other words, it isn't just the kind of sex you are having but who you are having sex with and in what environment.

Just as sexual networks may help explain HIV patterns among Black MSM, they can also be used to support HIV prevention. We need more research on how best to use sexual networks to enhance HIV prevention.

### **What is CDC doing to respond to the AIDS crisis among Black MSM?**

We are doing a lot, but there is always an opportunity for us to do more.

CDC's efforts for gay and bisexual men focus on three key strategies. The first is to scale up the most effective prevention strategies, including HIV testing, linkage to care, and screening for STDs. We're working with state and local partners to integrate HIV across multiple services, to scale up viral hepatitis vaccination, and take other steps to improve the health of Black MSM. And we are working with other federal agencies to help implement effective strategies.

Second, we are working with a range of partners to ensure that we are touching the lives of gay men in new ways—whether this is through directly funding community-based organizations to scale up effective interventions, or working with federal partners like Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration to engage Black gay and bisexual men who are using Federally Qualified Health Centers or other community institutions. A key element of our strategy is to ensure that the community is fully engaged in our efforts to address the needs of Black gay men.

Another part of our partnership strategy is to leverage the Act Against AIDS Leadership Initiative partnership and the Act Against AIDS campaign to ensure stronger inclusion of organizations that serve gay and bisexual gay men. We want to ensure that social marketing campaigns that target gay and bisexual men are disseminated more widely and effectively.

Finally, we are strengthening the use of our data and strategic information to ensure that policymakers have the information they need to target prevention dollars, scale up interventions, and engage gay men. CDC is trying to obtain a clearer sense of the population denominator of Black gay men so we have a better

understanding of disease rates within the community. We want to use surveillance to better define what is happening with Black gay men and to gather more real-time information on how gay men are changing their behaviors.

Of course, we can't do this alone, and it isn't our intention to try to do so. We are committed to working with other federal agencies, community-based organizations, and state and local health departments to better address the needs of Black gay men.

### **How do we make sure that Black MSM benefit from PrEP, ART as prevention, and other emerging prevention tools?**

The first thing we have to take account of is the reality of health inequities. The disparities we are seeing for Black gay men pertain not only to HIV but to a range of health conditions that Black gay men have to contend with. Given that, there are some specific things that we can and must do if we are committed to addressing health inequities. The first is to use our data and strategic information to better understand who is actually enrolled in care, who is maintaining care, who is getting antiretroviral treatment, and why these things are or aren't happening.

Second, we must raise providers' awareness of these health inequities and provide simple tools that can be implemented to improve performance. And holding providers accountable for performing better will be a key strategy for moving forward. Key targets need to be set for improving performance, and all of us must hold ourselves accountable for making improvements over time. We need to have standardized indicators that can enable us to report how we are doing at each step of the HIV spectrum, and then use the results to improve outcomes.

Finally, we need to ensure that we are supporting Black gay men, and

indeed all gay men, to take control of their care and engage with the care system. We need to confront the challenges of economic disadvantage, discrimination, and stigma. All of us, including providers, need to be honest that we are working in concert with Black gay men to address their needs.

**You've mentioned that CDC can't do everything on its own and that it needs to engage effectively with Black gay men. But many Black gay communities have weak community infrastructures. What needs to be done to build stronger community institutions among Black gay men?**

Communities responding to HIV have been at the core of how we respond to HIV—both in the U.S. and globally, in part because community-based organizations can actually engage and touch the lives of gay men in ways the public sector can't. Community organizations also provide culturally competent outreach and prevention services. CDC is committed to supporting investments in indigenous organizations to do the very best we can in these tough economic times to prevent new infections.

We need to understand that for all sectors that receive funding there is much greater accountability in today's environment. As part of that increased emphasis on accountability, we must ensure that dollars are being used for the most effective interventions. HIV has both social and structural drivers, as well as individual- and partnership level-drivers, and we need to ensure that finite resources are focused on the interventions that are most effective.

Community organizations need to look at opportunities that present themselves with health system transformation. Changes in the health system may well bring opportunities for greater sustainability

and for scaling up the most effective interventions. For example, we need to look carefully to see if there are ways that reimbursement for individual behavioral counseling and HIV screening can be leveraged to help community-based organizations become more sustainable.

We need to think carefully about what sustainability means for CBOs. We must find ways of ensuring fiscal sustainability, and we also need to train and nurture the next generation of prevention workers. How do we retool and expand and engage prevention workers at the community level? This question raises issues around training and capacity building for community partners. We need not only to train new workers in classic prevention approaches, but also ensure that they understand the full prevention, treatment, and care spectrum.

In short, the community response is critical to future progress in preventing new infections among Black MSM, but it is dynamic and is occurring within a dynamic environment.

**With HIV representing such a serious crisis among Black MSM, why hasn't there been more of an outcry for intensified attention to this problem?**

That is a difficult question to answer. We all have to do some soul-searching on what we are doing and what we can do to make things better. For one thing, we need to do a better job of using our data to tell compelling stories that grab the attention of the public and of policy-makers.

We also need to do much better in engaging the LGBT community writ large. A lot of people feel that effective treatments are here, so the sense of urgency about HIV prevention has lessened. Accompanying that is an increasing complacency, some have argued, within the community and the

broader society about the problem. We have to work harder to re-engage the broader LGBT community on AIDS.

**What is the role of Black leaders and institutions in reversing the AIDS crisis among Black MSM?**

We have come to a point where solutions to this issue have to begin within our community. That might be within the LGBT community, Black gay community, or the Black community as a whole. Each community has a role to play.

The Black community as a whole has many assets that can be brought to bear on this problem, whether it is leveraging Black colleges and universities, or Black businesses, or the faith community, which serves as a pillar of the Black community. We should recognize that gay men have always been a part of faith communities, and their lives have to be valued in a way that enables them to achieve their full potential. The reality is there are many churches that have been doing great work. We need to build on this.

Finally, the family is critically important. Family has always played a critical role in the Black community. We need to engage fathers and mothers on issues relating to sexual orientation, to help parents understand why not rejecting your gay and lesbian sons and daughters is so important. Having open and honest conversations within the family about HIV and sex is critical to bringing this epidemic to an end.

African-American athletes and celebrities represent another pillar of the Black community. These influential figures have the ability not only to talk about the epidemic writ large, but also about issues relating to sexuality. We already have great examples of Black celebrities who are taking on this fight, and we need to build on that.





# Ending AIDS Among Black MSM

## How Do We Move Forward?

**D**ue to the grave weaknesses in our national safety net and to the poor HIV-related policy and programmatic choices that have frequently been made, our country has little chance of reversing the worsening epidemic among Black MSM without a dramatic change of course. Without a radical change in direction, the promise inherent in the National HIV/AIDS Strategy and recent prevention breakthroughs will remain outside the reach of Black MSM, and the epidemic among Black MSM will continue to intensify. Unless a change of direction is immediately implemented, Black MSM will remain at the head of the line when it comes to need but at the very back of the line in accessing breakthrough treatment and prevention tools.

A combination of strategies will be needed to alter the epidemic's trajectory among Black MSM.

Stronger, more consistent leadership and commitment on AIDS and other critical Black MSM issues are absolutely vital to turn the tide against this health crisis. No longer can we permit HIV infection, an eminently preventable problem, to flourish unabated, or remain hidden in the shadows of stigma and denial.

As the Affordable Care Act expands access to insurance coverage, new approaches are needed to engage Black MSM in health services and to foster and sustain Black MSM-identified health clinics.

The legacy of under-prioritization of the health needs of Black MSM

must be jettisoned, with resource allocations, service strategies and research priorities brought into alignment with documented epidemiological patterns.

Urgent efforts are needed to address the root causes of Black MSM's disproportionate vulnerability to HIV. A multi-faceted, holistic agenda that includes housing, employment, education, and psychosocial support must be aggressively pursued for individuals and communities at risk.

Through policy choices, increased funding opportunities and capacity-building support—including full implementation of the National HIV/AIDS Strategy at federal, state, and local levels—we must provide Black MSM the means to draw on their considerable resiliency to turn back this health challenge and to sustain a robust, effective response to AIDS.

### **Demonstrate Leadership in the Fight Against AIDS for Black MSM**

AIDS will not be reversed without strong and sustained leadership by diverse constituencies and institutions. Those who *ought* to care must stop hiding their heads in the sand. *Every* stakeholder in the AIDS response—including government leaders, Black institutions, LGBT organizations, philanthropic agencies, the private sector, and the organized AIDS establishment—must recognize the fight against AIDS among Black MSM as a central priority.

### **Gay-Friendly Churches in Black Communities**

In recent years, a growing number of churches have exhibited non-judgmental openness to gay and bisexual parishioners. In some cases, these include churches that specifically aim to provide a welcoming spiritual environment for Black LGBT people. Leaders in pastoral efforts for LGBT individuals include the Unity Fellowship and the United Church of Christ. In May 2012, *The New York Times* profiled Harlem's Rivers at Rehoboth congregation, which has combined a ministry to LGBT people with worship traditions of Black America. According to a 26-year-old HIV-positive Black gay man who attends church at Rivers at Rehoboth, "I believe it helped save my life."<sup>1</sup>

#### **Notes**

1. The New York Times, May 28, 2012.

### **Steadfast in the Fight Against AIDS—An Example of LGBT Leadership**

While many LGBT organizations devote little attention and few resources toward the AIDS response, at least one national LGBT organization continues to prioritize the fight against AIDS, with particular attention to the epidemic's disproportionate effects on Black MSM. In 1983, Lambda Legal Defense and Education Fund brought and won the nation's first AIDS discrimination case. Since then, Lambda has been at the forefront in fighting for the civil rights, health, and well being of all LGBT people, with a notable focus on Black MSM. Lambda represented James Dorsey, an HIV-positive Black gay man from Detroit, in his successful effort to overturn the U.S. Job Corps' discriminatory testing-and-exclusion policy for young vocational training recipients. Lambda helped convince the Supreme Court in *Lawrence v. Texas* to overturn state sodomy laws, with a Black gay man serving as one of the co-litigants in the case. Today, several AIDS discrimination cases are on Lambda's docket, including one challenging the firing of an HIV-positive Atlanta policeman.

Ironically, the U.S. government, which has historically lacked community advocates in leadership on AIDS, is now in the vanguard when it comes to calling attention to the growing health crisis among Black MSM. Those parts of society that would naturally be expected to exert leadership—such as AIDS advocates and service organizations, the LGBT community, and Black leaders—are too often missing in action.

Churches offer both a challenge and an opportunity to build leadership in the fight against AIDS among Black MSM. Many Black MSM are in church on Sundays, and like other people, are in active search for spiritual sustenance and a sense of community in their lives. However, the spiritual homes where Black MSM normally go as a sanctuary against racism may also effectively deepen internalized homophobia, as studies correlate a high degree of religiosity with disapproval of homosexuality and opposition to same-sex marriage and other gay rights issues.<sup>95 96</sup>

Black MSM also have a role to play in catalyzing greater leadership regarding this health crisis. Indeed, Black MSM have considerable sources of resiliency with which to resist social discrimination and to thrive in the midst of hardship—reflected in the Greater Than AIDS campaign, a collaborative undertaking of the Henry J. Kaiser Family Foundation and the Black AIDS Institute that links the fight against AIDS among Black MSM to the historic struggle for civil rights by Black people in this country. By confronting homophobia, denial and apathy, Black MSM can help expedite the “moment of truth” among potential partners, demanding an end to the inattention to worsening HIV rates. The National Black Gay Men's Advocacy Coalition (NBGMAC) is working to strengthen Black gay advocacy that is focused on research, policy, education, and training. As part of its efforts, NBGMAC is providing organizing space and support for the Young Black Gay Men's Leadership

Initiative, which aims to create a national movement of young MSM, with a particular focus on HIV.

