

**Working Together to Save Our Lives II:
Calling Government and Philanthropy to Action**

HIV Risk among Black Men Who Have Sex with Men in New York State

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Introduction

In 1999, an “Emergency Strategy Meeting” was convened in Albany, New York by The New York State Black Gay Network, with the support of the Harlem Directors Group, a New York City-based, all-purpose HIV/AIDS service organization. Meeting participants wanted to ensure that the \$156 million allocated by the federal government that year to combat the growing crisis of HIV/AIDS in the African American community did not ignore the plight of Black gay men. It was their hope “that the disbursement of these monies by the various federal agencies [would] take into consideration the unique issues and concerns of Black gay men and other men who have sex with men.”

Their report “*Working Together to Save Our Lives: A Call to Action for Black Gay Men*” emphasized the importance of understanding “the social context in which gay men perceive risk, make decisions, and take actions in response to those risks.” The report also called for a research agenda that would address the unique, often complex nature of Black male sexuality. “Most of the HIV prevention relevant literature in this area has focused on white gay men. While some of this literature may be instructive, critical issues that are relevant to Black gay men have not been sufficiently considered.... Racism and homophobia, and other sociological, political and cultural factors particular to the experience of Black gay men and Black non-gay identified men must be considered by behavioral scientists.”

That report also articulated a broad range of service and program needs that must be in place in order to meet the challenges that the epidemic has posed for the Black community. High among the list of priorities was the call for capacity building, infrastructure development, and the provision of resources to increase the effectiveness of community-based organizations that represent and provide services for Black gay men and for non-gay identified men who have sex with men.

The Next Step: This Report

In response to the recommendations of that 1999 report, this paper was commissioned by the New York State Black Gay Network [NYSBGN] in partnership with the New York AIDS Coalition [NYAC] as a sequel to that original report. Specifically, our charge was to articulate “the needs of Black men who practice same sex desire” in the State of New York. We were particularly concerned with understanding the complex set of behaviors that place members of this group at risk for infection with HIV and a variety of sexually transmitted diseases. Additionally, we were interested in answering the question: “what must be done to develop programs and policies that will reduce the health risks confronted by this population and promote their general psychological and social well-being?” We consulted with administrators, advocates, policy makers, public health specialists, and representatives of the many organizations that work with Black men – gay or otherwise – both nationally and in the State of New York.

In preparing our findings and recommendations, we consulted multiple data sources including two separate qualitative studies of black men who have sex with men that were conducted between 2000 and 2002 by two of the authors of this report (DM and EF) and sponsored in part by the NYSBGN, the Community Research Group (CRG) of the Mailman School of Public Health and the New York State Psychiatric Institute, The New York City Department of Health, and a coalition of HIV/AIDS service organizations in the State and City of New York. Also cited are findings from a variety of data sets assembled by the Community Research Group over a period of years from 1986 to 2001. These data were derived from studies

that were conducted, in part, to understand the factors that contribute to the excess risk for HIV infection in poor communities of color here in the United States. The studies examine factors associated with crack cocaine and other drug use (Fullilove, Fullilove, Bowser, and Gross, 1990; Fullilove, Smith, Fullilove et al 1992); sexual risk behaviors and risk for HIV infection in San Francisco (Fullilove, Wiley, Fullilove et al, 1990); and the prevalence of health risk behaviors among residents of Harlem, New York, including those that result in possible exposure to HIV (Fullilove, Fullilove, Northridge et al, 1999).

As we will demonstrate, patterns of risk among Black men who have sex with men are complex and stem from a range of individual and community-level risk factors. Many of these factors are structural in nature, reflecting historical and contemporary social processes that shape and define the Black experience in the United States. We will also demonstrate that the most critical problem facing this population is not the paucity of data or of studies of Black men. Rather, it is the paucity of resources that have been directed to improving HIV prevention services. We will point out that there are organizations, agencies, advocates, social work and health care professionals who are well informed about the needs of these men and who have, in many instances, well-established track records of working to meet those needs. While there are often disagreements about which policy or which strategy must be implemented to achieve a specific set of goals and objectives, we believe that on the whole, as noted by one of our respondents, “What is lacking is the political will in mainstream America to put our knowledge and expertise to work.”

