NASTAD™

NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

BLACK MSM

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Black Men Who Have Sex with Men (MSM)

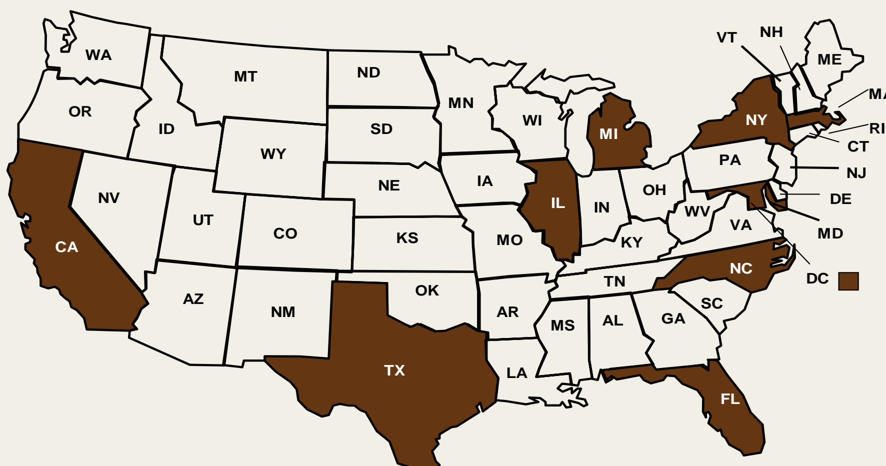
Findings from Targeted Interviews on HIV Prevention Activities Directed Toward Black Men Who Have Sex with Men (MSM)

INTRODUCTION

The National Alliance of State and Territorial AIDS Directors (NASTAD) has been analyzing health department programs targeting Black gay men/men who have sex with men (MSM) since 2005. In February 2006, NASTAD published Black MSM Issue Brief No. 1, *Black Men Who Have Sex with Men (MSM)*[1] in response to data released by the Centers for Disease Control and Prevention (CDC) at the 2005 National HIV Prevention Conference in Atlanta, GA, highlighting the HIV epidemic's continued disproportionate impact on Black MSM (BMSM). A CDC-funded study of MSM conducted in five U.S. cities (Baltimore, Los Angeles, Miami, New York City, and San Francisco) between June 2004 and April 2005, showed that 46 percent of BMSM tested were HIV-positive, and 67 percent of these men were unaware of their status. Issue Brief No. 1 focused not only on the alarming findings from the five-city study, but also provided a background on some of the issues facing BMSM, highlighted the components needed for effective prevention and treatment interventions for this population, and laid out recommendations for health departments (HDs) to respond to the high rates of HIV infection among this population.

With input from members of the National Black Gay Men's Advocacy Coalition (NBGMAC), NASTAD's Executive Committee determined that an analysis of health department HIV prevention activities directed toward BMSM was warranted. To facilitate this effort, NASTAD conducted a survey of state and directly funded local health departments. The qualitative survey was designed to obtain jurisdiction-level (i.e., state- or city-level) epidemiological data on HIV prevalence and incidence among BMSM, assess the level of resources directed toward BMSM, and document prevention and related activities directed to this population. The survey sought to identify barriers and facilitators associated with providing targeted HIV prevention services for BMSM. Issue Brief No. 2, *Survey of Health Department HIV Prevention Activities Directed Toward Black Men Who Have Sex With Men (MSM)*[2], released in February 2007, presented the findings from the analysis of the completed surveys.

Figure 1
NASTAD Targeted Interviews - Participating Jurisdictions



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Findings in Issue Brief No. 2 also served as a springboard for further efforts to determine policies and programs targeting BMSM. As a follow-up, NASTAD conducted detailed interviews with staff and community members from 14 jurisdictions across the U.S. These jurisdictions were selected based on their HIV/AIDS epidemiological profiles and their geographic location. Regions in the U.S. that have been overlooked in much of the HIV research focusing on BMSM were also specifically selected for inclusion in the interviews. The jurisdictions included: California (including the CDC directly-funded cities of Los Angeles and San Francisco), Florida, Illinois (including the CDC directly-funded city of Chicago), Maryland, Massachusetts, Michigan, North Carolina, New York (including the CDC directly-funded city of New York City), Texas, and the District of Columbia (Figure 1). The interviews provided additional detail of state-level and community-level responses to the HIV crisis among BMSM as well as facilitators and barriers to effective prevention targeting this population.

The findings from the targeted interviews are outlined in this issue brief and were presented during a technical assistance meeting entitled *Black Gay Men/MSM and HIV/AIDS: Confronting the Crisis and Planning for Action* held in Alexandria, VA on February 4-5, 2008. Meeting participants included state teams from the jurisdictions that participated in the targeted interviews.

METHODOLOGY

One-on-one and small group semi-structured interviews were conducted between October 2006 and May 2007. The interviews were conducted within health departments and local community based organizations (CBOs) in selected states. A total of 71 participants, including AIDS Directors, HD and CBO staff members, and community leaders participated in the targeted interviews. Participants from ten states and four cities were selected based on their HIV/AIDS epidemiological profiles and their geographic location in the U.S. (i.e., to represent areas in the Northeast, South, Midwest, and West). Regions that have been overlooked in much of the HIV research focusing on BMSM were also selected for inclusion in the interviews. Interview participants were chosen based on their length of experience working in HIV/AIDS prevention or treatment programs, their experiences living in the cities/communities in which they worked, and their familiarity with, and leadership on, issues related to HIV/AIDS within their jurisdiction.

Interviews covered a variety of topics. Broad questions were used to facilitate and guide discussions. Questions asked included: "How would you describe the HIV epidemic among Black persons, and particularly among BMSM, in your jurisdiction?", "Are there problems or issues particular to BMSM that promote risk behavior or hinder prevention efforts?", and "What would you say your state/jurisdiction is doing to respond to HIV infection among BMSM?" Participants were also asked to describe the support and resources available to them in responding to the epidemic
among BMSM in their state/jurisdiction. Probes were used to explore issues and salient points mentioned by participants.