### **Achieve Saturation HIV Testing Among Black MSM**

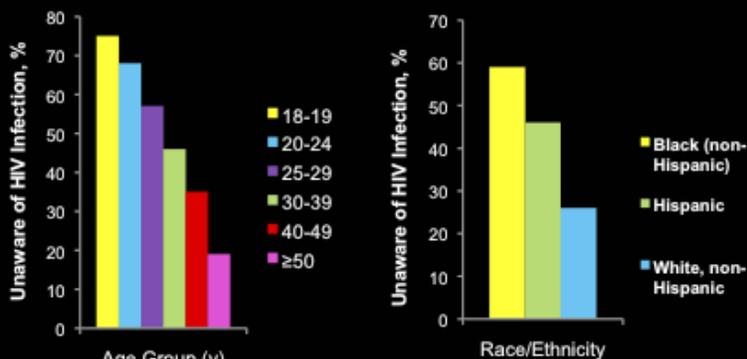
The HIV test is the gateway to care and treatment for people who are living with HIV. Early diagnosis enables clinicians to carefully monitor individual health and ensure timely initiation of treatment, improving health outcomes for the person living with HIV<sup>97</sup> and reducing the odds of further HIV transmission. According to CDC researchers, people who are living with HIV but unaware of their infection are 3.5 times more likely than those with an HIV diagnosis to pass the virus along to others.<sup>98</sup>

Although Black MSM have testing rates that are comparable to, or sometimes higher than, other subpopulations of MSM, disproportionately high background prevalence of HIV among Black MSM means that substantially higher rates of testing are needed to ensure prompt diagnosis. In the previously noted five-city survey of MSM, 67% of Black MSM who were HIV-positive had previously unrecognized infection, compared to 18% of whites.<sup>99</sup>

Over the years, CDC and state and local health departments have expanded beyond stand-alone testing centers, investing in alternative testing delivery approaches, such as rapid testing through mobile services. Studies suggest that these innovative methods have the potential to improve program uptake and quality.<sup>100</sup> CDC has indicated it intends to de-prioritize these alternative testing methods, looking instead to mainstream health care settings as the primary venue for HIV testing. While this might conceivably be prudent for some populations, the considerable and well-documented barriers that Black MSM face when it comes to accessing basic medical care argue in favor of continued support for a range of

## MMWR 2010: Majority of Young MSM unaware of their HIV+ status

Prevalence of human immunodeficiency virus (HIV) infection and proportion unaware of HIV infection among men who have sex with men, by selected characteristics — National HIV Behavioral Surveillance System, 21 U.S. cities, 2008



CDC. *MMWR Morb Mortal Wkly Rep.* 2010;59(37):1201-7.

testing options to reach Black MSM.

However, America continues to pursue a largely passive approach to testing, primarily relying on individuals themselves to obtain information and summon the motivation to voluntarily seek testing services. A much more proactive approach is required. Substantially greater efforts are needed to *market* testing by positioning knowledge of HIV serostatus as a fundamental community norm. Such efforts should draw from the extensive body of evidence regarding factors that facilitate and deter test-seeking, as well as from state-of-the-art learning from the marketing field.

Failure of state and local health departments to prioritize Black MSM for testing services also undermines efforts to ensure prompt diagnosis for Black MSM. As previously described, Black MSM are seriously under-prioritized with respect to targeted HIV testing services at state health departments. This diminishes the strategic value of taxpayer-supported testing services. According to data supplied by 29 health departments, white MSM accounted for the largest share of tests conducted, while Black MSM represented the largest share of

positive test results.<sup>101</sup> Better aligning targeted testing resources with actual need would not only help close the testing gap for Black MSM but also enhance the cost-effectiveness and public health impact of limited testing dollars.

Although CDC has recommended that HIV testing be routinely offered to patients in health care settings<sup>102</sup>, these recommendations have yet to be fully embraced in health care settings. A 2009 survey of general internists identified broad awareness of the CDC guidelines, but only half (52%) had increased testing, with only 2% of patients having been tested in the past month.<sup>103</sup> Surveys of health care providers suggest they perceive themselves to be ill-prepared to implement routine testing and require capacity-building support from public health officials.<sup>104</sup> Making HIV testing routine for all patients is especially vital for Black MSM, who are notably less likely than white MSM to disclose their same-sex attraction to health care providers, rendering risk-based targeting of testing recommendations substantially less effective for Black MSM.<sup>105</sup> Improving the capacity of health providers to deliver culturally competent care to

Black MSM is vital to increase testing uptake, as Black MSM remain less likely than other MSM to be tested for HIV and are consequently at higher risk for unrecognized infection.<sup>106</sup>

One important impediment to implementation of routine screening is the lack of comprehensive third-party coverage; routine screening is an optional benefit under Medicaid, and as of 2010 fewer than half the states provided for Medicaid coverage for routine HIV testing.<sup>107</sup>

Expanding health coverage—an issue addressed in greater detail in the following section—may have an important role in increasing testing rates among Black MSM. In a recent study involving Black MSM in San Francisco, lacking health coverage was significantly associated with unrecognized HIV infection.<sup>108</sup>

Even if Black MSM have the good fortune to have a physician with whom they are open, they still may not be encouraged to have an HIV test. A recent CDC study found that even when Black MSM disclosed their sexual orientation to their providers, these men were less likely to be tested for HIV and more likely to have unrecognized HIV infection.<sup>109</sup> These results may not improve even when Black MSM have Black physicians. According to a 2011 survey by Janssen Therapeutics and the National Medical Association, only one-third of patients of Black physicians were tested for HIV in the past year. HIV stigma appears to be the main reason Black doctors avoid recommending the test, with 57% of the doctors surveyed saying they feared the suggestion would be regarded as “accusatory or judgmental” and 43% concerned that their patients would be offended.<sup>110</sup>

### Maximize the Therapeutic and Preventive Benefits of Antiretroviral Therapy

To capture the prevention promise of antiretroviral therapy—and to promote the equally urgent aim of

### **HPTN 061: Testing a Multi-Component Approach for Black MSM**

The NIH-supported trial HPTN 061 aims to assess the feasibility of implementing a multi-component intervention for Black MSM, with an eye toward mounting a community-level randomized controlled trial to reduce HIV incidence in this population. The multi-component program seeks to increase condom use, decrease community viral load, and prevent STDs.

Involving more than 2,400 Black MSM, interventions include risk-reduction counseling, HIV testing, and referral for STD testing and care. Participants are screened for substance abuse, mental health issues, partner violence, experience of homophobia, and provision of counseling and referral for care. Peer health navigators are available to help Black MSM enrollees receive the health and social services they need.

In addition to its primary measures, the study also seeks to obtain HIV incidence data, describe the social and sexual networks of Black MSM, and improve understanding of Black MSM's attitudes toward other prevention methods.

reducing HIV-related illness and death among Black MSM—the country must do a much better job of closing utilization gaps at each step of the HIV treatment continuum. People who test HIV-positive must be immediately linked to HIV primary care, treatment must be initiated in a timely manner, and patients must remain in care and rigorously adhere to prescribed antiretroviral regimens. Because of shortcomings at each step in the treatment continuum, CDC estimates that only 28% of all people living with HIV have achieved viral suppression.<sup>111</sup> With Black MSM exhibiting poorer results than other MSM at each stage of the treatment continuum, it is likely that even fewer than 28% of HIV-positive Black MSM have experienced treatment success.

Nationally, nearly one in four (23%) people newly diagnosed with HIV do not enter HIV care within three months of diagnosis.<sup>112</sup> Although national data are limited on racial/ethnic and risk group comparisons with respect to linkage to care, evidence suggests that effective linkage to care is less likely for newly diagnosed Black MSM than for white MSM. In New York City, for example, Black MSM are not only more likely than white MSM to be diagnosed with AIDS within one month of testing HIV-positive, but they are less likely than their white counterparts to be linked to care within three months of HIV diagnosis.<sup>113</sup> Likewise, a study in San Francisco found that Black MSM confront severe challenges in being linked to appropriate treatment and care after receiving an HIV diagnosis.<sup>114</sup>

As in the case of HIV testing, which primarily depends on voluntary utilization, the country's approach to care linkage remains largely passive. While testing sites are at least theoretically required to provide a referral to care, they are typically not under an obligation to verify that care linkage has actually occurred.<sup>115</sup> A recent HRSA-funded study involving young MSM of color in eight sites

around the country found that early linkage was more likely to occur if the person providing the positive test result actually called to make the follow-up medical appointment.<sup>116</sup>

Once linked to care, Black MSM, as well as other people living with HIV, must be retained in continuous care to permit ongoing health monitoring. In the above-noted HRSA study involving young MSM of color, Latino MSM were significantly more likely to be retained in care than Black MSM (96% to 80%).<sup>117</sup> Clinical experts recently joined together to articulate evidence-based guidelines to ensure prompt linkage to care and retention in care for people testing HIV-positive<sup>118</sup>; these need to be fully implemented.

Implementation of the Affordable Care Act will enhance access to HIV primary care for Black MSM. The Act's Medicaid provisions will significantly extend coverage to many single, non-disabled males who currently struggle to obtain Medicaid eligibility although the Supreme Court ruled in June 2012 that states may not be required to expand Medicaid coverage under the new legislation. In addition, subsidies to people with limited incomes will enable a greater number of people to obtain private health coverage.

In the run-up to full implementation of the Affordable Care Act in 2014, urgent efforts are required to ensure full and continuous funding for Ryan White-funded AIDS Drug Assistance Programs (ADAPs). In a country where one in six Americans lacks health coverage, ADAP serves as a vital lifeline to antiretroviral medicines and other HIV-related drugs. Yet while federal funding for ADAP has risen in recent years, many states have flat-funded or cut ADAP, causing perilous funding shortfalls. As of May 2012, more than 2,500 people living with HIV were on ADAP waiting lists in 10 states.<sup>119</sup> These waiting lists have particularly pernicious effects for Black MSM, as states with ADAP funding shortfalls are disproportionately found in the South (six of 10 states) where epidemics

are heavily concentrated among Black MSM. Although some clients on the ADAP waiting list may be able to obtain medicines from drug assistance programs operated by pharmaceutical companies, such a patchwork approach that requires patients to jump through multiple hoops to obtain essential drugs is inconsistent with a sound national effort to combat HIV/AIDS.

However, ensuring a means of payment for medical services, while essential, will not be sufficient on its own to maximize service uptake. Policy reforms to expand health coverage need to be coupled with extensive investments in building the competence of health care providers to effectively and sensitively address the needs of Black MSM.<sup>120</sup> Typically, cultural competency trainings in the health field address racial, ethnic, or language differences but often fail to take account of homophobia, gender identity, or class-based biases. The list of publications available through HRSA's National Multicultural Center is revealing; while guides are offered for different racial or ethnic groups, no single guide is available for LGBT care or specifically for Black MSM, the sole population in which new HIV infections are significantly on the rise.<sup>121</sup>

Increasing the number of Black gay health care providers—or at the very least, the number of health providers who leave medical, nursing, and allied health schools having been trained in the delivery of culturally competent care for Black MSM—is critically important to the long-term goal of maximizing the effectiveness of biomedical HIV tools. The Affordable Care Act includes numerous provisions and considerable new funding to train and deploy primary care workers.<sup>122</sup>

Disappointing data regarding sub-optimal HIV adherence rates underscore the importance of an open, trusting relationship between HIV-positive Black MSM and their providers. To date, delivery of HIV care and treatment remains overly clinical in approach, failing to take account of the life issues that may

affect a patient's ability to adhere to prescribed regimens. Although numerous studies have found peer-based and other approaches effective in promoting treatment adherence<sup>123</sup>, too few clinical settings prioritize such interventions or integrate peers as part of multi-disciplinary care teams. Targeted funding should be available to train and deploy a national network of Black MSM to provide peer-based adherence support and patient navigation services.

Engaging Black MSM in efforts to promote treatment uptake is essential. Although extensive evidence indicates that peer-driven treatment education and advocacy programs are highly effective in increasing treatment utilization and adherence<sup>124</sup>, few such programs are based in minority communities and even fewer specifically cater to Black MSM.