Contextual Factors in the HIV/AIDS in the Black Community

Much HIV/AIDS research focuses on the risk behaviors that expose individuals to infection. Of equal importance, however, are the social determinants of such risk taking, including social norms around condom use and drug use. Social norms also influence when and if the negotiation of “safe sex” behaviors will occur and, as we shall highlight throughout this report, social norms have a significant impact on attitudes towards same-sex sexual behavior.

Homophobia has traditionally been cited as one of the determining social influences that shape Black male sexuality. Homophobia structures the way in which men and women perceive HIV risk; it serves as a filter through which HIV prevention messages are acknowledged or ignored by men and women; and it influences community-wide perceptions of the importance of the HIV epidemic and the nature of the community’s response to that threat.

However, homophobia may be too simplistic as a causal explanation for many of the more secretive attitudes and sexual behaviors exhibited by many Black men who have sex with men. Webster’s definition of homophobia as “an irrational fear of homosexuals and homosexuality” does not describe the complex set of forces that created the sexual identity of the men we interviewed in the studies described here. While the disapproval and prejudices of their neighbors, families, and friends played an important role in this process, other factors must be considered as well.

African American men have struggled to create a masculine identity that “fits” within the American mainstream and that provides them with a sense of “pride of self.” In the data that we will present in this report, men describe vividly the pressures they feel to prove their own masculinity and to measure up to community and personal expectations of manliness, regardless of—or perhaps in spite of, their sexual orientation. Those pressures that Black men experience

to fulfill their own and their community's expectations for them "to be men" are nothing if not complex.

Problem

At the end of the year 2001, a total of 816,149 AIDS cases had been reported to the Centers for Disease Control. Of these 149,341 or approximately 18 percent of that national total were reported from the State of New York and 15.4 percent were reported from New York City alone (CDC, 2002).

Nationally, the epidemic continues to have a disproportionate effect upon people of color. As noted in the CDC's *HIV/AIDS Surveillance Report*, Blacks and Hispanics accounted for 72 percent of persons living with AIDS at the end of the year 2001(CDC, 2002). In New York State, 83 percent of confirmed AIDS cases in that state in 1999 were among people of color, and 76.2 percent of those state cases are residents of New York City. Table 1 presents a comparison of cumulative AIDS cases by exposure category, race/ethnicity and gender for the State and City of New York.

Table 1
Cumulative AIDS Cases by Exposure Category, Race/Ethnicity and Gender*

Exposure Category	Cumulative NYC	Cumulative Rest of State
	N (%)	N (%)
Exposure Category		
MSM	34,225 (30.5)	6,863 (25.6)
IDU	48,587 (43.3)	11,504 (43.0)
Hetero Contact	10,132 (9.0)	2,440 (9.1)
Undetermined	13,781 (12.3)	4,088 (15.3)
Race/Ethnicity		
White	37,263 (24.3)	10,616 (39.7)
Black	47,872 (42.6)	10,481 (39.2)
Hispanic	36,195 (32.1)	5,517 (20.6)
Other	970 (<1)	149 (<1)
Gender		
Male	85,829 (76.4)	21,508 (80.4)
Female	26,471 (23.6)	5,255 (19.6)

*source: New York State Department of Health

Nationally, as well as in the City and State of New York, the "face of AIDS" is that of a Black or Hispanic male. He is either an intravenous drug user or a man reporting a same-sex exposure to HIV or a combination of both of these risk exposures. The epidemic has a distinct geography as well. The concentration of cases among Black and Hispanic individuals is reflected in the number of cases reported from the neighborhoods where a majority of the Black and Hispanic residents of the City (and the State) reside (NYCDOH, 2002). From a geographical

standpoint, therefore, AIDS is as much a disease of poor communities of color as it is an epidemic of the individual residents of those communities (Fullilove and Fullilove, 1999).