All interview recordings were transcribed and personally-identifying information was removed from transcripts to ensure the anonymity of participants. A multistage process was employed in analyzing transcripts from the interviews. The process was guided by the principles of Grounded Theory[3] and included the following steps: (a) transcript review and note-taking, (b) creation and refinement of a codebook used to organize the qualitative data and capture themes, (c) systematic coding of the transcripts using three coders, (d) discussion of coding disagreements and assessment of inter-coder reliability, and (e) use of the qualitative data analysis program NVivo7 to organize the data and assist in the identification of themes. In total, over 120 codes were defined and used to document and organize the qualitative data. These codes can be grouped into six broad categories: 1) Barriers, 2) Facilitators, 3)Interventions, 4) Funding, 5) Relationships, and 6) Unique Issues. Themes within each of these broad categories were identified, and are described below. It should be noted that themes were looked at across states to better understand the key findings; findings unique to specific states or regions are not examined in this issue brief.

BARRIERS

Participants frequently spoke of barriers to effective HIV prevention and treatment efforts directed toward BMSM. As demonstrated in Table 1, barriers were discussed in all of the interviews that were conducted. Several sources of these barriers were noted: the most frequent included HDs, CBOs, interventions, structural and psychosocial factors, social networks, and stigma. Syndemics, the internet, racism and religion were less frequently identified as barriers. The frequency of endorsement of certain barriers provides an idea of the barriers which were perceived to be most prominent among interview participants. However, as the results show, many of these barriers were interconnected.

HD-based barriers were frequently linked to a lack of capacity-building efforts with BMSM-serving CBOs. Participants suggested that the dearth of capacity building negatively affects the performance of organizations serving BMSM. CBO participants noted feeling as if HDs were "passing you around like a collection plate…no one wants the responsibility of meeting your need[s]." Another HD participant affirmed this notion, specifically noting "I don't think that we have invested enough in developing the capacity of some of our community organizations, particularly indigenous organizations." This lack of capacity building was strongly tied to a paucity of BMSM staff within HDs and CBOs. For example:

> *It's hard to maintain growing a generation of new workers who are African American, and gay, and Black. It has been an ongoing challenge. It's something that we have not been, and providers have not been, successful at. Something breaks down along the way.*

The lack of culturally and sexually diverse staff was tied to another key barrier linked to HDs: a lack of cultural competency. Participants high-

Table 1
Frequency of codes identifying barriers to effective responses

CODE	CODE DEFINITION	PERCENT OF INTERVIEWS	NUMBER OF REFERENCES
BARRIERS	*Barriers to HIV prevention, intervention, and treatment among BMSM*	100%	414
Health Departments	*Barriers originating from health departments*	69%	96
Community Based Organizations	*Barriers originating from community based organizations*	62%	75
Interventions	*Barriers originating from interventions (or the lack thereof) targeting BMSM*	67%	52
Syndemics	*Barriers related to issues around the interconnectedness of poverty, violence, and substance use*	38%	21
Internet	*Barriers related to internet use among BMSM*	26%	16
Structural factors	*Barriers related to transportation/geography, access to healthcare, history of institutionalized racism*	64%	60
Psychosocial factors	*Barriers related to low self-esteem, poor self-concept, and loneliness*	74%	90
Social networks	*Barriers related to family, friendship, and sexual networks*	74%	80
Stigma	*Barriers related to internalized and external stigma around homosexuality, sex, and HIV/AIDS*	67%	61
Racism	*Barriers related to personal, social, or institutional racism*	33%	18
Religion	*Barriers related to religion*	31%	21

lighted the importance of having HD staff at all levels of the department who "look like" members of the communities they serve. Many noted that people of color, and BMSM specifically, were still underrepresented in their HD and were typically in administrative and not leadership roles.

Cultural competency and capacity-building efforts were also key barriers tied to CBOs. Participants suggested that some CBOs lack the capacity to truly understand the needs and concerns of the Black community and implement interventions that are inappropriate or inadequately developed for use with BMSM. The following exchange from two participants highlights this point:

> Participant A: *What happens is when the dollars…switch over to [the] African American community, the programs that have traditionally been working in the White communities, they take those same programs and put Kente cloth on it and call it black…And I've always had a problem with that. The cultural sensitivity is just not there.*
>
> Interviewer: *It's a constant theme [in our interviews], and we all have our own stances around different types of initiatives that try to prepackage interventions and then, as I think you beautifully put, wrap them in Kente cloth basically and say, "Here you go. That's for you."*
>
> Participant B: *No, we want Gucci…It's not a one-size-fits-all [solution]…I think the bottom line in this part of the conversation is that when you're doing cultural interventions and when you talk about addressing capacity [for intervening with] a specific culture, it has to be respectful of that culture. It has to be a "for us, by us," kind of intervention, as opposed to something that is a grant given to us to say, "I know what you need. I'm gonna fix it for you." The organization style that's most effective is from the people to the people.*

The insights of the previous participants reflect the issues surrounding who is best able to deliver interventions and what the content of interventions targeting BMSM should reflect. Participants suggested that health departments "don't really have access to our high-risk populations." However, many minority-serving CBOs that did have access lacked "the infrastructure, the administrative capacity, [and] the board capacity to continue to survive." Thus, CBOs that were not "culturally competent," but that had a greater capacity to execute complicated intervention programs, were often those attempting to physically and programmatically reach BMSM, albeit unsuccessfully.

The lack of competency in implementing culturally-based approaches to prevention and treatment was related to intervention and outreach efforts. For example, participants noted that venue-based outreach efforts, which have been useful in reaching certain groups of gay men, did not always pan out because of the lack of BMSM socializing in traditional outreach venues such as conventional gay bars and nightclubs. One participant noted "so the fact that we were venue-based, you know, the club being a venue, we felt like we were missing out on a lot of the folks who really needed to hear the message." In this respect, CBO staff noted that they worried that they were "reaching the same old people" and not those in greatest need of prevention and testing programs.

Discussions about intervention-related barriers were also tied to cultural competency. Specifically, participants indicated frustration with the lack of culturally appropriate interventions available for BMSM. Most HD and CBO participants worked with CDC-sponsored Diffusion of Effective Behavioral Interventions (DEBI) projects. Many participants noted that there is only one DEBI intervention to date that focuses specifically on BMSM. The lack of DEBI interventions was not the only concern; issues with implementing interventions that were designed under experimental conditions within "real world" settings also represented a challenge. One participant, whose comments were echoed by many others, noted that "we focus a lot on the DEBI interventions, which are hugely important, but they're also expensive and labor intensive."