### **Dramatically Reduce STDs Among Black MSM**

Untreated STDs increase the risk of HIV acquisition by two to five times.<sup>125</sup> HIV-positive individuals who have an STD are also more likely to pass the virus to a sexual partner.<sup>126</sup>

The background prevalence of other STDs is significantly higher among Black MSM, contributing to the spread of HIV. According to surveillance data, HIV-positive Black MSM were more than four times more likely to be diagnosed with an STD within one year of testing HIV-positive than white MSM, while Black men overall were

**2004**

Candidates for vice president (Republican Dick Cheney and Democrat John Edwards) fumble when debate moderator Gwin Ifill asks them about AIDS in Black America

**2005**

CDC reports that 46% of Black MSM surveyed in five U.S. cities were HIV-positive

### **A Vaccine and a Cure**

A classic vaccine prevents infection from ever taking hold. In the case of HIV, a preventive vaccine would prevent an individual from becoming infected even after being exposed to the virus. Alternatively, some have suggested that a workable vaccine might allow infection to occur but would prevent the virus from progressing to active disease—a somewhat less desirable result than achieved by a classic vaccine but one that would nevertheless have enormous public health benefits.

A cure would eradicate the virus from individuals who have become infected. While current treatments dramatically slow the rate of viral replication within the body, they cannot reach certain reservoirs where viral replication continues. Although viral replication with treatment occurs at a much lower rate than without treatment, the fact that the virus hasn't been eradicated means that the body will eventually develop resistance to HIV drugs. To truly cure HIV and allow individuals to discontinue taking antiretroviral drugs, it is believed that therapeutic options are needed to reach reservoirs that cannot be fully reached by existing medicines.

2005

Noah's Arc, about four Black gay friends, premieres on the Logo TV network

2006

National Black Gay Men's Advocacy Coalition is formed

## Relationship Issues and HIV Risk Behavior

Sexual HIV transmission is not a solitary act, but rather one that occurs through human relationships.<sup>1</sup> Primary sex partners account for more than two-thirds of incident HIV infections among MSM.<sup>2</sup>

Evidence indicates that many MSM are using various partnership strategies in an effort to reduce their risk of contracting HIV. In particular, serosorting (or the selection of a partner with like HIV status) has emerged as a common risk-reduction strategy for some MSM.<sup>3</sup> Some MSM also use seroadaptive behavior, also known as sexual positioning, by engaging solely in insertive anal intercourse with unknown-status or HIV-positive partners.<sup>4</sup> Men in long-term partnerships sometimes aim to “negotiate” safety by agreeing on collective risk-reduction strategies, although evidence suggests that some couples fail to adhere to agreed-on rules for negotiated safety.<sup>5</sup>

Whether as a result of skepticism regarding the safety of such relational strategies or of less extensive understanding of the science of HIV transmission, evidence suggests that Black MSM are less likely than white MSM to use serosorting or sexual positioning as a risk-reduction strategy.<sup>6</sup>

Black MSM are 11 times more likely than other MSM to have sex with Black men.<sup>7</sup> Although having sex with members of one's own race or ethnicity is common, regardless of race/ethnicity or sexual orientation, there is some evidence that racist attitudes within the broader gay community may actually increase the likelihood that Black men will choose other Black men as their sexual partners.<sup>8</sup> Disturbingly, a recent survey found that a substantial share of Black MSM mistakenly believe that having sex only with other Black men reduces their risk of becoming infected, and these men were more likely to have undiagnosed HIV infections.<sup>9</sup>

### Notes

1. Auerbach (2004), *J Acquir Immune Defic Syndr* 37:S122-S125.
2. Sullivan PS et al. (2009) *AIDS* 23:1153-1162.
3. Bruce D et al (2012). *AIDS Behav* Feb. 15 (epub ahead of print).
4. Wei C et al. (2011) *AIDS Behav* 15:22-29.
5. Davidovich U et al. (2000). *AIDS* 14:701-706.
6. Wei C et al. (2011); Eaton LA et al. (2010) *Am J Pub Health* 100:503-509.
7. Millett GA (2012) *CROI Paper #1094*.
8. Raymond & McFarland (2009). *AIDS Behav* 13:630-637.
9. Millett GA (2011) *J Acquir Immune Defic Syndr* 58:64-71.

three times more likely than white men to have had an STD prior to their HIV diagnosis.<sup>127</sup> According to surveillance data from 27 states, rates of syphilis among Black MSM increased from 2005 to 2008 at eight times the rate for white MSM.<sup>128</sup> In New York City, Black MSM are 495 times more likely than males generally—and 183 times more likely than other Black males—to be diagnosed with primary or secondary syphilis.<sup>129</sup>

Several steps are needed to lower STD rates among Black MSM.<sup>130</sup> For starters, health care providers must have a much higher index of suspicion when their male patients present with possible symptoms of an STD. In 2006-2007, a survey of Massachusetts MSM, 70% of whom had engaged in unprotected receptive anal intercourse and 50% of whom had been previously diagnosed with an STD, found that while 98% had visited a health care provider in the previous year, only 39% had been screened for STDs.<sup>131</sup> Physicians need to be comfortable soliciting and receiving information from their patients regarding same-sex sexual conduct. A clinician who undertakes a proper, comprehensive sexual history of his or her patients should elicit any information regarding anonymous sexual encounters. As many cases of STDs may be missed solely by examination of the urethra, examining the anus is especially critical.

With gonococcal resistance on the rise, proper treatment is essential, underscoring the need for clinicians to be versed in state-of-the-art treatment of STDs. Where reasonable evidence exists that a patient may have an STD, clinicians should opt for presumptive treatment rather than waiting on laboratory confirmation. This approach is not only prudent from the standpoint of public health but also recognizes limitations of existing laboratory tests for MSM; the nucleic acid test is standard for confirmation of gonorrhea, although the FDA has not approved the NAT for anal or oral gonorrhea. Locating and treating partners of patients with

newly diagnosed STDs is vital in order to prevent the STD from continuing to circulate within sexual networks.

Community education plays a central role in preventing STDs. Since the emergence of AIDS more than three decades ago, community concern about STDs has plummeted, with many MSM failing to recognize the degree to which untreated STDs increase the risk of HIV. In contrast to the 1970s and early 1980s, many MSM today are wholly unaware of where to go for STD screening and treatment. New initiatives are needed to give MSM the facts about STDs and to drive home the importance of prevention and treatment.

### **Introduce Pre-Exposure Prophylaxis**

PrEP offers a potentially powerful new tool for individuals at substantial, ongoing risk for HIV, but much about this new strategy remains unknown. Only about 50 Black MSM were enrolled in the original iPrEX trial that found tenofovir-based oral PrEP to be effective in reducing the odds of HIV acquisition among MSM. The effects of long-term use of antiretrovirals on HIV-negative MSM have not been determined, and there are concerns that PrEP might increase the likelihood of drug resistance in men who seroconvert while using PrEP. It is also unclear whether healthy, HIV-negative men will carefully adhere to the daily prophylactic regimen—an important consideration, given that the original iPrEX study found that adherence is critical to the protective effect of prophylaxis. How best to deliver and pay for prophylaxis also remains unknown, especially for vulnerable populations such as young Black MSM.<sup>132</sup> These concerns and questions are not insurmountable, but they must be answered expeditiously with the needs of Black MSM foremost in mind.

To obtain answers to these questions, NIH is supporting HPTN 073, the first targeted PrEP trial for

Black MSM. The trial protocol is currently under development, with expectations for enrolling 400-500 Black MSM. Operating under the assumption that ready access to essential services will be critical to Black MSM's ability to benefit from PrEP, the trial will assess the effectiveness of client-centered care coordination in optimizing PrEP outcomes for Black MSM. HPTN 073 seeks to shed light on optimal strategies to increase Black MSM's acceptance uptake and adherence with respect to PrEP.

Unfortunately, due to funding limitations, researchers have been forced to alter the trial design, reducing its scope.

PrEP currently resides in a common “no man's land” of newly validated health tools. While substantial resources are often directed toward the evaluation of investigational new health technologies, precious little funding is made available to learn how best to use these tools in the real world. With a potentially important new tool such as PrEP, federal agencies responsible for health (including NIH and CDC) must collaborate to develop a well-funded, thoughtful plan to learn as much as possible about PrEP roll-out and program implementation.

In light of the legacy of mistrust of mainstream health systems in many Black communities, strong, consistent, and respectful community engagement and leadership are essential to the success of HPTN 073 and to future uptake of PrEP.<sup>133</sup> This is vital for all Black MSM, but especially critical for young Black MSM, who may be embarrassed to discuss HIV, know little about the current state of HIV research, and be concerned about issues of safety and side effects.

### **Effectively Target Black MSM with High-Impact Prevention**

To maximize the impact of HIV prevention, services must be effectively targeted. As previously noted, available

evidence indicates that Black MSM receive a share of prevention and testing services that is sharply lower than their proportion of new HIV infections. All agencies involved in the fight against AIDS—CDC, HRSA, SAMHSA, state and local health departments, and other stakeholders—need to ensure that limited prevention, testing, linkage, treatment, and care dollars are targeted to those with the greatest need.

As one sign of the lack of accountability for ensuring that dollars go where they are most needed, most HIV funders don't even track the percentage of funds supporting services for Black MSM, in part because they are not required to do so as part of the implementation of the National HIV/AIDS Strategy, which tracks allocations according to race/ethnicity, gender, and exposure category. For example, in its fact sheets on CDC activities addressing Black MSM, the agency reports that 44% of its prevention spending in Fiscal Year 2009 focused on MSM; the fact sheet fails to note the racial or ethnic makeup of the MSM who received CDC prevention services that year, nor does it observe that MSM overall accounted for 64% of incident infections that year.<sup>134</sup> All agencies involved in the HIV response—at federal, state, and local levels—need to specifically track expenditures for Black MSM to ensure that they receive their fair share of resources.

In addition to correcting imbalances in the magnitude of prevention services available to Black MSM, public health funders also need to take steps to sharpen the content of prevention programs. In particular, prevention programs targeting Black MSM need to correct dangerous misperceptions (such as the belief that having sex with one's own race or ethnicity protects against transmission—see text box). Prevention programs for Black MSM should also emphasize the risks to young men of sex with older men. In Mississippi, young Black MSM who

**2006**  
 CDC recommends routine HIV testing in health care settings

**2008**  
 CDC estimates that the number of new infections among MSM increased by about 50% from 1991 to 2006, with especially high rates among young Black MSM

**2009**  
 10,800 Black MSM are newly infected in the U.S.

**2010**  
 HIV prevalence among Black MSM found to be twice as high as among white MSM in CDC-sponsored 21-city survey

### Support from an Important Quarter

Leaders at CDC are actively urging the state and local health departments that receive CDC funding to increase their HIV prevention outlays for Black MSM. According to Dr. Kevin Fenton, director of the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, prevention and research funding for Black MSM should at least be doubled. Fenton, who himself is a Black gay man, says homophobia plays a role in the under-prioritization of the HIV-related needs of Black MSM. “Our own stigma, our own homophobia, cascades down in our funding and allocations, intentionally or unintentionally resulting in underfunding of gay men’s work across the country,” Fenton told a community forum in Atlanta in March 2012.<sup>1</sup>

#### Notes

1. Bagby D (2012). GAVoice. Available at: <http://www.thegavoice.com/news/national-news/4374-cdc-leader-homophobia-impacts-funds-for-hiv-prevention>.

report having older sex partners were found to be 5.5 times more likely to be HIV-infected.<sup>135</sup>

A central failing of current prevention efforts for Black MSM is the shortage of social marketing initiatives to build awareness of prevention and treatment options and increase HIV science and treatment literacy among Black MSM. This deficit is especially concerning in light of the growing array of biomedical prevention tools. Robust, targeted social marketing campaigns should educate Black MSM that starting treatment as early as possible improves health outcomes, that current therapies have few side effects, and that HIV can be treated with a single pill a day.

### Build Sustainable Community Infrastructure

To be sustainable, the fight against AIDS among Black MSM will demand a robust and effective community infrastructure. Government alone is simply incapable of reversing this health crisis and needs strong and reliable community partners to be effective.

Unfortunately, the community infrastructure for Black MSM is weak and underdeveloped. Most of the organizations working to combat AIDS among Black MSM are small and underfunded. While grant funds are often available to support implementation of specific programs, few funders provide the general operating support that small organizations need to build

administrative capacity, learn new skills, or undertake community education and outreach.