New York State also led the nation in the number of HIV-positive and confirmed AIDS cases reported among prison inmates in state prisons nationwide. As of the year 2000, approximately 6000 HIV-positive inmates were reported from New York State. These cases represent 8.5 percent of the population in custody in New York State facilities. The number of New York's HIV-infected inmates is approximately twice that of the numbers of infected prisoners reported from Florida and Texas, is more than three times that reported for the State of California. Nationally, New York held roughly 25 percent of all inmates known to be HIV positive in US prisons at the end of the year 2000 (US Department of Justice, 2002).

The proportion of inmates living with HIV, both men and women, is also greater than those reported from other states. New York's 600 women inmates who are reported to be living with HIV in New York State prisons represent 18.2 percent of the State's total female inmate population. Similarly, the 5,400 males in the New York system comprise 8 percent of the State's male inmate population (US Department of Justice, 2002). Approximately 90 percent of all HIV-infected inmates, according to the New York State Department of Health, were Black (50.2 percent) or Hispanic (41.8) (NYSDOH, 2002) and approximately 73 percent are residents of New York City (Fullilove and Fullilove, 1999). The role of the prison in shaping the community epidemic of HIV/AIDS is often overlooked, but it is clear that the circulation of inmates of color from the prison to their home communities and – in too many cases – back to prison again is a factor in the HIV epidemic among both drug users and among men of color who have sex with men, as well.

These findings, while dramatic and disheartening, represent trends that have been observed in the HIV/AIDS epidemic since its first decade (Institute of Medicine, 1990, National Research Council, 1993, Institute of Medicine, 2001). More recent, however, has been the re-emergence of concern about the role of men of color who have sex with men in the continuing evolution of HIV/AIDS in the US. In a seven-city study of HIV incidence among young men who have sex with men, conducted between 1994 and 1998 (the Young Men's Study [YMS]), the prevalence of HIV infection in a sample of 3,492 men aged 15-22 was 7.2% (MMWR, 2001). Rates of infection were significantly higher among Blacks (14.1 percent), men of mixed race (13.4 percent), and among the 530 respondents recruited into the study from New York City (12.1 percent). Although men who participated in the study were recruited from venues where men who have sex with men congregate, study participants included men who defined themselves as bisexual, heterosexual, or transgender (MMWR, 2001). "Gay" identity is not universally embraced, in other words, by men who are lumped together under the category of "black men who have sex with men."

Of equal significance, however, was the rate of unrecognized infection among young Black men in the study. In an analysis of young Black males from the Young Men's Study, 139 of 150 participants (93 percent) who tested HIV positive were unaware of their HIV status. "Of those with unrecognized infection 99 (71 percent) reported either that there was no chance, that it was very unlikely, or that it was unlikely that they were infected with HIV...." A sizeable proportion (77 percent) reported having engaged in anal intercourse with another man and 16 percent of the 536 men who had previously tested HIV negative were found to be HIV positive when tested by researchers conducting this study (MMWR, 2002). In view of these findings, the Editorial Note accompanying this report recommended that

health care providers should assess the HIV risks of their patients routinely and encourage all MSM at risk for HIV to test at least annually. Findings from this report indicate that demand for testing by young BMSM might be increased by implementing efforts that increase personal risk perceptions; addressing concerns about testing positive by conveying the benefits of early diagnosis and HIV care; and marketing the availability of oral fluid, urine-based, or finger-stick HIV tests that do not require venipuncture (MMWR, 2002, pgs 735-736).

These recommendations provide a significant backdrop for our report. We present findings from two studies conducted with samples of young Black men who reported a range of sexual identities. We were particularly interested in the perceptions of respondents about the urgency posed by the HIV/AIDS epidemic. We also asked about their perceptions of the significance of “naming” or labeling their sexuality and/or their sexual preferences. We asked them about their perceptions of homophobia and other forms of stigma, and we asked how these perceptions influenced their risk-taking and/or their health seeking behaviors. We also examined data collected from a survey of social service and community based organizations that work with Black men who have sex with men. We were interested in their perceptions of what must be done to improve programs and services for such men, irrespective of the age of the population served.