Perhaps the most prominent barrier that was discussed during the interviews had to do with psychosocial factors. The broad term "psychosocial" was used to categorize the concepts of self-concept and self-esteem, overall mental health, and risk perception and awareness among BMSM. Psychosocial issues tied to poor self-concept, low self-esteem and poor mental health served as key barriers that formed a thread linking many of the other barri-

> *It's hard to maintain growing a generation of new workers who are African American, and gay, and Black. It has been an ongoing challenge. It's something that we have not been, and providers have not been, successful at. Something breaks down along the way.*

ers of which participants spoke. One participant poignantly stated sentiments that were shared by many participants:

> *So basically, in terms of HIV for Black gay men, it's not – and this is the punch line – it's not a question of them not knowing how to save their lives. It's a question of them knowing if their lives are worth saving.*

Participants talked about how poor self-concept, low self-esteem, and loneliness are intrinsically linked to self-hatred and the internalized homophobia for many BMSM. This represented an enormous challenge that many participants found overwhelming. They noted that lowered self-concept and self esteem leads BMSM to "make the bad choices," which included unprotected sex, use of drugs and alcohol, and a lack of disclosure around sexual orientation and HIV status. Thus, risky behavior among BMSM emerged out of personal and social factors that made it difficult for BMSM to value themselves and experiences, and these personal and social factors, as participants noted, are quite difficult to change.

Social network-based barriers were also prominent in the interviews. Interview participants suggested that a lack of gay-affirming venues and an organized community in which BMSM can feel comfortable participating impeded the ability to mount effective responses to the epidemic. Even when BMSM-oriented venues (namely nightclubs and bars) were present in a community, participants noted that they frequently changed locations or went out of business. One participant noted that "a lot of Black gay men are 'hidden,' which means that they stay home. They do house parties…they don't go to gay bars, for example, they stay more hidden." The "hidden" quality of networks of BMSM spoke more to social and cultural factors that kept men from being gay in public in spite of a personal desire for community-building and intimacy with other BMSM. For example:

> *And engaging this population [is difficult]… [We found] through our project [that] one of the emerging themes is loneliness. People feel kind of just out there…But it has to do with – it's still not okay to be out there about having sex, much less having sex with other men. [The message comes] from their communities, their families, as well as a larger culture.*

Participants also spoke of high-risk sexual networks as a major barrier to effective responses to the HIV epidemic. One noted that BMSM "have less room for error" based on the higher prevalence of HIV within the community. The risk involved in participating in sexual networks of BMSM was tied to a lack of disclosure about HIV status or knowledge of one's status. One participant's testimony highlights this issue:

> *In our case management, we'll have 10 or 12 clients that got infected by the same person; they keep identifying that same person every time. They come in, that same name keeps popping up…but that person is not case manageable, they're on our case load but they never come [in], they never comply, they never want to talk about things, they never want to be open and discuss these issues.*

Stigma, like psychosocial factors, represented another frequently discussed barrier that was related to many of the other barriers identified by participants. They suggested that stigma was directly tied to poor self-concept among BMSM. Internalized stigma was described as multidimensional and affecting several different behaviors, from "coming out" to engaging in health-seeking behaviors such as HIV testing. For example:

> *Because I think one of the core issues is self-value …that we are struggling with deep-seated internalizations of a whole range of oppressions that converge. It's internalization of racism, internalization of homophobia, internalization of misogyny. All these things converge and you are then seeing how the epidemic, the stigmatization of it, and [of] the prevention and treatment [of HIV], then gets internalized, as well.*

Stigma was described as something that BMSM internalize and as something that these men encounter in their families, communities, and neighborhoods. One participant explained that "people are still doing that whisper thing – 'he got the monster' – so internally we still have stigma." Others noted that people with HIV are ostracized and that an HIV diagnosis "can be a social death sentence." As the words of these participants suggest, stigma is both an individual-level and a social phenomenon that makes it difficult for BMSM to feel free to be who they are. As one participant explained, "you still have the closet mentality even if you're out. You just feel like there's certain places you can go and there's certain things you can do and [it just] feels like you're restricted, extremely restricted." Indeed, our participants suggested that community-level stigma weighed very heavy on BMSM and undermined prevention efforts, making it difficult to orchestrate effective responses.

Other barriers, including structural factors, syndemics, the internet, racism, and religion, were also discussed in the interviews. Structural factors and use of the internet among BMSM were associated with one another. A major structural barrier was related to geographic distance and transportation issues in facilitating access to intervention and outreach programs and com-

munity-building activities. The physical distance between BMSM living in rural areas or large states made it difficult for men to physically connect, which lead to the use of the internet to meet other men. Participants suggested that the internet was primarily used as a means to meet sexual partners, and represented a potentially high-risk venue in which BMSM meet other men. Finally, though not mentioned in the interviews as frequently as other barriers, racism (specifically institutionalized racism) and religion were most often discussed in relation to the stigma issues described previously. Findings related to syndemics, which referred to the intersection of poverty, violence, and substance use, were also interspersed within themes linked to psychosocial factors and structural factors.

FACILITATORS

It is important to highlight that, though barriers to mounting effective responses to the HIV epidemic among BMSM were repeatedly discussed in the interviews, facilitators to prevention efforts were also emphasized by participants with almost the same frequency. As demonstrated in Table 2, facilitators were mentioned in all the interviews that were conducted. Specifically, participants frequently identified HD-, CBO-, and intervention-based facilitators, as well as psychosocial and social network-based ones. Similar to barriers, facilitators that participants spoke of were interrelated.