Among the indigenous Black gay organizations that currently exist, many have been heavily oriented toward delivery of CDC-certified Effective Behavioral Interventions (also known as DEBIs). Apart from the fact that few DEBIs have been specifically developed for or validated for use with Black MSM, reliance on delivery of DEBIs serves as an exceedingly fragile reed on which to build a durable HIV prevention infrastructure. With its commitment to “High-Impact Prevention,” CDC will be de-prioritizing DEBIs in the coming years, focusing instead on prevention strategies that offer a greater likelihood of success.

Yet relatively few AIDS organizations in communities of color—and even fewer Black gay organizations—have developed extensive expertise in biomedical prevention interventions or health care delivery. Few, for example, have strong working partnerships or formal linkages with clinics, hospitals, or health centers. And few, if any, are prepared for the challenges and opportunities potentially resulting from health care reform.

### Develop New Prevention Tools for Black MSM

At the same time that intensified efforts focus on bringing existing tools to scale, equally urgent attention is needed to develop new prevention

tools to help Black MSM reduce their risk of HIV transmission or acquisition. With the goal of building on earlier PrEP study results to achieve even greater protection, researchers are now testing other prophylactic regimens for use on their own or in combination with tenofovir.<sup>136</sup>

Another critical focus for researchers is the development of one or more safe and effective rectal microbicides. These products are gels or lubricants that can be used during anal intercourse to reduce the risk of HIV or STD transmission. A microbicide might arguably be superior to PrEP, in that it could be used at the time of sex rather than on a daily basis. Moreover, a lubricant that increases sexual pleasure might result in greater usage than a daily pill that would need to be taken by a healthy, HIV-negative person.

Several rectal microbicide products are currently being evaluated in clinical studies—all but one of them in early Phase I trials. The most advanced, which is expected to begin Phase II testing in early 2013, involves a reformulated version of a tenofovir-based gel that was found to be effective in reducing the risk of HIV acquisition by women.<sup>137</sup> The gel has been reformulated to reduce the risk of irritation.

Ultimately, the development of a preventive vaccine will be needed to bring the epidemic to a definitive end. In 2009, for the first time, researchers reported that an experimental vaccine offered partial protection against infection.<sup>138</sup> Follow-up efforts aim to build on this promising sign to improve the strength and durability of protection against HIV infection.<sup>139</sup>

For those living with HIV, the Holy Grail is a cure for the disease. NIH has identified research toward a cure as one of its top priorities and is currently pursuing a range of related research efforts, including studies designed to shed light on strategies to eradicate HIV from reservoirs within the body that current therapies are unable to reach.<sup>140</sup>

## **Implement a National Plan to Reduce the Vulnerability of Black MSM**

Gay and bisexual men of all races and ethnicities experience numerous health disparities, separate and apart from the elevated rates of HIV.<sup>141</sup> As one example, decades of research have found that LGBT youth are at heightened risk for suicide.<sup>42</sup>

There is evidence that Black MSM suffer disproportionately from economic hardship, social discrimination, and trauma. In one study of HIV-positive MSM, Black MSM were found to be 80% more likely than MSM generally to have experienced childhood sexual abuse.<sup>143</sup> Black MSM are more than twice as likely as other MSM to be low-income or to have been incarcerated in the past year,<sup>144</sup> and Black LGBT youth are more likely than white LGBT youth to attempt suicide.<sup>145</sup> A startling 85% of young MSM of color enrolled in a five-year HRSA study reported having experienced bullying related to their sexuality, with 35% also reporting race-related bullying.<sup>146</sup> In a study of Black MSM in San Francisco, having HIV infection was significantly associated with homelessness.<sup>147</sup>

Studies demonstrate that multiple health and social challenges often combine in synergistic ways to increase HIV risk and worsen health outcomes for Black MSM.<sup>148</sup> According to data from the Multicenter AIDS Cohort Study, a substantial share of HIV-positive Black MSM study participants suffer from multiple health problems, such as depression, stress, substance abuse, intimate partner violence, and sexual compulsiveness. Significantly, the study found strong relationships between these conditions, with independent evidence of individual health problems strongly predicting other health problems.<sup>149</sup> Evidence suggests that many of these health and social problems either stem from, or are exacerbated by, internalized homophobia.<sup>150</sup> According to a recent study involving 1,154 Black MSM

in New York City and Philadelphia, recent experience of homophobia is associated with increased odds of engaging in unprotected anal intercourse.<sup>151</sup>

Although the confluence of economic, personal, and social disadvantages that disproportionately affect Black MSM presents a dense and complicated challenge, we are not without tools with which to combat these ills. For example, legal reform to expand the rights and social acceptance of LGBT people has been shown to have important health benefits. In the 12 months after approval of same-sex marriage in Massachusetts, for example, there were significant declines in medical care visits, mental health care visits, and mental health costs among gay and bisexual men compared to the 12 months prior to the change in the law.<sup>152</sup> A second study found that state laws against hate crimes and employment discrimination on the basis of sexual orientation were associated with substantial declines in psychiatric disorders, anxiety, and post-traumatic stress disorder among LGBT people.<sup>153</sup>

In addition, Black MSM need ready access to services to mitigate the many health challenges they confront. LGBT people generally often have difficulty accessing appropriate, non-judgmental substance abuse and mental health services<sup>154</sup>, and Black MSM experience additional obstacles due to poverty and racism. Through the Ryan White program, HRSA provides financial support for substance abuse, mental health, and other supportive services for people living with HIV, but the agency does not track the degree to which these Ryan White programs reach MSM of color.

### SYLVESTER

Sylvester learned to sing in church. At the Palm Church of God and Christ in Los Angeles, Sylvester sang gospel, with a particular partiality to an old standard performed by Aretha Franklin. According to an interview he gave with the *San Francisco Chronicle*, Sylvester was abused as a boy by an evangelist at the church.

After singing gospel at conventions across California, Sylvester began performing with the Cockettes, a group of female impersonators. Their extravagant costumes and outlandish performances garnered attention across the country.

But it was disco that made Sylvester a star—one of the brightest stars in the firmament of popular music. Starting with his first solo album, *Lights Out*, which included the Pointer Sisters as backup singers, Sylvester released a series of blockbuster albums that



Sylvester

earned him a gold LP and two number one hits.

One of his number one hits, “You Make Me Feel (Mighty Real),” effectively became an anthem for Gay Liberation.

Sylvester was recording an album in the mid-1980s when he was diagnosed with AIDS. Although Sylvester was a star of the first order, his mounting medical bills threatened him with bankruptcy, prompting his record company to release a “greatest hits” collection to raise money.

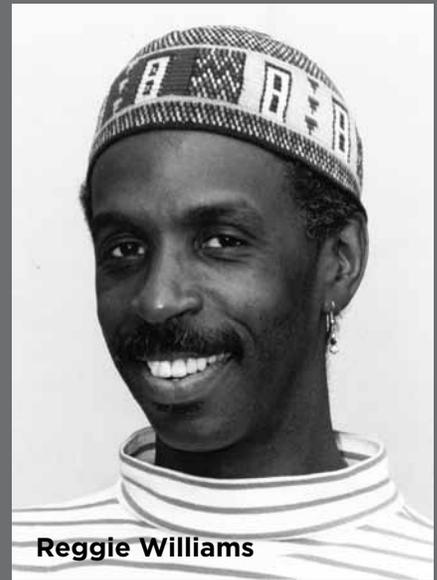
In 1988, Sylvester joined the People with AIDS group in the San Francisco Gay Pride march, attending in a wheelchair. In illness, as in the rest of his life, Sylvester was out loud and proud.

Sylvester died at age 42 on December 1988 at his home in the Castro district of San Francisco, his mother at his side.

### REGGIE WILLIAMS

A child of Cincinnati, Reggie Williams trained as an X-ray technician. Taking the advice of the Village People to “go west,” Reggie moved to Los Angeles to work at Cedar-Sinai Hospital. While at Cedar-Sinai, he began seeing cases of what was then called Gay-Related Immune Disease, or GRID.

Reggie moved to San Francisco at the time the epidemic was beginning to explode. He became executive director of the AIDS program of National Association of Black and White Men Together, which aimed



Reggie Williams

to combat racism within the gay community.

Recognizing that HIV prevention efforts were not reaching Black gay men, Reggie convened a meeting of the AIDS Task Force of the local chapter of Black and White Men Together. The work of that task force would eventually give rise to the National Task Force on AIDS Prevention, which was founded in 1988 and played a leading role in raising awareness of the epidemic’s disproportionate burden among Black gay men.

As the head of the National Task Force, Reggie became one of the most familiar faces and among the most inspirational leaders of the early gay response to AIDS. In 1989, Reggie led a protest in Washington D.C. to demand more federal support for AIDS research and for nutrition, housing, and health care for people living with

HIV, many of whom had been made destitute as a result of their disease.

Reggie demanded respect from those who ought to care—including the broader Black community and the gay community. “My personal struggle with AIDS has forced me to demand respect and dignity from my people,” he said. “Black gay men need to be able to come home.”

In 1994, Reggie moved with his partner to Amsterdam. He died there of AIDS-related causes in 1999.

### CRAIG HARRIS

Described by friends as a provocateur, Craig Harris combined his artistic pursuits as a poet with an intense commitment to activism.

After graduating from Vassar College, Craig immediately threw

social justice and inclusion. After a special AIDS plenary session at the American Public Health Association annual meeting in Las Vegas in 1986 failed to include a single person of color, Craig rushed the stage, took the microphone away from then-San Francisco Health Commissioner Merv Silverman, and announced the formation of a new national organization specifically dedicated to addressing the HIV-related needs of people of color.

People who were close to Craig remember him as a devoted friend. “He was gregarious, and he had this ability to talk to people easily,” recalls longtime AIDS activist George Bellinger Jr., a close friend. “Men, women, straight, gay. Craig was always able to draw people to him. He did a lot of multicultural stuff long before people began talking about how

“He was hardheaded until the very end,” Bellinger recalls with humor. “I remember him smoking in his hospital room! He would get excited about finding the right foundation to use to cover up his lesions.”

Craig Harris died in 1993 at the age of 34.

### JAMES DORSEY

James Dorsey was a teenager in 1986 when he traveled from his home in Detroit to Kentucky to begin a new life. James had just enrolled in the U.S. Job Corps, a vocational training program for disadvantaged youth. The program—designed for people between ages 15 and 21—takes young people away from their home environment to provide intensive job training in secure residential settings.

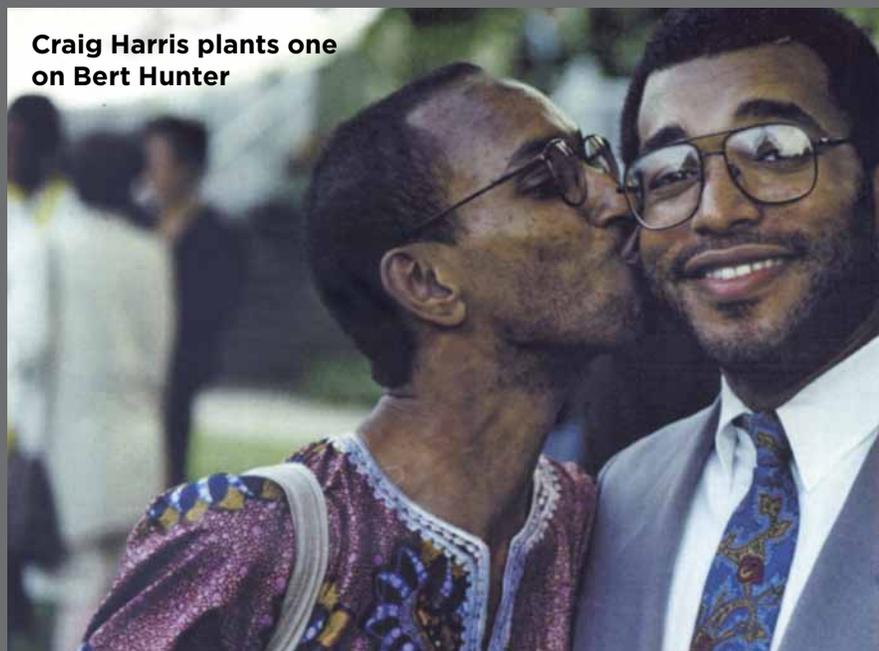
Unbeknownst to James, a routine medical exam upon his arrival at the Kentucky Job Corps facility included an HIV test. Job Corps began mandatorily testing all program entrants in the 1980s under the Reagan administration and automatically ejecting those who tested HIV-positive. Having HIV-positive people living in dorms with uninfected Job Corp enrollees was simply too dangerous, the Reagan administration contended.