Data Sources and Methods

The first study (Malebranche, personal communication) was conducted between December 2000 and February 2001. Eight focus groups were conducted in various cities in New York State including Manhattan, Brooklyn, Albany, Rochester and Buffalo. An additional group, which served as the pilot for this study, was conducted in Atlanta, Georgia. Participants (n=81) were recruited through a collaboration between the New York City Department of Health Preventive Medicine Residency Program, the Mailman School of Public Health of Columbia University, and the New York Black Gay Network, a coalition of community-based organizations (CBO's) and service providers in New York State that targets Black men who have sex with men for HIV prevention and other services.

Inclusion criteria for this study included: being a male of African descent, being 18 years of age or older, English speaking, and identifying as a man who has had sex with other men. Recruitment for the focus groups was accomplished through email messages to CBO clients, announcements made during routine meetings of CBO clients and staff, mailed flyers announcing the study, and word of mouth. Potential participants were screened to determine if they met inclusion criteria and those accepting to be in the study were asked to give informed consent to have the focus group recorded and transcribed.

The focus groups were conducted in private rooms at a CBO in each of the cities represented in the study. Each session lasted 90 to 120 minutes and respondents were given \$25.00 for their participation. Participants were invited to discuss a variety of topics ranging from their perceptions of their sexual behavior and its expression, the manner in which they perceive themselves to be perceived by others (both their peers and other members of their community), the degree to which these perceptions affected their desire to access services, and the degree to which these perceptions affected their relationships with medical providers in general and physicians and clinicians in particular.

The specific aims of the study were to: 1] explore the subjective healthcare experiences of Black men who have sex with men, 2] describe the perceived influence of their race and sexuality on the doctor-patient interaction; 3] describe the perceived barriers to healthcare

utilization; 4] investigate perceptions of the doctor-patient relationship and; 5] explore factors affecting adherence to medical regimes.

The second study (Fields, unpublished masters thesis) involved interviews of 19 young Black men who have sex with men in New York City (n=9), Rochester (n=5), and in Buffalo (n=5).

Once again, the collaboration of the New York State Black Gay Network was essential to the realization of this study as was the participation and cooperation furnished by Promoting Resources for Youth and Sexual Acceptance in Northern Manhattan. Both agencies are dedicated to serving the needs of men of color who engage in same-sex sexual relations.

Participants were recruited through the assistance of staff of these organizations that contacted men of African descent between the ages of 18-24 and invited them to participate. Participants were not required to self-identify as “gay” or bisexual but they did acknowledge current or previous same-sex behavior. Interviews were conducted one-on-one with the principal investigator (EF) and lasted between 90 and 120 minutes.

Interviews focused on “structural and contextual” factors that promote health risk behaviors and that influence in some significant way the sexual behavior of the respondent. Thus the social, environmental, communal, and other contextual factors that influence all aspects of sexual behavior were explored. Perceptions of race, of sexuality, perceptions of the meaning – personal and societal – of adopting a particular sexual identity, and perceptions of what constitutes “masculinity” were all examined.

The protocols for these two studies were all reviewed and approved by the Institutional Review Board of the Health Sciences Campus, Columbia University.

The final primary data source was provided by a survey of community-based organizations that serve Black gay, bisexual, men who have sex with men in urban and rural New York State. In addition to information about populations served and services provided, respondents were asked to describe their perceptions of the strategies that are effective in promoting prevention of HIV; of advocating for their client population, of the barriers/obstacles that prevent programs from being effective; and of the opportunities and barriers for funding the work of their agencies. The majority of the questions in the survey were open-ended in format and respondents were encouraged to give detailed comments.