One important HD-based facilitator was linked to the presence of HD-sponsored capacity-building efforts to assist in the development and growth of BMSM-serving CBOs. When HDs took a genuine interest in the day-to-day affairs of CBOs with which they work, those CBOs were better able to meet their performance expectations and effectively deliver interventions. For example, one AIDS director noted that "I think that the big thing for us is we stopped kind of saying…'that's not our business.' Okay [an HD-funded CBO] has a bad board. Well [we used to think] that's not our business. Well, certainly it's our business." When HDs made the efficient functioning of CBOs "their business," both parties were better off. By assisting with the identification of talented board members and skilled management staff, providing trainings on how to apply for state and federal grant programs, and assisting with program evaluation activities, many HDs were in a stronger position to be able to work with those CBOs in implementing effective responses to the epidemic among BMSM

And I think we made some headway by [teaming up] with the Department of Health prostate, colonoscopy and heart association. When they're doing seminars, we team together because I think when it comes to African-Americans…holistic health approaches [are needed].

Communication between HDs and CBOs was also a key facilitator. Interview participants spoke of the need for transparency between HDs and the organizations with which they work. This transparency led to trust, which provided immeasurable aid in engaging in collaborative efforts aimed at the reductions of HIV infections among BMSM. Likewise, taking the time to listen to CBOs and community members – even when their message was negative – was instrumental in fostering positive relationships and facilitating prevention efforts.

As one participant noted:

> *I hear all of the stuff, all of their great challenges, all of their successes, all the nightmares that they're having about their project. I get to hear all of it…I just say, "bring it on. Tell me. Communicate.' I go out and I just get beat up and it's fine with me…I'm so willing to get beat up because until people can feel like, 'I can tell you anything,' then they can't tell me anything.*

As the previous quote suggests, HD staff who are open and available to CBO leaders were able to forge strong working relationships. For example, the executive director of one CBO noted that "whenever I've been in a quandary, needed some guidance…I've been able to call [my AIDS director] and it's been really valuable for me." One AIDS director referred to this as 'preaching the leadership.' The person elaborated, explaining "you know, walking the walk. I mean, if we preach and then we don't do anything [we won't have] decent progress."

CBO-based facilitators were also identified, and were related to those mentioned in reference to HDs. Competency was a key facilitator, and tied not only to cultural understanding but also management and leadership. Participants confirmed that when CBOs were headed by charismatic and capable persons they were more likely to be effective in delivering interventions and working the HDs in reaching BMSM. Likewise, participants felt that when CBO staff and providers looked like the BMSM that they serve, they are more likely to be able to affect change in these men. For example:

> *It is very important to see someone in front of you who represents you. If I had HIV, I would want to see someone who is like me. Not someone with the virus, but someone who can*

Table 2
Frequency of codes identifying facilitators to effective responses

CODE	CODE DEFINITION	PERCENT OF INTERVIEWS	NUMBER OF REFERENCES
FACILITATORS	*Barriers to HIV prevention, intervention, and treatment among BMSM*	100%	311
Health Departments	*Barriers originating from health departments*	54%	136
Community Based Organizations	*Barriers originating from community based organizations*	77%	81
Interventions	*Barriers originating from interventions (or the lack thereof) targeting BMSM*	59%	57
Internet	*Barriers related to internet use among BMSM*	23%	13
Structural factors	*Barriers related to transportation/ geography, access to healthcare, history of institutionalized racism*	15%	7
Psychosocial factors	*Barriers related to low self-esteem, poor self-concept, and loneliness*	44%	23
Social networks	*Barriers related to family, friendship, and sexual networks*	56%	38
Religion	*Barriers related to religion*	18%	11

> *relate to me. For the young people, the thing that they say [is] that there's no one at the table that looks like me, that can talk like me.*

Interventions were also discussed as facilitators to effective responses to the HIV epidemic among BMSM. Participants mentioned that innovative outreach programs that meet BMSM "where they are" are extremely important to mounting effective intervention efforts. One key example given was the use of holistic interventions that incorporate more than just HIV and/or issues unique to gay men into their programs. Given the internalized and social stigma surrounding HIV and homosexuality, holistic interventions are more likely to get BMSM involved. Many participants spoke of the use of "homegrown" holistic interventions as a way to reach BMSM in their communities. For example, one participant described the process of developing a holistic intervention bridging HIV prevention with cardiac and colon health:

> *And I think we made some headway by [teaming up] with the Department of Health prostate, colonoscopy and heart association. When they're doing seminars, we team together because I think when it comes to African-Americans…holistic health approaches [are needed]. We start [by] saying hey, let's talk about your colon. Let's talk about your prostate. Oh, by the way [let's talk about] HIV/AIDS and other STDs. Make it all around and then it wouldn't be so stigmatizing.*

Psychosocial-based facilitators such as education and skills-building and promoting positive self concept in BMSM were mentioned by many participants. Specifically, participants suggested information about HIV/AIDS and how to use a condom were not problems for most BMSM. However, skills-building related to condom use efficacy and harm-reduction behaviors were noted as important psychosocial facilitators. For example, one participant suggested that BMSM reduce their vulnerability for engaging in risky behavior by focusing on the behaviors, such as alcohol use, that may make them more vulnerable. The person noted "If you know that [when you have] three drinks [that] you're not coherent, try drinking one. And to really, you know, support that [by] only taking $10 with you to the club or $15 to the club, and those types of things."

The most important psychosocial facilitator mentioned was that of self-concept and more specifically, self-esteem. Participants suggested that increasing BMSM's positive sense of self was instrumental in facilitating their engagement in healthy behaviors and relationships. The following is one of many examples participants gave regarding how promoting self worth can lead to healthy behaviors:

> *Now I say that to say…to this [young BMSM], you are worth something. I need you here next year, in five years. Protect yourself. You know? So I didn't say here, wear a condom. [I said] I need you here and if you test positive, I'm going to lose you… Very often we don't do that kind of work. You are worth something because out there the rest of the world is saying no, you are not worthy of anything, you are not part of us. And I'm saying no, you need to be here. You owe me that much. You see what I'm saying and he got it. He got it. And I bet you that any time he's doing whatever he's doing, he'll be thinking about it. I know that.*