James was told he was HIV-positive by a Job Corps staff member. Without receiving pre- or post-test counseling and without obtaining a medical referral, James was provided with one-way bus fare back to Detroit.

James was devastated. Upon his return to Detroit, he fell into a deep depression. But then he got angry. And, finally, he decided to take action.

He contacted the Lambda Legal Defense and Education Fund, which brought a lawsuit against the Job Corps in federal court in Washington. In his lawsuit, James asserted that the federal government had violated his constitutional rights.

When asked why he decided to file suit, James replied: “I thought about Dr. King and everything he did for



himself into gay and AIDS activism. He was former executive director of New York City’s Minority Task Force on AIDS, the first board chair of the National Minority AIDS Council (NMAC), and a staff member in the HIV prevention unit at Gay Men’s Health Crisis (GMHC).

His role in the founding of NMAC illustrates his fierce commitment to

important it was.”

Craig suffered during his final years. Still at work at GMHC, Craig navigated the agency’s staircases with difficulty. He continued to show up every day for work, but was aided by his supervisor, Robert Penn, who worked with Craig to incorporate flexible, shorter work hours.

He also remained determined.

Black people. He stood up for our rights, and I thought I had no choice but to do the same.”

As a result of the lawsuit, the Job Corps shelved its HIV policy in 1989. Thanks to James’ courage, HIV-positive young people have since had the right to obtain vocational training through the Job Corps.

In the early 1990s, James died in Detroit.

## KEITH CYLAR

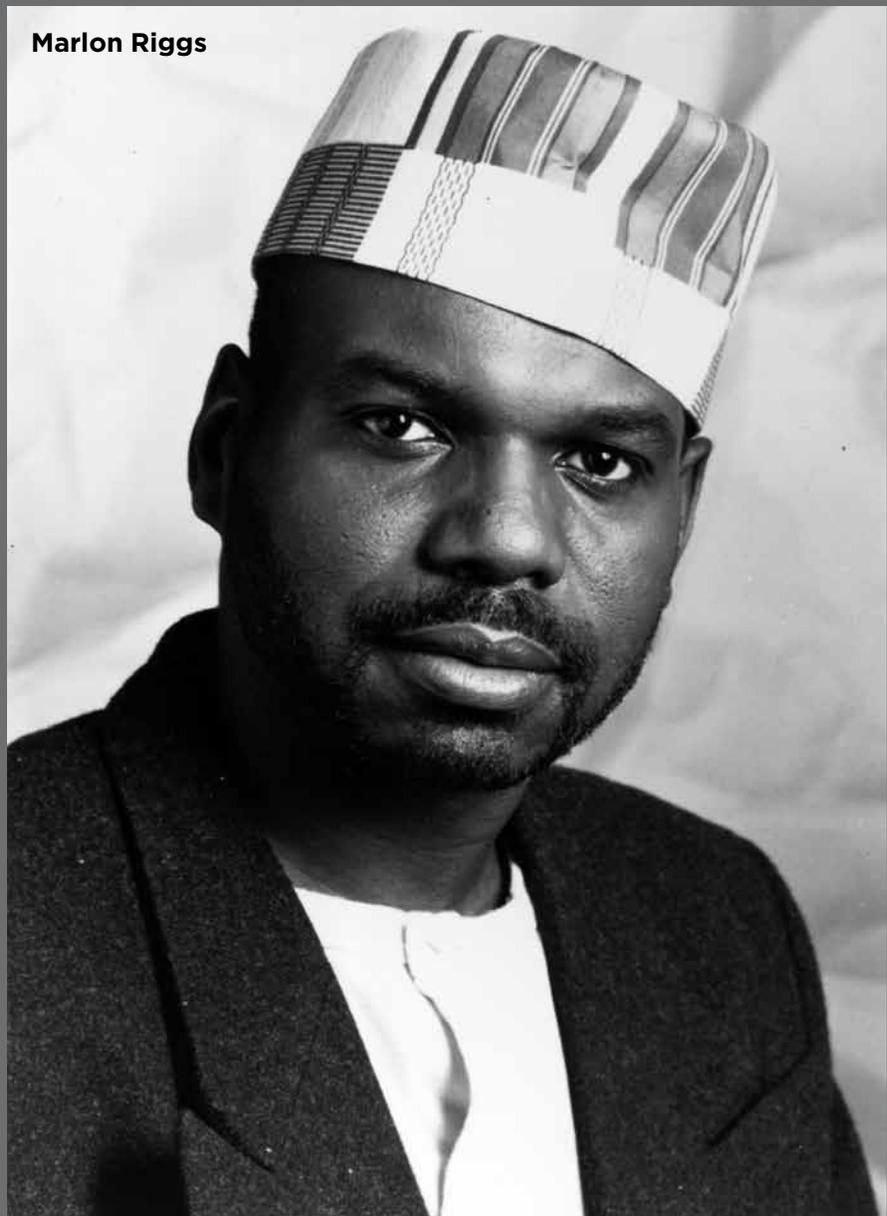
Keith Cylar was full of anger and passion. But his friends—and the countless people he influenced—also remember his zest for life and his sense of humor.

Keith lost his first lover to AIDS in 1988, the same year he graduated from Columbia University with a master’s degree in social work. He made his way to the activist group ACT UP, where he founded the group’s housing committee, which began protesting New York City’s failure to address the growing crisis of homelessness among people living with HIV.

With his new life partner, Charles King, and AIDS attorney Virginia Shubert, Keith founded Housing Works. The organization was a new approach to AIDS services—one emphasizing housing as the linchpin of AIDS services and focused exclusively



Keith Cylar



Marlon Riggs

on the most vulnerable, especially those suffering from homelessness or housing instability in the country’s most precarious, congested, and expensive housing market.

Together, Keith and Charles nurtured Housing Works. Today, the organization is the largest AIDS service provider in New York City, with an annual budget exceeding \$50 million.

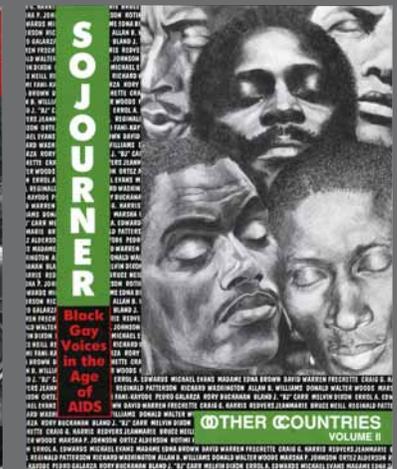
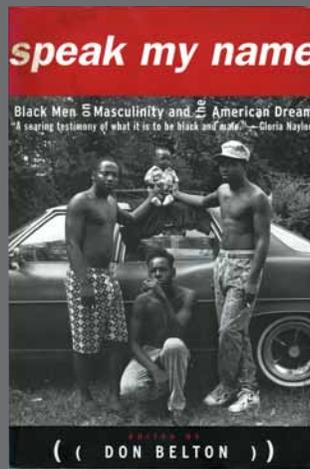
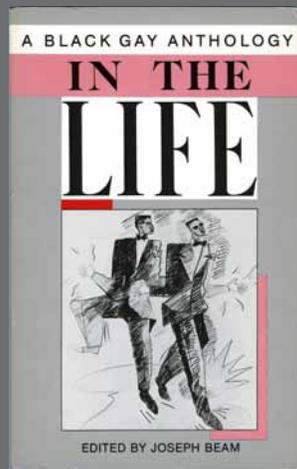
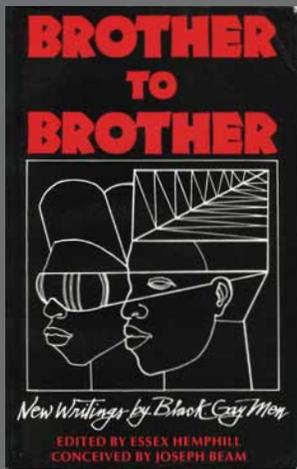
Housing Works was never your normal, staid AIDS service organization. Its militant tactics made enemies within the Giuliani administration, but they achieved extraordinary results, leading to the

creation of tens of thousands of units of affordable housing for New Yorkers living with HIV. From its outset, Housing Works was deeply committed to the empowerment of its clients, involving them in all aspects of the agency’s operations.

Keith died in 2004 at the age of 45 of cardioarhythmia.

## MARLON RIGGS

Like many of his artistic and intellectual peers in the Black gay literary renaissance, Marlon Riggs



coupled his aesthetic innovation with courageous activism.

Born to a civilian military family in Texas, Marlon moved a lot in his youth. While in junior high school in Georgia, he felt “caught between these two worlds where the whites hated me and the blacks disparaged me.”

Graduating *magna cum laude* with an interest in history from Harvard University, Marlon focused his intellectual pursuits on the history of racism and homophobia. Ultimately, he made his way to film as his primary mode of expression. His films touched on a range of topics, including the penetration of racial stereotypes in American culture and the historic depiction of Black people on prime-time television.

His artistic courage inserted him into America’s culture wars. His second major film, *Tongues Untied*, created a firestorm of protest from the radical right when it appears on the PBS series *P.O.V.* The film was a personal and ferocious exploration of life as a Black gay man. Because Marlon had received \$5,000 in support from a regional arm of the National Endowment for the Arts, the film was used by critics to demand de-funding of PBS and the NEA.

Marlon’s activism extended beyond AIDS and gay rights. He authored a fierce op-ed commentary in the *New York Times* excoriating former President George H.W. Bush for his use of the infamous Willie Horton

advertisement during the 1988 election. And he also became a leading activist in favor of the independence of public television.

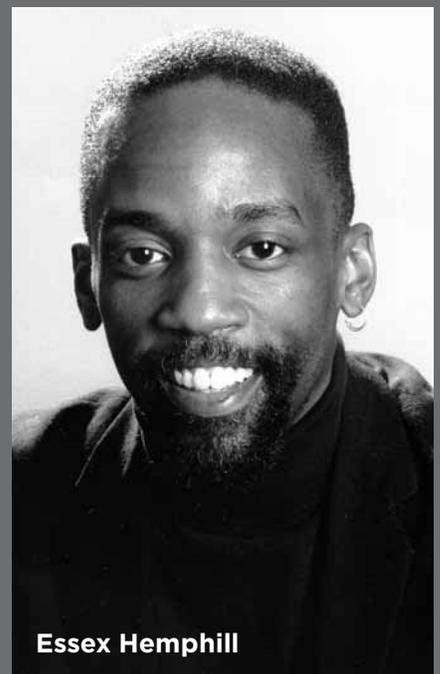
Marlon worked on his last film, *Black Is . . . Black Ain’t*, even as his body was rapidly deteriorating due to the effects of HIV. He died in 1994 at age 37, leaving an extraordinary body of work as well as a host of questions about what was lost—to Black gay men, and to the world at large—by the fact that such a brilliant life was cut so short.

### ESSEX HEMPHILL

Essex Hemphill was a leading poet, essayist, and thinker in the Black gay renaissance of the 1980s and 1990s. But the nature and subject matter of his poetry—confronting profound homophobia and racism, and written in an age when thousands upon thousands of Black gay lives were being cut short by AIDS—also made him a profoundly influential activist.

Born in Chicago, Essex was raised in Southeast Washington, D.C. He began writing poetry at age 16.

His writing cut to the heart and gave voice to the anguish, anger, and frustrations of many. As one commentator wrote after his death, Essex’s poetry concerned “black and gay men, faced with the prospect of death, [who] managed to love and live fiercely.” His poetry addressed the



Essex Hemphill

role of family in the lives of Black gay men, the objectification of Black men in broader society, and the impact of AIDS.

Essex achieved national attention when his work was included in *In the Life*, a breakthrough collection of writing by Black gay men. The documentary films *Tongues Untied* and *Looking for Langston* brought his work to an even broader audience. Essex edited *Brother to Brother: New Writings by Black Gay Men*.