Analysis of Data

Tapes from focus groups and from individual interviews were recorded and transcribed. The transcripts and the written comments from the CBO surveys were all examined for thematic consistency. Of particular interest were comments directed to racial and sexual identity, the formation of sexual identity, perceptions of racism and homophobia, perceptions of belonging or exclusion from community life, perceptions of HIV risk behavior, perceptions of the relevance and effectiveness of HIV prevention efforts, and perceptions of barriers to medical, social, and community based services for Black men who have sex with men.

The findings reported here represent summaries of the issues and themes that were most consistently expressed by respondents. Where possible, we have attempted to represent areas of consensus, but we have attempted, as well, to present variations in perceptions and points of view.

Findings

We found little evidence of a monolithic, uniform sexual identity among our respondents. Among the 81 participants in the focus group study, for example, only slightly more than 50 percent of our respondents self-described themselves as “gay” (Table 2).

Table 2
Self-Reported Sexual Orientation of Study Participants

Sexual Orientation	Number Focus Groups	%	Number Interviewees	%
Gay	43	53.1	5	26.3
Bisexual	10	12.3	9	47.3
Homosexual	10	12.3	1	5.3
Same Gender-Loving	10	12.3	0	0.0
Other (e.g. Two-Spirited)*	7	9.8	4	21.0
TOTAL	81	99.8	19	99.9

Respondents describe a variety of pressures that lead to choosing a “label” for themselves and what they do sexually. Some were clear that being “gay” was an ideological position that had less to do with sexual behavior and more to do with a set of beliefs about how men, most notably white gay men, are expected to function in society. To reject the label “gay” was perceived as affirming a Black identity, an attempt to find another way of expressing both a racial and a sexual identity. “I am what I am not; you know what I’m trying to say here? I’m Black, I ain’t gay”

However, the pressures to be a regular, straight man were also present in the comments of respondents. “A lot of people don’t want to be put in a gay, a homo category, a faggot category, and I’m the same way. I don’t because society – society is harsh against gay people. So people are – a lot of guys are trying to – you know, straighten up in a way, you know, meaning act more masculine to fit into mainstream society – to kinda like camouflage themselves or something.”

Respondents were also clear that their race was a significant factor in their sense of self and in the development of an identity, as noted by a focus group respondent from Rochester. “Being a Black man is a hard struggle. Not just being gay, being straight – being a general black man is an everyday struggle. I don’t care how you put it: white America either wants me in a cell or in a grave.” A focus group respondent from Albany noted “For me, whether it’s sexuality or just gender, it’s always gonna be an issue of race. I’m gonna be seen as a black man.”

Despite an acute awareness of their racial identity, respondents were almost unanimous about the negative way in which their sexuality might be perceived within the Black community. Although some reported that they had been able to achieve a sense of acceptance of their sexual identities by their neighbors and others in their community, many others felt a need to adopt an appearance, a set of attitudes, and a set of outward behaviors that hid their sexuality and their sexual preferences. “I don’t want people to know what I do sexually because when people know what you do sexually, they want to judge you. Nothing else matters, nothing else.” A respondent from Buffalo noted “in order to fit in, that’s a big thing about fitting in, in order to fit in or to not be talked about or to not have your self-esteem lowered any more than what it might already be, you just try to go with the flow and you act in the same nature as the typical straight Black male would act.”

In many studies examining sexuality and the formation of a sexual identity, the role of the church is frequently cited. The primacy of the faith community in Black America is particularly important, both as a source of spiritual strength, but often, as a cause of the rejection. In a published study of the role of stigma and its impact on HIV infection and prevention in the African American community (Fullilove and Fullilove, 1999), one of our respondents described the hypocrisy and the complexities of the Black Church's attitudes towards same-sex sexual behavior.

I really see a persistent problem in the church, and when I say persistent, I mean over, I'm now 60 and I've been working in the church since I was 10 years old. And the issue of sex, this business of homosexuality has been wrapped in hypocrisy for too many years. Because even when I was a kid of 10, 12 when I first started playing piano I used to hear ministers say they were going to find them a real sissy to play music in their church.... So while on the one side of the pulpit the picture was condemning sex between people of the same sex, on the other side in order to enhance and build their congregation and get the people shouting they were willing to forget the so-called theological issues in order to enhance their pocket book, so you know. The hypocrisy must be addressed....