Social networks represented important facilitators to orchestrating effective responses to HIV among BMSM. Notably, participants spoke of community-building efforts that connect BMSM and strengthen existing networks and communities as important ways to reduce isolation and improve BMSM's visibility. Interview participants suggested that creating spaces, and building and utilizing existing social spaces such as Black Gay Pride celebrations, House and Ball community social events, and house parties in which BMSM participate, should be the mission of many HDs and CBOs. One interview participant, in discussing the importance of Black Gay Pride celebrations noted, "I think we need to continue finding ways to uplift each other. Where can you go, if you're Black LGBT [lesbian, gay, bisexual, transgender]? You don't have those opportunities. So now, we create them…you can actually [go to] a [Black Gay] Pride where you can have your own people who look like you and understand you." Another participant highlighted the "enormity" of the House and Ballroom scene, which attracts many young BMSM, in working to dismantle internalized stigma and promote self worth. He noted:

> *But people our age also discount the enormity of [the House and Ball community]. It's something that sissies do. It's something that little kids do. It brings the community down. And there are some things that are not so good that go on in ballrooms, right? But as everything, it has its good and bad. But I think as a practice, as a cultural practice, as a practice that can also be put to use to help reduce the impact of this epidemic on an entire community, it has to have some sort of recognition, which in some cases it's beginning to get that recognition, but clearly not as much as it should. So I think that [the House and Ball community], in some ways, if we want to look at it as a model, offers a way to challenge that self-hatred or that internalization of those oppressions because it affirms femme people. It affirms femininity. It affirms a whole range of gender expressions and performances.*

Social networks also served as facilitators to reaching BMSM through peer-led and social network-based prevention and messaging strategies. Participants suggested that using other BMSM to deliver interventions was touted as highly effective. Likewise, participants noted working with university students, nightclub owners, sex party promoters, and notable figures within the Black and BMSM communities to assist in getting the message out and implementing interventions as key facilitators. For example:

> *We have gone to universities with primarily large African American student populations and do the ambassadorships as well as work with the Hellenic organizations, all the sororities and fraternities, to get them to have ambassadors so that they can do training statewide…It's all peer modeled. We believe that peers are the best way of doing [HIV prevention work].*

Other types of facilitators, namely religion and the internet, were brought up by participants, though not as frequently as those mentioned previously. Religion was frequently discussed as a facilitator within the context of BMSM finding gay-affirming churches that allowed them to grow spiritually, socially, and personally. Also, the internet represented an important facilitator to some participants, who suggested that it be explored as an outreach venue. As noted, the isolation and lack of community many BMSM experience may lead them to go online to find other men. Because of this, participants felt that the internet and websites attracting BMSM were prime outreach and intervention venues. For example, one participant described creating "a safer sex website [similar to] Adam for Adam where folks can meet and hook up…it's a hook up site that infuses safer sex messages." Likewise, other participants noted using social networking websites such as *MySpace* to locate BMSM and provide them with safer sex and harm reduction information.

Funding was an important theme that was brought up by interview participants. As Table 3 demonstrates, issues around funding came up in 90 percent of the interviews that were conducted. Some of the key points of discussion

were around funding politics, limited resources in funding programs targeting BMSM, using epidemiological profiles to make funding decisions, and efficient use of federal and state funds in implementing prevention efforts. Issues around creatively funding intervention programs and the destabilization of programs were less frequently discussed, though strongly tied to other themes.

FUNDING

The findings from the interviews do not speak as much to the *quantity* of financial support HDs and CBOs obtain from federal and state governments as they do to the *quality* of this support. The interview findings suggest that funding dilemmas that HDs and CBOs face are more nuanced than simply not having enough financial support. Namely, participants spoke about the politics involved in securing funding for the programs and services supported in their jurisdiction. For example, funding opportunities were at times seen as biased toward urban areas. One participant noted, "when we look at the national kinds of grant opportunities, those opportunities are more large-city focused." Another participant from a different jurisdiction had very similar sentiments:

> *We have exactly one directly funded community based organization… We compete every year with CDC. They compete. They help them. We provide them TA. They never get awarded. I think it's this ongoing deliberate bias on the part of the Centers for Disease Control that we are not a big U.S. city. Because we're not a big U.S. city and a big state… we don't get funded.*

Politics around funding also presented itself in the kind of work the HDs and CBOs were allowed to do based on funding restrictions. One participant noted that conservative funding restrictions prevent HD and CBOs from mounting the most robust and culturally-appropriate responses:

> *[The government] does not allow the word sex or gay to be mentioned, therefore…campaigns that will be so useful [and] are specific to the target population that we have, are not allowed to be implemented, because [of what has] been perceived by some groups at the national level [to be] inappropriate.*

Another key funding issue identified by participants had to do with the limited resources that HDs and CBOs had to engage in prevention efforts targeting BMSM. Many participants from different jurisdictions noted that decreasing funding create a difficult situation in which innovative work becomes devalued. In this way, limited funding served not only to erode programmatic efforts, but innovation as well. The following quotes from interviews conducted in two different jurisdictions exemplify this problem:

> *Quote #1*
> *Participant A: And I could just add…we took a 2.98 percent budget rescission from CDC.*
>
> *Participant B: That's right.*

Table 3
Frequency of codes identifying funding issues to effective responses

CODE	CODE DEFINITION	PERCENT OF INTERVIEWS	NUMBER OF REFERENCES
FUNDING	*Barriers to HIV prevention, intervention, and treatment among BMSM*	90%	169
Creative funding	*Obtaining additional funds without going through traditional sources; movement of internal dollars*	23%	17
Competing priorities	*Juggling multiple priority populations (including BMSM)*	26%	20
Program destabilization	*Loss of funding resources that contribute to the demise of a program targeting BMSM*	28%	19
Efficiency in use of funds	*Utilizing funding to the fullest extent in order to execute programs targeting BMSM*	31%	22
Limited resources	*Not enough money to develop or implement programs targeting BMSM*	49%	40
Epidemiological profiles	*Utilizing epidemiological profiles to determining funding for BMSM/at-risk groups*	36%	29
Politics	*Acquiring or losing funding based on the local or national political landscape*	54%	35

Participant A: *Which was [several hundred thousand dollars]. We had to do some serious cutting in terms of our expenses. If we get another rescission, which is certainly possible, we would have to cut some programs. There's no way we can avoid [putting] out less money.*

Participant B: *Absolutely…In 2004, when we had our last competitive RFA, we actually competed around $4 million as [name] has already pointed out. This year we have about $2.7 million to compete. You see, there are less resources available for community based organizations and health departments in terms of implementing programs across the state, … which means ultimately that there are less services available to the communities and to high-risk individuals. We've already let one of – some of our agencies know who had these demonstration projects, trying out new and innovative things that we have had to eliminate that program area from our RFA completely.*