This leading light of the remarkable flowering of Black gay writing and thought died in 1995 of AIDS-related complications.



## 14

# Action Plan to End AIDS Among Black MSM

## Priority Action Steps

Black MSM's place in the line for HIV services and support must be commensurate with their share of the national epidemic. To effectively deploy the tools available to end AIDS among Black MSM, the Black AIDS Institute offers the following priority recommendations and urges their immediate adoption:

### Develop a results-driven national plan to end AIDS among Black MSM

As one of its highest priorities, HHS should immediately spearhead an inclusive process—involving relevant federal agencies (e.g., CDC, HRSA, CMS, Office of Minority Health, SAMHSA), Black MSM, Black and LGBT leaders, the philanthropic and private sectors, and state and local health departments—to develop a clear, results-driven national plan to end the epidemic among Black MSM. The plan should specifically identify roles and responsibilities of all actors, specify timelines for results, and set forth transparent accountability mechanisms and periodic reporting of progress. The key aim of the national plan should be to dramatically lower community viral load among Black MSM and thereby reduce the rate of new infections. This plan needs to include the following elements:

- A prioritized effort to ensure universal knowledge of HIV serostatus among Black MSM, including support for diverse, scaled-up testing strategies; intensified professional education for health care and community-based personnel; targeted, state-of-the-art social marketing to position knowledge of HIV serostatus as a fundamental social norm; and assignment by the U.S. Preventive Services Task Force

of an A or B grade for risk-based HIV testing.

- A national effort to build robust, sustainable community capacity for Black MSM, with extensive support for the establishment of a national network of health centers specifically designed by Black MSM; community skills-building, general operating support, and organizational development for Black MSM community organizations; and the establishment of durable linkages with MSM-friendly health care settings.

- Intensified implementation research and support for adoption of best practices to ensure timely health care linkage and retention for Black MSM.

- Ensure Black MSM's ready access to affordable, high-quality, culturally appropriate health and social services, through full implementation of the Affordable Care Act, as well as prioritized cultural competence training for health care workers to increase their ability to provide appropriate care and treatment to Black MSM.

- Support for initiatives to increase Black MSM's demand for health services, including strong financing for targeted programs to build HIV science and treatment

literacy; community education efforts to increase awareness of the availability of well-tolerated, easy-to-take HIV treatment regimens; peer-based patient support and navigation services in health care settings; and high-priority efforts to roll out pre-exposure prophylaxis among Black MSM.

- A nationwide campaign to dramatically reduce STDs among Black MSM, including intensive, targeted community awareness campaigns, as well as provider education regarding the conduct of patient sexual histories, signs and symptoms of STDs among MSM, proper treatment of STDs, and prompt partner-notification activities.

- Ensuring that HIV prevention programs for Black MSM address misconceptions about HIV transmission and increase awareness of risks to young men from having sex with older men.

- Elimination of funding disparities in HIV prevention, treatment, care, and research that disadvantage Black MSM, including requiring all federal funders to track the share of resources dedicated to Black MSM.

- Concrete steps to ensure Black MSM's full and equal access to appropriate and affordable mental health and substance abuse services.

2010

MSM account for 70% of all new HIV diagnoses among Black males

2010

Multi-country study of MSM finds that pre-exposure antiretroviral prophylaxis reduces the odds of HIV transmission by 44%

2010

President Obama unveils first National HIV/AIDS Strategy, which calls for urgent action to address HIV/AIDS among MSM

### **Exert genuine, sustained leadership in the fight against AIDS among Black MSM**

Diverse non-governmental actors must recognize both that AIDS remains a severe and worsening crisis among Black MSM and that government alone cannot turn the tide against AIDS.

■ Leading advocacy, civic, and service organizations within the respective LGBT and Black communities—at national, state, and local levels—should immediately commit to hire a senior focal point to oversee work to support a sound and effective AIDS response for Black MSM. These same organizations must pledge to take specific steps to promote

Black MSM to leadership positions within their respective agencies.

■ The Congressional Black Caucus should work to ensure that Black MSM receive their fair share of HIV prevention, treatment, and care funding through the Minority AIDS Initiative.

■ Philanthropic organizations—including those that focus on AIDS issues, Black communities, and the LGBT community, as well as those that serve specific states or localities—should immediately pledge to substantially increase resources

for efforts to end AIDS among Black MSM. Similarly, the private sector—especially the pharmaceutical industry and companies that serve Black communities—must increase philanthropic outlays to support HIV-related programs and build community capacity for Black MSM. Philanthropic and corporate funders should prioritize general operating support for Black MSM organizations, as well as innovative program models for health care demand creation, HIV science and treatment literacy, and peer navigation.

### **Combat homophobia and other social challenges faced by Black MSM**

Governmental and non-governmental actors must join together with Black MSM to address the root causes of Black MSM's vulnerability to HIV and the factors that diminish health care access.

■ Congress should enact the Employment Non-Discrimination Act, repeal the Defense of Marriage Act, and ensure full and robust integration of LGBT service members

in the armed forces. Until such time as Congress takes these steps, all states and municipalities must ensure that strong, enforceable laws are in place to prohibit discrimination on the basis of sexual orientation and to recognize same-sex relationships.

■ Black organizations at the national, state, and local levels should follow the lead of the NAACP and formally endorse both non-

discrimination against LGBT people and legal recognition of same-sex marriage. Black organizations should actively recruit and promote Black MSM as leaders. Black organizations should also actively lead community dialogues on the harmful effects of anti-gay prejudice and childhood sexual abuse.



1. Lieb S et al. (2011). Statewide Estimation of Racial/Ethnic Populations of men Who Have Sex with Men in the U.S. *Public Health Reports* 126:60-72.
2. U.S. Census Bureau (2012). Population (Table 1). Available at: <http://www.census.gov/prod/2011pubs/12statab/pop.pdf>.
3. Prejean J et al. (2011). Estimated HIV Incidence in the United States, 2006-2009. *PLoS ONE* 6:e17502.
4. Hall HI et al. (2007). Racial/Ethnic and Age Disparities in HIV Prevalence and Disease Progression Among Men Who Have Sex With Men in the United States. *Am J Pub Health* 97:1060-1066.
5. Lieb S et al. (2010). Estimated HIV Incidence, Prevalence, and Mortality Rates Among Racial/Ethnic Populations of Men Who Have Sex With Men, Florida. *J Acquir Immune Defic Syndr* 54:398-405.
6. Mead H et al. (2007). *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook*. New York: Commonwealth Foundation. Available at: [http://www.commonwealthfund.org/~media/Files/Publications/Chartbook/2008/Mar/Racial%20and%20Ethnic%20Disparities%20in%20U%20S%20%20Health%20Care%20%20A%20Chartbook/Mead\\_raceethnicdisparities\\_chartbook\\_1111%20pdf.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Chartbook/2008/Mar/Racial%20and%20Ethnic%20Disparities%20in%20U%20S%20%20Health%20Care%20%20A%20Chartbook/Mead_raceethnicdisparities_chartbook_1111%20pdf.pdf).
7. Institute of Medicine (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley BD et al., eds). Washington DC: National Academies Press.
8. U.S. Census Bureau (2011). *The Black Population: 2010*. Available at: <http://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf>.
9. Lieb S et al. (2011).
10. CDC (2012). *HIV Surveillance Report*. Vol. 22. ("CDC 2010 Surveillance Report")
11. CDC 2012 Surveillance Report.
12. CDC 2012 Surveillance Report.
13. CDC (2011). HIV Surveillance—United States, 1981-2008. *MMWR* 60:689-693.
14. Prejean et al. (2011).
15. CDC (2011). HIV and AIDS Among Gay and Bisexual Men: CDC Fact Sheet. Available at: <http://www.cdc.gov/nchhstp/newsroom/docs/fastfacts-msm-final508comp.pdf> ("CDC Gay/Bisexual Fact Sheet").
16. Pathela P et al. (2011). Men Who Have Sex With Men Have a 140-Fold Higher Risk for Newly Diagnosed HIV and Syphilis Compared with Heterosexual Men in New York City. *J Acquir Immune Defic Syndr* 58:408-416.
17. CDC (2005). HIV Prevalence, Unrecognized Infection, and HiV Testing Among Men Who Have Sex With Men—Five U.S. Cities, June 2004—April 2005. *MMWR* 54:597-601 ("CDC Five-City Survey").
18. Schwarcz S et al. (2007). Prevalence of HIV Infection and Predictors of High-Transmission Sexual Risk Behaviors Among Men Who Have Sex With Men. *Am J Pub Health* 97:1067-1075.
19. Koblin BA et al. (2000). HIV prevalence of HIV infection among young men who have sex with men in New York City. *AIDS* 14:1793-1800.
20. CDC (2010). Prevalence and Awareness of HIV Infection Among Men Who Have Sex With Men—21 Cities, United States, 2008. *MMWR* 59:1201-1207 ("CDC 21-City Survey").
21. CDC (2009). HIV Infection Among Young Black Men Who Have Sex With Men—Jackson, Mississippi, 2006-2008. *MMWR*
22. Prejean et al. (2011).
23. Prejean et al. (2011).
24. CDC Gay/Bisexual Fact Sheet (2011).
25. CDC (2008). Subpopulation Estimates from the HIV Incidence Surveillance Systems—United States, 2006. *MMWR* 57:985-989.
26. Hall HI et al. (2012). Trends in HIV Diagnoses and Testing Among U.S. Adolescents and Young Adults. *AIDS Behav* 16:36-43.
27. Hall HI et al. (2012).
28. Hall HI et al. (2012).
29. Stall R et al. (2009). Running in Place: Implications of HIV Incidence Estimates Among Urban Men Who Have Sex with Men in the United States and Other Industrialized Countries. *AIDS Behav* 13:615-629.
30. U.S. Census Bureau (1980). Population. Available at: [http://www2.census.gov/prod2/decennial/documents/1980/1980censusofpopu8011u\\_bw.pdf](http://www2.census.gov/prod2/decennial/documents/1980/1980censusofpopu8011u_bw.pdf).
31. CDC (1985). Update: Acquired Immunodeficiency Syndrome—United States. *MMWR* 34:245-248.
32. Bakeman R et al. (1986). AIDS risk—group profiles in whites and members of minority groups. *New Eng J Med* 315:191-192.
33. Samuel M, Winkelstein W (1987). Prevalence of human immunodeficiency virus infection in ethnic minority homosexual/bisexual men. *JAMA* 257:1901-1902.
34. Wooten D (1989). Statistics Paint Grim Picture for Future of AIDS Cases Among African Americans in California. *BLK* No. 5.
35. Lemp GF et al. (1994). Seroprevalence and HIV Risk Behaviors Among Young Homosexual and Bisexual Men: The San Francisco/Berkeley Young Men's Survey. *JAMA* 272:449-454.
36. Valleroy LA et al. (2000). HIV Prevalence and Associated Risks in Young Men Who Have Sex With Men. *JAMA* 284:198-204.
37. CDC Five-City Survey (2005).
38. White House (2010). *National HIV/AIDS Strategy for the United States*. Available at: <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>.
39. Millett G et al. (2005). Focusing "Down Low": Bisexual Black Men, HIV Risk and Heterosexual Transmission. *J Nat'l Med Assoc* 97:52S-59S.
40. Prejean et al. (2011).
41. CDC (2011). *Funding Allocations Distributed Under Program Announcement*

(PA) 04012 by State and Local Health Departments in 2008 and 2009 for CDC-Supported HIV Prevention Projects (“CDC Funding Analysis”).

42. CDC Funding Analysis (2011).

43. Wilson PA, Moore TE (2009).

Public Health Responses to the HIV Epidemic Among Black Men Who Have Sex With Men: A Qualitative Study of US Health Departments and Communities. *Am J Pub Health* 99:1013-1022.

44. Gasiorowicz M, Stodola J (2011).

HIV Prevalence Estimates and Alignment Among Recent Diagnoses, Targeted Tests, and Prevention Services by Demographic and Racial/Ethnic Group in Wisconsin. *AIDS Ed Prev* 22(supp.):7-16.

45

46. New York City Department of Health and Mental Hygiene (2011). *New York City HIV/AIDS Annual Statistics*. Available at: <http://www.nyc.gov/html/doh/downloads/pdf/ah/surveillance2010-tables-all.pdf>.