But the church is a powerful influence in the lives of African American men. It has been the one institution that has nurtured the Black community during the painful, arduous climb from slavery. Moreover, the significance of the role of the church in the Civil Rights Movement of the 50s and 60s cannot be overstated. Nonetheless, some of our respondents described a strong, but nonetheless torturous relationship with the church and its role in their lives. "People ask me why do you keep going to church and you in the church with the life that you're living? Cuz I can't help myself. That's a saving station, that's a help station. That's where I can go get strength and power and whatever I need. I go to church every Sunday sometimes during the week, and if I don't, if I miss church on Sunday, my whole week isn't right because it's been in my life for so long."

Another respondent noted, "It was a constant battle between serving God and doing what I wanted to do, you know, so I mean its hard being bisexual and being a Christian because they collide with each other. They don't go together. I mean you're supposed to pray – pray about it. I mean that's what I did, but I fell away. Like I stopped going to church. I don't even consider myself a Christian anymore, but I do plan on going back."

Community expectations play a major role in the way black men adopt a public and private sexual identity. "We are looked on to be – for no other phrase – we are to be that nigga. We are to be that bomb shit that's fucking, bringing money, and getting food, the support. We're not supposed to cry, we're not supposed to have issues, we're not supposed to be that sissy."

Community influences and community attitudes not only create a barrier that men must confront in order to have a sense of self, these factors drive many men to hide their sexuality and to avoid any behavior that might label them as gay. The *down low* phenomenon – viz. behaving as a heterosexual but having a secret life involving sex with other men – was a frequently cited theme in our data. Some gay men in our sample believed being on the DL was about trying to maintain some sense of normalcy.

Because they have to fit in with – I mean the quote on quote normal society which I don't think there is a normal society, but they have to fit in with the normal criteria of the way life is supposed to be. I guess that they just need that to cover up so that they won't be clockable or they might get killed or they might get bashed or something.

By contrast, a respondent living on the “down low” described his need to meet and behave in a way that fit community expectations.

Well for me, I tend to ignore and totally deny that side of me and just try to be the straight guy, so you know I was going out with women and all that stuff and just carrying on like a regular person quote unquote. The more feedback I got on the whole gay thing from other people around and in the church and all that stuff, the more I wanted to be straight. So I would think that there is a lot of people who is in that situation because nobody wants to be the outcast, nobody wants to be, you know, not accepted into the community that they associate with. If you are going to be there, then you want to be loved. You want to be favorable in people’s sight. So that is one thing that I did want to be, so I said okay, fine. I’ll be straight.

Others were uncomfortable identifying with the term “gay” because of the connotations it carries. A respondent from Rochester noted “Just the word gay and what’s associated with it, you know what I mean, and the stereotypes. It’s a lot easier for me you know what I mean. ‘Cause honestly I know that I’m gay, you know what I mean; I know I’m gay, but I just say I’m bisexual ‘cause it just feels better.”

Nonetheless, the pressures to belong, to engage in all of the behaviors that are associated with the image of African American manhood were cited as powerful incentives to keep up appearances.

DL is when you have a broad personality...DL is when nobody knows about your sexuality because you don’t have a stereotypical way about you. You’re a man and that’s as far as it goes. You know, you’re just a man. You know, there’s nothing gay about you except your sexual activity, which is in private basically, so that’s it . . . yeah.

Some spoke of not wanting to give up “man things” because of their sexuality and of wanting to remain “one of the fellas.”

It’s a culture now that people’s in. You know, if you mess around, fine, you mess around but you keep it real; you still have this mentality of being a man and you know, playin’ basketball or chillin’ wit’ your boys, smokin’ weed and drinkin’, you know, so it’s...I think, I don’t know. It’s just like society probably just feels that, you know, we don’t, we shouldn’t be (tapping table) out there like that, we shouldn’t be open; we should just keep it, keep it on the low.