Quote #2
Participant: *Well, we have no choice. We're working with what we have. But, yeah, because of rescissions we've lost about $300,000 in our CDC prevention funds over the past few years.*

Interviewer: *And why is that?*

Participant: *… So we are doing more with less. It's an issue. We certainly have a lot more need than we have resources to address that need. And I think that every single state will tell you that. We actually lost some state funds in 2002 because – I don't know if anybody else has told you but – our economy is in horrible, horrible shape in this state. After Louisiana we are the worst economy in the nation and it's not getting any better. Right now we're looking at an $800 million deficit for this current fiscal year.*

Two other frequently mentioned topics linked to funding were the interrelated topics of funding based on epidemiological profiles and efficiently using funds. Interview participants spoke of issues present in trying to determine how to use funds in a way that would best respond to their local HIV epidemics. For example, one participant spoke of the issues involved in funding interventions and programs based on epidemiological profiles. The participant noted that the ever-changing quality of epidemiological profiles makes it difficult to fund current areas of concern while predicting what the future epidemic may look like:

… So we are doing more with less. It's an issue. We certainly have a lot more need than we have resources to address that need. And I think that every single state will tell you that.

> *To me, prevention works, but then you look at the numbers we have now among MSM, and you see we haven't been doing much with MSM and look what happened…it's like that game that you play as a kid when you knock down the one and then the other one comes up. As much as this graph sort of argues to move resources away from injection drug users, I'm like, "Wow, we could do that." And then in five years we will be like, "Huh, look at our numbers among IDU." It's just we need more resources so that there's stuff going on with all populations all the time.*

Funding programs based on epidemiological profiles was difficult at times, but also represented the way for HDs to most efficiently use the funds they had available. However, using funds efficiently was not solely based on epidemiological factors. Many HD-based participants noted that the challenges in efficiently using funds had to do with social pressures to put dollars into the communities that their constituents felt needed them the most. For example:

> *Everybody seems real comfortable saying the increasing numbers and how many African-American MSMs are living with HIV. But when you started talking about the money and the response and the need to focus your dollars there, then everyone kinda got vague and weird. Because we all know the pot is only so big, it wasn't increasing. And so whenever you start talking about a focused response, the underlying is you're really saying we're gonna have to start redirecting dollars…So there's that undercurrent that says if we are going to acknowledge that we need a focused response, that money's gonna have to come from somewhere. And borrowing any new resources, it's gonna have to be redirected.*

Lastly, though not as frequently discussed, creative funding, competing priorities, and program destabilization represented other key funding-related themes. Creative funding was largely

mentioned in reference to efforts on the part of HDs and CBOs to secure funds outside of the traditional channels of CDC and state/local government support. Participants spoke of applying for grant opportunities in other agencies within the U.S. Department of Health and Human Services (i.e., the National Institutes of Health) and from private foundations. Competing priorities and program destabilization issues were often talked about within the context of previously discussed themes such has limited resources and efficiency in use of funds.

RELATIONSHIPS

The status of relationships among key stakeholders was an important theme discussed by interview participants. As Table 4 demonstrates, 87 percent of the interviews conducted mentioned the important role of relationships in successfully executing prevention activities targeting BMSM. Relationships were mentioned in three notable categories: cooperative agreements and synergy (or lack thereof) between CDC, HDs and CBOs to conceptualize and execute grant deliverables, collaborations or effectiveness (or ineffectiveness) of community partnerships, and White-Black relationships which were generally linked to skepticism, differing approaches and a lack of understanding between Black and White MSM working together in communities.

The findings suggest that while funding and other factors such as adequate staffing are important, building relationships and collaboration within their jurisdictions contributed to stronger service delivery efforts. In terms of cooperative agreements, participants expressed some understanding of how they should be executed. For example, one participant said: " ... it's bidirectional, cooperative agreements are bidirectional. And so I understand that we have both the authority and the responsibility to negotiate that ... our cooperative agreements enable us, and require us, to be responsive to the needs of our jurisdictions – to provide targeted programming to the most at-risk."

Interview participants stated that strong bi-directional communication between HDs and CBOs – particularly when problems arise – is intrinsically linked to healthy relationships. And, as referenced as a key facilitator, transparency between HDs and the organizations with which they work led to trust among both parties. The "trust factor" was also mentioned by participants as a fundamental component to establish and maintain healthy relationships among stakeholders. The following excerpt from a HD staff participant exemplifies this theme:

> *A strength of our approach and our philosophy is that we don't come in as a state, we're here to help. Yeah, we have certain expertise, but we don't know it all, and we will readily admit that. And I would say that, without exception, the staff that is working in community based organizations on a day-to-day basis have a very honest and bidirectional relationship.*
>
> *I mean there's nothing they can't tell us, even when they're failing, however they define failing. They'll tell us instead of hiding it ... And certain agencies will be the first to tell us when we didn't do it right... And, cause they know we're not gonna say, 'oh, you're bad, we're holding back your funding, we're gonna say, okay, how do you fix it, how can we fix it, what went wrong that you didn't do it the way you said you were gonna do it, how can we prevent it in the future and what help do you need?'*

A topic mentioned among some community participants was skepticism and questions surrounding the motivation of non-Black organizations wanting to serve BMSM. Participants expressed a

Table 4
Frequency of codes identifying relationships among stakeholder that are related to effective responses

CODE	CODE DEFINITION	PERCENT OF INTERVIEWS	NUMBER OF REFERENCES
RELATIONSHIPS	*Barriers to HIV prevention, intervention, and treatment among BMSM*	87%	153
Cooperative agreements	*Synergy (or lack thereof) between CDC, HDs, and CBOs*	46%	29
Collaborations	*Collaborations among stakeholders*	59%	50
White-Black relationships	*Race-based issues between CBOs; organizational turf battles*	46%	35

resistance to collaborate due to a lack of perceived "authenticity" of these organizations. As one participant noted:

> *My experience with other [White] community based organizations that do this kind of work is that they're very – they tend to be – my experience has been they tend to be very trend-based, wherever the epidemic is and where the funding is, that's where they'll go. That doesn't really set very well with me ... if you're committed to African American MSMs, you would have been doing the work a long time ago when we were said to be invisible and difficult to work with and all that kinds of stuff. I'm not one of the biggest promoters of collaboration unless I feel like it's a true collaboration. I've tried to collaborate with other organizations locally, but they've always had an ulterior motive.*

A strength of our approach and our philosophy is that we don't come in as a state, we're here to help. Yeah, we have certain expertise, but we don't know it all, and we will readily admit that.