47. Public Health Solutions (2011).

*NYC Ryan White Part A Service Category Scorecards 2008-2010*. Available at: <http://www.healthsolutions.org/hivcare/documents/RW%20Service%20Category%20Reportcard%202008-2010%209-9-2011.pdf>.

48. Peterson JL, Jones KT (2009). HIV Prevention for Black Men Who Have Sex With Men in the United States. *Am J Pub Health* 99:976-980.

49. Johnson WD et al. (2005). HIV prevention research for men who have sex with men: a seven-year update. *AIDS Educ Prev* 17:568-589.

50. Ginther DK et al. (2011). Race, Ethnicity and NIH Research Awards. *Science* 33:1015-1019.

51. Bardo S (2012). Shame = Death: HIV/AIDS Complacency in the Gay Community. Huffington Post. Available at: [http://www.huffingtonpost.com/sal-bardo/hiv-aids-complacency-gay-community\\_b\\_1367583.html](http://www.huffingtonpost.com/sal-bardo/hiv-aids-complacency-gay-community_b_1367583.html).

52. Human Rights Campaign (2012). *Growing Up LGBT in America: HRC Youth Survey Report, Key Findings*.

53. Funders Concerned About AIDS (2011). *U.S. Support to Address HIV/AIDS in 2010*.

54. Xu F et al. (2007). Prevalence of circumcision and herpes simplex virus type 2 infection in men in the United States: the National Health and Nutrition Examination Survey (NHANES), 1999-2004. *Sex Transm Dis* 34:479-484.

55. Crosby R et al. (2007). Differences in HIV Risk Behaviors Among Black and White Men Who Have Sex with Men. *Sex Transm Dis* 34:744-784.

56. Millett GA et al. (2006). Greater

Risk for HIV Infection of Black Men Who Have Sex With Men: A Critical Literature Review. *Am J Pub Health* 96:1007-1019.

57. Koblin BA et al. (2006). Risk factors for HIV infection among men who have sex with men. *AIDS* 20:731-739.

58. Millett GA et al. (2007). Explaining Disparities in HIV Infection Among Black and White Men Who Have Sex with Men: A Meta-Analysis of HIV Risk Behaviors. *AIDS* 21:2083-2091.

59. CDC (2011). HIV Risk, Prevention and Testing Behaviors Among Men Who Have Sex With Men—National HIV Behavioral Surveillance System, 21 U.S. Cities, United States, 2008. *MMWR* 60:SS12:1-34 (“CDC Extended 21-City Report”).

60. Millett GA et al. (2012). A Meta-analysis of HIV Infection Racial Disparities Among MSM: US. 19<sup>th</sup> Conference on Retroviruses and Opportunistic Infections. Seattle, March 5-8. Paper #1094.

61. Millett GA et al. (2007). Circumcision Status and HIV Infection Among Black and Latino Men Who Have Sex With Men in 3 US Cities. *J Acquir Immune Defic Syndr* 46:643-650.

62. Millett GA et al. (2007).

63. Millett GA et al. (2012).

64. Millett GA et al. (2006). Greater Risk for HIV Infection of Black Men Who Have Sex With Men: A Critical Literature Review. *Am J Pub Health* 96:1007-1019.

65. Millett GA et al. (2012).

66. Millett GA et al. (2012).

67. Millett GA et al. (2012).

68. Fields SD et al. (2008). Childhood Sexual Abuse in Black Men who have Sex with Men: Results from three Qualitative Studies. *Cultural Diversity & Ethnic Minority Psychology*, 14 (4), 385-390.

69. Cohen MS et al (2011). Prevention of HIV-1 Infection with Early Antiretroviral Therapy. *New Eng J Med* 365:493-505.

70. Quinn TC et al. (2000). Viral load and heterosexual transmission of human immunodeficiency virus type I. Rakai Project Study Group. *New Eng J Med* 342:921-929.

71. Fauci AS (2011). AIDS: Let Science Inform Policy. *Science* 333:13.

72. Grant RM et al. (2010). Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men. *New Eng J Med* 363:2587-2599.

73. Das M et al. (2010). Decreases in Community Viral Load Are Accompanied by Reductions in New HIV Infections in San Francisco. *PLoS ONE* 5:e11068.

74. Harlem Adherence To Treatment Study (2003). *Harlem Hospital Peer Support for HIV Treatment Adherence*. Available at:

## Whatever Happened to the “Down Low” Phenomenon?

In 2004, the media became fixated on “men on the down low”—a phrase meant to refer to non-gay-identified MSM who kept their sex with other men a secret. Major newspapers—such as the *Los Angeles Times* and the *New York Times*—featured the phenomenon, and Oprah Winfrey devoted a segment of her widely viewed talk show to the “DL issue.” It was suggested that the high rates of HIV infection among Black women might be explained, in part, by large numbers of surreptitiously bisexual Black men who were becoming infected during sex with other men and then passing the virus to their female partners.

The phenomenon was titillating and made for great newspaper copy and sensational TV viewing. The only problem is that there didn't seem to be a lot of evidence to support the media hysteria. While there are certainly Black MSM who also have sex with women—as there are in other racial or ethnic groups—extensive research has failed to detect any connection between DL identification and unprotected anal or vaginal sex.<sup>1</sup>

### Notes

1. (Bond L et al. (2009) *Am J Pub Health* 99:S92-S95.

2011

CDC reports that new HIV infections among Black MSM rose by 48% from 2006 to 2009

2011

Major study finds that antiretroviral treatment reduces the risk of HIV transmission among serodiscordant couples by 96%

2012

President Obama and the NAACP endorse same-sex marriage

[http://www.peernyc.org/Assets/web\\_docs/Peer%20Adherence%20Support%20Manual%20\(HIV\).pdf](http://www.peernyc.org/Assets/web_docs/Peer%20Adherence%20Support%20Manual%20(HIV).pdf)

75. Malebranche DJ et al. (2004). Race and Sexual Identity: Perceptions about Medical Culture and Healthcare Among Black Men Who Have Sex with Men. *J Nat'l Med Assoc* 96:97-107.

76. Christopoulos KA et al. (2011). Linkage and Retention in HIV Care Among Men Who Have Sex with Men in the United States. *Clin Infect Dis* 52(Supp.2):S214-S222.

77. Raymond HF, McFarland W (2009). Racial Mixing and HIV Risk Among Men Who Have Sex with Men. *AIDS Behav* 13:630-637.

78. Millett GA et al. (2012).

79. Alexander M (2010). *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. New York: The New Press.

80. Millett GA et al. (2012).

81. CDC 21-City Survey (2010).

82. CDC (2011). Vital Signs: HIV Prevention Through Care and Treatment—United States. *MMWR* 60:1618-1623 (“CDC Vital Signs”).

83. Christopoulos KA et al. (2011).

84. Millett GA et al. (2012).

85. Millett GA et al. (2012).

86. Oh DL et al. (2009). Evaluation of adherence and factors affecting adherence in combination antiretroviral therapy among white, Hispanic and black men in the MACS cohort. *J Acquir Immune Defic Syndr* 52:290-293.

87. Hightow-Weidman LB et al. (2011). Baseline Clinical Characteristics, Antiretroviral Therapy Use, and Viral Load Suppression Among HIV-Positive Young Men of Color Who Have Sex with Men. *AIDS Patient Care STDs* 25(Supp.1):S9-S14.

88. CDC Vital Signs (2011).

89. Ramchand & Fox (2008). Access to Optimal Care Among Gay and Bisexual Men: identifying Barriers and Promoting Culturally Competent Care, in *Unequal Opportunity: Health Disparities Affecting*

*Gay and Bisexual Men in the United States*. New York: Oxford University Press.

90. Heck JE et al. (2006). Health care access among individuals involved in same-sex relationships. *Am J Pub Health* 96:1111-1118.

91. U.S. Census Bureau (2011). *Income, Poverty, and Health Insurance Coverage in the United States, 2010*. Available at: <http://www.census.gov/prod/2011pubs/p60-239.pdf>.

92. CDC Extended 21-City Report (2011).

93. CDC (2010). Vital Signs: Health Insurance Coverage and Health Care Utilization—United States, 2006-2009 and January-March 2010. *MMWR* 59(early release):1-7.

94. Ross JS et al. (2006). Use of health care services by lower-income and higher-income uninsured adults. *JAMA* 295:2027-2036.

95. Schwartz J (2010). Investigating Differences in Public Support for Gay Rights Issues. *J Homosexuality* 57:748-759.

96. Olson LR et al. (2006). Religion and public opinion about same-sex marriage. *Social Sci Qtrly* 87:340-360.

97. Sabin CA et al. (2004). Late presenters in the era of highly active antiretroviral therapy: uptake of and responses to antiretroviral therapy. *AIDS* 18:2145-2151.

98. Marks G et al. (2006). Estimating sexual transmission of HIV from persons aware and unaware they are infected with the virus in the USA. *AIDS* 20:1447-1450.

99. CDC Five-City Survey (2005).

100. Spielberg F et al. (2011). Iterative Evaluation in a Mobile Counseling and Testing Program to Reach People of Color at Risk for HIV—New Strategies Improve Program Acceptability, Effectiveness, and Evaluation Capabilities. *AIDS Ed Prev* 23(Supp.):110-116.

101. Fisher HH et al. (2011). Characteristics of First-Time and Repeat HIV Tests Among Men Who Have Sex with Men at CDC-Supported Sites, 2007.

*AIDS Ed Prev* 23(Supp.):17-29.

102. CDC (2006). Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. *MMWR* 55(R-14):1-17.

103. Korthius PT et al. (2011). General Internists' Beliefs, Behaviors, and Perceived Barriers to Routine HIV Screening in Primary Care. *AIDS Ed Prev* 23(Supp.):70-83.

104. Myers JJ et al. (2011). Barriers and Facilitators to Enhancing HIV Testing in Publicly Funded Primary Care Clinics: Findings from San Francisco. *AIDS Ed Prev* 23(Supp.):84-95.

105. Bernstein KT et al. (2008). Same-Sex Attraction Disclosure to Health Care Providers Among New York City Men Who Have Sex With Men: Implications for HIV Testing Approaches. *Arch Intern Med* 168:1458-1464.

106. Millett GA et al. (2011). Mistaken Assumptions and Missed Opportunities: Correlates of Undiagnosed HIV Infection Among Black and Latino Men Who Have Sex With Men. *J Acquir Immune Defic Syndr* 58:64-71.

107. Henry J. Kaiser Family Foundation (2012). State Medicaid Coverage of Routine HIV Screening. Available at: <http://www.kff.org/hiv/aids/upload/8286.pdf>.

108. Fuqua V et al. (2012). Using Social Networks to Reach Black MSM for HIV Testing and Linkage to Care. *AIDS Behav* 16:256-165.

109. Millett GA et al. (2011).

110. PRNewsWire (2011). Stigma Remains a Significant Barrier to Routine HIV Testing by African-American Physicians, Survey Finds. Available at: <http://www.prnewswire.com/news-releases/stigma-remains-a-significant-barrier-to-routine-hiv-testing-by-african-american-physicians-survey-finds-126510328.html>.