Respondents identified a variety of responses to these pressures. One response involves the appropriation of places and spaces where a variety of behaviors were possible. These spaces range on a continuum from cruising spots that promoted HIV risk behaviors to *houses* which created a sense of safety and community, on the other.

I mean the fact that society looks down on us is the reason why Prospect Park, Fort Tryon exist. If we was able to get on the F train on 42nd and Fifth Avenue and just hug up on somebody and kiss them like you mean it....Uhm, if we were able to do that, I don’t think cruising spots would be that popular.

Nonetheless, some of these spaces, particularly the houses, promote healthy attitudes and play an important role in HIV prevention. “Yes, because also members of my house, they also or we like also like talk about prevention and everything amongst ourselves and we basically talk about HIV, you know like, we have group discussions about like counseling group sessions and we talk about problems we go through or what we are dealing with....” At their best, these spaces exist in contrast to those that promote anonymous, often risky sexual encounters where personal safety is secondary to rapid, furtive gratification. “...all the gay bars and all this other

stuff just looking to get laid, just with that one mission in mind, to get laid or whatever, by like the cutest person that they can find or whatever; it's like stupid...."

Unfortunately, HIV risk behavior and risky places abound even in houses. Respondents noted that the support and sense of community provided by houses was often coupled by exposure to risky sexual behavior, particularly when they were one of a few safe spaces. A participant from Buffalo noted;

All kinds of stuff happened. Sex acts on videotapes and strippers and, ooh, now that I think of it, it all leads to sex- most of it - you know, dudes and stuff becoming girls and stuff like that and going out and bringing straight dudes back to the house and all that and the party line - that meeting people from the party line, bringing them over there and stuff like that; it all ends up to everybody tryin' to get a seat and tryin' to be sexual and be like that. That's what it all ends up to be. A lot of group sex; a lot of orgies and things like that.

The places that offer medical and HIV services to these men are also sometimes seen as part of the problem.

After I expressed my need. Say, for instance, I tell him, "I need to be tested for HIV. What risk category do you represent? . . . "I'm a man who has sex with men." . . . The climate kind of changes. He goes from looking at me as an individual that is taking care of himself to a risk category.

To avoid the problems of being treated as something other than human, one man spoke openly of avoiding any reference to his sexuality.

Another reason why I think I may lie because say like, this doctor, he or she may have religious beliefs about the gay lifestyle. They could be against that. And I'm afraid that he or she may not give me the same treatment like they would do for someone, I guess, they say is "normal."

As for jails and prisons, their role in the creation of risk spaces and their refusal to provide for the men who engage in HIV risk behaviors led one respondent to comment:

I'm pissed off at, especially wit' the federal prisons and prisons in general like Rikers and, you know, Sing-Sing, all of them for not distributing condoms inside prisons for the men who are having sex in there knowingly and then coming out, you know, seeing their girls and they girls are so desperate to get some from their boys and you know they come out not wearing a condom and you know they are already infected and infecting them and then what happens is, you know, it keeps on.

Responses of Community Based Organizations

Our examination of the responses to the NYSBGN questionnaire to community-based organizations serving Black men who have sex with men revealed a significant level of agreement and consistency. Responding organizations were asked, among other issues, to list prevention priorities for Black men of all sexual persuasions, to list the most effective prevention activities or programs targeting this population, and to list the key obstacles facing such men and the programs and organizations that serve them. Presented in Table 3 is a selection of the prevention priorities for working with this population:

Table 3
CBO Survey Responses: Prevention Priorities

Creating alternate spaces for socialization apart from bars, cruising spaces, etc.
Peer support/stronger support systems
Incentives to engage/retain clients
More resources for HIV prevention
Effective programming to combat homophobia
Link prevention programming with community organizing efforts
Getting negative men to be consistent condom users
Space for programs with increased ability to do outreach to more folks
Reaching a broader spectrum of BSMs, doing outreach in bars and clubs
Reach the invisible population (DL population)

Our examination of these surveys revealed a number of common themes. There was an almost universal consensus that there were too few resources available for the size and the scope of the problem these organizations were expected to confront. There was also significant consensus about the effectiveness of outreach activities, particularly if peers workers were used to reach “hidden” populations.