Moreover, CBO participants spoke of their frustrations surrounding the approaches to reaching the population by organizations primarily serving the broader gay community. Specifically, interview participants mentioned that the approach of these organizations was geared more towards an individual accepting their sexuality without necessarily acknowledging the tremendous impact of race. As a CBO participants expressed:

> *What it feeds back into is the general MSM population and its attempt to get Black gay and bisexual men to acclimate, and not be a separate community, at least that's my perception. So these dialogues are happening both socially and programmatically, but it's still like ends up being this point of, 'But don't you agree with this?' 'Why can't you agree with this?' 'Why does it have to be different?' 'It doesn't have to be different.'*

As these findings suggest, participants expressed that fostering and maintaining healthy relationships among stakeholders is paramount to their ultimate success in reaching BMSM. However, many participants stated the need for continued dialogue with stakeholders in order to thoroughly dissect issues of trust, communication, as well as providing opportunities to examine cross-cultural perspectives that can often lead to the erosion of key relationships.

UNIQUE ISSUES

The final set of themes discussed in the interviews link to unique issues that HDs, CBOs and community members face in mounting effective responses to the HIV epidemic among BMSM. It should be noted that this theme, and the sub-themes that comprise it, emerged out of the qualitative data. In other words, the interviews were not conducted specifically in an effort to better understand norms, the "Down Low" (DL) phenomenon, and interracial sex among BMSM – these topics were brought out by interview participants and, through the course of the analysis, emerged as especially important to consider in understanding the response HDs and CBOs have had to the HIV crisis among BMSM. As noted in Table 5, unique issues were mentioned in an overwhelming majority (90 percent) of the interviews conducted.

Norms within the Black gay community and Black community in general were often brought up by participants within the context of barriers HDs and CBOs face in effectively responding to the epidemic. These norms were connected to psychosocial-, stigma-, and social network-based barriers. One issue related to norms that was often discussed was linked to the meanings of being gay and coming out among BMSM. Specifically, participants discussed the importance of coming out as important to building self-esteem and promoting a positive sense of self. However, others noted that there are few incentives that BMSM perceive in coming out as gay, bisexual, or same gender-loving. The following excerpts taken from two different interviews exemplify the two sides of the debate:

> *Quote #1*
> *Again, the vernacular is different. The religious context is different. The history of sexuality is different in the community. I think that needs to be paid attention to. The ways that male sexuality gets constructed in a white versus black context really has to be wrestled with... But for me, it's still a function what does the closet serve to that individual? How does the closet serve as a survival mechanism for an individual in either one of those cultural contexts? That's a place that's worth working on and I do believe gay folks should come out. And I don't believe that's just a white overlay. I actually believe the closet is just as deadly in either context.*

> *Quote #2*
> *I think there needs to be a conversation within the larger*

Table 5
Frequency of codes identifying unique issues among BMSM that are related to effective responses

CODE	CODE DEFINITION	PERCENT OF INTERVIEWS	NUMBER OF REFERENCES
UNIQUE ISSUES	*Barriers to HIV prevention, intervention, and treatment among BMSM*	90%	166
Norms	*Norms within the Black and BMSM communities*	72%	94
"Down-low" phenomenon	*BMSM who are "on the down low;" non-gay identified BMSM*	49%	27
Interracial sex	*Sex that BMSM have with men who are non-Black*	41%	24

> *African-American community about what incentives exist in the Black community for gay men to come out.*

While these quotes suggest different nuances of the debate around whether BMSM should disclose their sexual orientation and behavior to their families, friends, and communities, they both highlight the norm of a lack of disclosure of same-sex desires to those around them. The norm of not coming out was strongly tied to stigma and the lack of community in which BMSM can participate. This is not to say, however, that participants felt that there was no BMSM community. More accurately, participants felt that not all facets of BMSM participated in the community, and this was largely due to a lack of desire to come out.

Norms not specific to BMSM within the Black community were also observed as issues HDs and CBOs must face in creating effective prevention responses. Interview participants highlighted the importance of understanding the norms associated with Black masculinity. Specifically, participants spoke of the existence of hypermasculinity within the Black community, as well as a focus on fatherhood among Black men and being family-centered. For example:

> *There is such a sense of shame and guilt with being gay, especially for Black people. I think that that comes because Black children, Black little boys particularly, never get to be little boys. You're always little man from the time you can walk… If you fall down, you can't cry…you have to learn how to do 'man things'…you can be a murderer, a rapist, anything, but do not be a sissy. We can justify anything [else] you do, but just don't be that.*

Participants suggested that the openness of the gay community goes counter with the ways that some BMSM were brought up. Again, the importance of family and heteronormative values within the Black community produced a context in which BMSM may find it difficult to be openly gay, as the following quote suggests:

> *Participant: I think with the [Black] Pride movement, you have some folks who don't want to be associated with almost the flamboyance of that movement. There's not a lot of balance as far as the different sub-groups that make up African-American MSM… And because of that, folks aren't necessarily going to participate. Especially in this city, because…there's a lot of emphasis on just being, being a man. You know, being a southern Black man.*
>
> *Interviewer: And what does that actually mean?*
>
> *Participant: I mean, it just means you are expected to go forth and provide for your offspring. And be macho and do manly things. And just all the bravado that comes along with the South.*

Related to norms within the BMSM and Black communities was the "Down Low" or "DL" phenomenon. Participants acknowledged that this terminology was over-used within research and practice, as well as popular culture. One notable theme was that the DL is treated as if it is unique to BMSM, though it is not. One participant said, "I think the DL phenomenon is overstated…we have White gay men who are in the closet, [but] we don't call them DL." Another participant highlighted the misconception (particularly among Black women) that the DL is a black-specific phenomenon noting, "African-American women now feel that [the DL] is something that is unique to only Black men which we all know is not true. That's a big fallacy." The fallacy of the DL as unique to BMSM contributed to a context in which