111. CDC Vital Signs (2011).

112. CDC Vital Signs (2011).

113. New York Ryan White Part

- A EMA (2011). Ryan White Part A Application.
114. Fuqua V et al. (2012).
115. Garland PM et al. (2011). HIV Counseling, Testing and Referral Experiences of Persons Diagnosed with HIV Who Have Never Entered HIV Medical Care. *AIDS Ed Prev* 23(Supp.):117-127.
116. Hightow-Weidman LB et al. (2011). Early Linkage and Retention in Care: Findings from the Outreach, Linkage, and Retention in Care Initiative Among Young Men of Color Who Have Sex With Men. *AIDS Patient Care STDs* 25(Supp.1):S31-S38.
117. Hightow-Weidman LB et al. (2011).
118. Thompson MA et al. (2012). Guidelines for Improving Entry into and Retention in Care and Antiretroviral Adherence for Persons with HIV: Evidence-Based Recommendations From an International Association of Physicians in AIDS Care Panel. *Ann Intern Med* 156:817-833.
119. National Association of State and Territorial AIDS Directors (2012). ADAPs with Waiting Lists. Available at: [http://www.nastad.org/Docs/115104\\_ADAP%20Watch%20update%20-%205.18.12.pdf](http://www.nastad.org/Docs/115104_ADAP%20Watch%20update%20-%205.18.12.pdf).
120. Malebranche DJ et al. (2004).
121. AIDS Education and Training Center, National Multicultural Center. Products/Publications Developed by the AETC-NMC. Available at: <http://www.aetnmc.org/products.html>.
122. American Public Health Association (2011). *The Affordable Care Act's Public Health Workforce Provisions: Opportunities and Challenges*.
123. Kalichman SC et al. (2011). Integrated Behavioral Intervention to Improve HIV/AIDS Treatment Adherence and Reduce HIV Transmission. *Am J Pub Health* 101:531-538.
124. Bogart LM et al. (2012). Community HIV Treatment Advocacy Programs May Support Treatment Adherence. *AIDS Ed Prev* 24:1-14.
125. CDC (2010). The Role of STD Detection and Treatment in HIV Prevention—CDC Fact Sheet. Available at: <http://www.cdc.gov/std/hiv/stdfact-std-hiv.htm>.
126. Wasserheit JN (1992). Epidemiologic synergy: Interrelationships between human immunodeficiency virus and other sexually transmitted diseases. *Sex Transm Dis* 9:61-77.
127. Whiteside YO et al. (2012). Occurrence of New Sexually Transmitted Diseases in
128. Su JR et al. (2011). Primary and Secondary Syphilis Among Black and Hispanic Men Who Have Sex With Men: Case Report Data From 27 States. *Ann Intern Med* 155:145-151.
129. Pathela P et al. (2011).
130. Blank S, Schillinger J (2012). New York City Department of Health and Mental Hygiene. Personal communication.
131. Johnson CV et al. (2009). Health Care Access and Sexually Transmitted Infection Screening Frequency Among At-Risk Massachusetts Men Who Have Sex With Men. *Am J Pub Health* 99:S1987-S192.
132. Nelson LE (2012). Integration PrEP into the National HIV Prevention Toolkit: Focus on Young Black MSM in the United States. Presentation Sponsored by Young Black Gay Men's Leadership Initiative (YBGLI) and National Black Gay Men's Advocacy Coalition.
133. Jones V (2012). Community Engagement. National Black Gay Men's Advocacy Coalition.
134. CDC (2011). Highlights of CDC Activities Addressing HI Prevention Among African American Gay, Bisexual, and Other Men Who Have Sex With Men. Available at: [http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/highlights\\_CDC\\_Activities\\_July\\_2011.pdf](http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/highlights_CDC_Activities_July_2011.pdf).
135. Olster Am et al. (2011). HIV Risk Among Young African American Men Who Have Sex With Men: A Case-Control Study in Mississippi. *Am J Pub Health* 101:137-143.
136. AVAC (2012). Ongoing and Planned Pre-Exposure Prophylaxis (PrEP) Trials. Available at: <http://www.avac.org/ht/a/GetDocumentAction/i/3113>.
137. Karim QA et al. (2010). Effectiveness and Safety of Tenofovir Gel, an Antiretroviral Microbicide, for the Prevention of HIV infection in Women. *Science* 329:1168-1174.
138. Reks-Ngarm S et al. (2009). Vaccination with ALVAC and AIDSVAX to Prevent HIV-1 Infection in Thailand. *New Eng J Med* 361:2009-2220.
139. Warren M (2012). The "Best Hope" for AIDS Vaccine Advocacy. Huffington Post. Available at: [http://www.huffingtonpost.com/mitchell-warren/the-best-hope-for-aids-va\\_b\\_1522161.html](http://www.huffingtonpost.com/mitchell-warren/the-best-hope-for-aids-va_b_1522161.html).
140. National Institute of Allergy and Infectious Diseases (2012). HIV/AIDS: Cure. Available at: <http://www.niaid.nih.gov/topics/hiv/aids/research/cure/Pages/default.aspx>.
141. Woltiski RJ et al. (2008). Health Disparities Affecting Gay and Bisexual Men in the United States: An Introduction, in *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the United States*. New York: Oxford University Press.
142. Haas AP et al. (2011). Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations. *J Homosexuality* 58:10-51.
143. Welles SL et al. (2008). History of Childhood Sexual Abuse and Unsafe Anal Intercourse in a 6-City Study of HIV-Positive Men Who Have Sex with Men. *Am J Pub Health* 99:1079-1086.
144. Millett GA et al. (2012).
145. O'Donnell S et al. (2011). Increased Risk of Suicide Attempts Among Black and Latino Lesbians, Gay Men, and Bisexuals. *Am J Pub Health* 101:1055-1059.
146. Hightow-Weidman LB et al. (2011). Racial and Sexual Identity-Related Maltreatment Among Minority YMSM: Prevalence, Perceptions, and the Association with Emotional Distress. *AIDS Patient Care STDs* 25(Supp.1):S39-S45.
147. Fuqua V et al. (2012).
148. Ayala G et al. (2012). Modeling the Impact of Social Discrimination and Financial Hardship on the Sexual Risk of HIV Among Latino and Black Men Who Have Sex With Men. *Am J Pub Health* 102:S242-S249.
149. Dyer TP et al. (2012). Application of Syndemic Theory to Black Men Who Have Sex with Men in the Multicenter AIDS Cohort Study. *J Urban Health* doi:10.1007/s11524-012-9674-x.
150. Peterson JL, Jones KT (2009). HIV Prevention for Black Men Who Have Sex With Men in the United States. *Am J Pub Health* 99:976-980.
151. Jeffries WL et al. (2012). Homophobia is Associated with Sexual Behavior that Increases Risk of Acquiring and Transmitting HIV Infection Among Black Men Who Have Sex With Men. *AIDS Behav* doi: 10.1007/s10461-012-0189-y.
152. Hatzenbuehler ML et al. (2011). Effect of Same-Sex Marriage Laws on Health Care Use and Expenditures in Sexual Minority Men: A Quasi-Natural Experiment. *Am J Pub Health* 102:285-291.
153. Hatzenbuehler ML et al. (2009). State-Level Policies and Psychiatric Morbidity in Lesbian, Gay, and Bisexual Populations. *Am J Pub Health* 99:2275-2281.
154. SAMHSA (2001). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. Available at: <http://kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf>.

# 16 About

## **Black AIDS Institute**

[www.blackaids.org](http://www.blackaids.org)

The Black AIDS Institute, founded in 1999, is the only national HIV/AIDS think tank in the United States focused exclusively on Black people. The Institute's mission is to stop the AIDS pandemic in Black communities by engaging and mobilizing Black leaders, institutions, and individuals in efforts to confront HIV. The Institute interprets and makes recommendations on public and private sector HIV policies, conducts trainings, builds capacity, disseminates information, and provides advocacy and mobilization from a uniquely and unapologetically Black point of view.



## **Black Gay Research Group**

[www.thebgrg.org](http://www.thebgrg.org)

The Black Gay Research Group (BGRG) is a diverse group of Black gay men committed to creating a platform for presenting, discussing, and analyzing scholarly work being produced by and on Black gay men. Inaugurated in the spring of 2001, the BGRG has evolved from an informal discussion group to a structured group of professional Black gay men who have accomplished a number of objectives: It hosted four Black Gay Research Summits (2003, 2005, 2010, and 2012); conceptualized a Black gay research think tank; and developed a national Black gay research agenda.

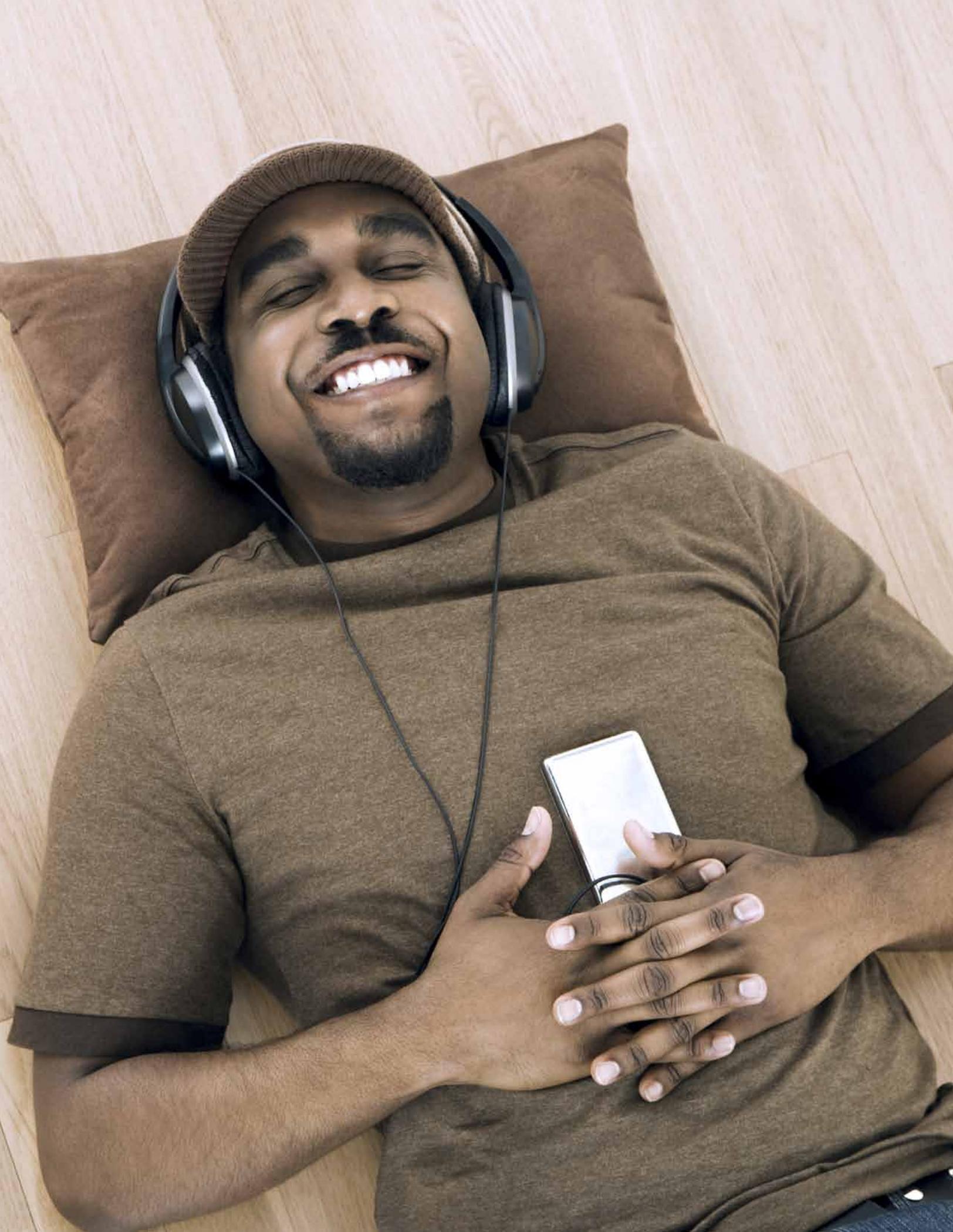


## **National Black Gay Men's Advocacy Coalition**

[www.nbgmac.org](http://www.nbgmac.org)

The National Black Gay Men's Advocacy Coalition (NBGMAC) is committed to improving the health and well-being of Black gay men through advocacy that is focused on research, policy, education and training. NBGMAC was founded in April 2006 following months of strategic organizing by Black gay activists concerned about the lack of response to data showing the disproportionate burden of HIV on Black gay men. NBGMAC is principally a policy driven coalition of organizations and members are committed to saving the lives of Black Men.





For more information or more copies of this report, contact:

## Black AIDS Institute

1833 West Eighth Street #200  
Los Angeles, California 90057-4257  
213-353-3610 ■ 213-989-0181 fax ■ info@BlackAIDS.org

[www.blackaids.org](http://www.blackaids.org)  
[www.thebgrg.org](http://www.thebgrg.org)  
[www.nbgmac.org](http://www.nbgmac.org)