BMSM on the DL are considered vectors of HIV transmission and infection. This stigmatizing context, participants suggested, was related to a lack of openness around sexuality among BMSM. For example:

> <u>Participant A:</u> *We did hear pretty consistently…that [BMSM] don't identify as gay. They would not give themselves that label and that they resent people trying to make a big deal of that and put them in a box like that. In other words, who they have sex with is not who they are. I don't know how to describe that.*

> <u>Participant B:</u> *I think demonizing these men with this whole Down Low sensationalism has done nothing but make it worse. You're just driving that behavior way underground…It's yet another way to demonize the Black man's sexuality.*

BMSM's lack of giving themselves a label as gay or bisexual led to the idea that the "DL" was becoming an identity among BMSM, particularly those who were younger. The idea that men would publicly identify themselves as DL ran counter to the meaning of being on the Down Low, and this idea puzzled many participants. For example, one noted "you've got to ask yourself what's DL mean now. You're DL, right, but you have a picture of yourself on a sex site looking for another man on the internet. So how DL could you really be?" Other participants suggested that the DL was fast becoming an identity, or a new label that BMSM gave themselves to signify their resistance to the Black gay and mainstream gay communities. The following quote highlights this point:

> *So down-low is becoming a culture of resistance or a culture of existing. And, why a resistance? You're resisting all of this… You're resisting the pink triangle. You're resisting the rainbow… You're resisting being boxed. You're resisting your mother and your grandmother [saying], 'When are you going to bring a girlfriend?' And so, you're [like] 'okay, let me resist this…I need to exist.' So you end up passing.*

The last major finding within the overarching theme of unique issues was related to interracial sexual behavior and its effects on the mental and social well-being of BMSM. These findings were some of the most provocative observed, as well as the most meaningful in terms of describing how the intersection of race and sexuality must be considered in understanding the psychosocial and social network-based barriers faced by BMSM and the HDs and CBOs that serve them. Interview participants suggested that interracial sex was prominent in some areas while it was relatively non-existent in others. However, the frequency of interracial sexual behavior was not considered as problematic as the consequences of this behavior. Notably, some participants noted that BMSM are sexually objectified by White gay men. This sexual objectification impacted BMSM on the individual level as well as the community level. Participants who were both Black and White noted the sexual objectification of BMSM and suggested that this process affects all BMSM, whether or not they engage in sexual activity with White men. The following two quotes explicitly highlight this point:

> *Quote #1*
> *I don't think our White gay male community is any different than what we see – the characteristics and the dynamics, the interracial dynamics that happen – in other communities… It's not about, 'Where did you go to college?' or 'What [are] your goals and what [are] your dreams' … or 'What [are] your hobbies?' No, it's, 'How big is your dick?' Point blank. And, if you don't have a big dick you're in trouble because [the White gay man is] gonna go to the next brother.*

> *Quote #2*
> *There's this ongoing fetishism of…gay Black men that is quite persistent in that after the sex is*

Again, the vernacular is different. The religious context is different. The history of sexuality is different in the community. I think that needs to be paid attention to. The ways that male sexuality gets constructed in a white versus black context really has to be wrestled with…

done…the possibilities for equal partnership and value go down… I think what happens is as guys try to socialize in some of these more traditional venues they're accepted, but they're accepted for their bodies, for their asses, and for their dicks, and what that can do for the White person. So you end up with this real persistent racism and acceptance only for what you can do for the White man and not for what you can do as a whole person… And we're gonna meet just through certain venues, whether it's the cruising areas or whether it's the bathhouse or the multiple internet sites, we'll connect with you for that, but you're not good enough to be with us in our white circles or our white events.

As these findings suggest, racism and sexual stereotyping pervade the gay community, and may lead BMSM to feel socially isolated and to devalue themselves and their sexuality. While there are certainly diverse gay communities within the U.S. that affirm the lives and experiences of BMSM, interview participants suggested that these communities were too few, and that the prejudice and lack of social access experienced by BMSM was too pervasive.

CONCLUSION

The findings presented in this issue brief speak to key issues HDs and CBOs face in developing and implementing effective responses to the HIV epidemic among BMSM. The focus was on obtaining perceptions and experiences of staff within HDs and CBOs and on giving this often overlooked but extremely important group of stakeholders and on-the-ground responders a "voice." The findings presented allow HD and CBO staff and practitioners, community members and leaders, and the Black community as whole to have a better understanding of important issues that must be addressed in order to effectively respond to the HIV crisis among BMSM.

The findings presented in this issue brief should be interpreted with caution for several reasons. First, though the qualitative data collected can be considered of high quality and capturing many of the nuances involved in understanding the experiences of HDs, CBOs, and communities of BMSM, the data do not represent all perceptions and experiences. Time and resources did not allow the interviewers to speak with stakeholders in many states where BMSM make up a disproportionate number of HIV cases. Therefore, it is likely that some issues unique to certain areas may not have been identified. Second, as noted previously, differences in key themes by region were not explored. While these differences are important to consider, the goal was to provide an overarching view of the responses HDs and CBOs have had to heightened rates of HIV infection among BMSM. Third and related to the previous point, differences in perceptions and experiences based on organizational differences (i.e., HD versus CBO) or staff titles (i.e., AIDS director versus CBO executive director) were not examined. Titles and organizational affiliations were purposefully left out of quotes in an effort to protect the anonymity of participants.

Overall, it is believed that this study contributes significantly and meaningfully to understanding the HIV epidemic among BMSM. More work is needed to determine the ways in which HDs and CBOs can improve their responses to the epidemic among BMSM. Nonetheless, the findings presented here document the ongoing and rigorous work that HDs and CBOs are engaged in to improve the lives of BMSM and promote the essential, heightened attention that must be given to the HIV epidemic among BMSM in the United States. Lastly, NASTAD will work closely with state/city teams and provide them with comprehensive technical assistance to support action plans developed during the February 2008 Black gay men/MSM technical assistance meeting.

ENDNOTES

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