The importance of knowing and working in the places and spaces where Black men congregate and seek male partners was frequently emphasized, and the variations in the way men label themselves and their sexuality was also recognized. Working to increase self-esteem so that men could be less hidden in their sexual self-expression—and therefore at less risk for HIV and other STDs—was also noted as an important component of an effective prevention campaign.

A number of respondents described the need to promote general health and resist the temptation of believing that the only problem Black men have is HIV/AIDS. Closely allied with this observation was the almost universal acknowledgement of the need for assistance and resources for capacity building, so that a broader cross-section of the community might be reached.

Respondents were acutely aware of the down low phenomenon. The need to map places where such men meet, to provide them with “safe” places to talk to others about their hidden sexuality and the risks that their behavior promotes, and to provide opportunities for them to struggle with the self-esteem issues that force them into hiding were all emphasized.

Discussion

Few aspects of human behavior are more complex than sexuality. There is ample evidence that – contrary to popular opinion – sexual identity is not fixed and may change throughout the life of the individual. Our findings from this examination of two samples of black men who engage in same sex sexual behavior suggest that the sexuality of some Black males is the product of individual, community, and societal forces. This complex of factors creates pressures to be, as one of our respondents noted, “...that nigga. We are to be that bomb shit that’s...bringing money, and getting food, the support. We’re not supposed to cry, we’re not supposed to have issues, we’re not supposed to be that sissy.”

How much of sexual behavior is the expression of innate, inborn characteristics, and how much of it is a response to social and societal pressures to behave according to expectations? Our findings suggest that a significant component in Black heterosexual behavior is at least partially a function of the expectations that Black men experience to “look and act straight.” Ten percent of the participants in our focus group study described themselves as heterosexual – despite the fact that they had engaged in same-sex sexual encounters – and many men refused to label their sexuality at all.

A number of respondents to the New York State Black Gay Network survey called for a study of Black male sexuality that would help clarify the complex of factors that creates such significant variation in sexual behavior and sexual identity. Certainly, our data suggest that such studies would be useful, particularly if they seek to be as inclusive of as many types of sexual expression as possible, would seek to sample from as many sectors of the Black community as possible, and would attempt to understand how individual, social, and communal forces influence sexual behavior and perceptions of sexual risk.

In previous studies we have attempted to demonstrate that the African American community – particularly in the New York Metropolitan Area – has undergone significant changes over the course of the past 60 years (Wallace, Fullilove, Wallace, 1992; Wallace, Wallace, Andrews et al, 1995; Fullilove and Fullilove, 1999; Watkins and Fullilove, 2001). Wilson (1987) and Massey (1993) have described changes in the urban landscape that resulted in racially segregated communities that were characterized by hyper-concentrations of poverty. Successive waves of drug epidemics, high rates of crime, and a general pattern of excess morbidity and mortality became the norm in many of these poor communities of color. In Harlem, for example, the life expectancy for Black males in 1980 was lower than that of men in Bangladesh, arguably one of the poorest nations in the Developing World (McCord and Freeman, 1990).

We have further argued that HIV/AIDS is one important end result of this spiral of decline that poor communities of color nationwide have been undergoing since the 1960s. Behaviors that never would have been tolerated in these communities in the post World War II years – the public sale and use of drugs, for example, or the exchange of sex for drugs, often in public places – became commonplace in some urban neighborhoods in the late 1980s and early 1990s. The significantly elevated prevalence of such behaviors in these communities was an important symptom of the degree of social collapse it had suffered.

Stevan Hobfoll, in an insightful book entitled *Stress, Culture, and Community* (1998), has hypothesized that the primary motivation of human beings is to create and preserve resources at both an individual and community level. When those resources are threatened and/or removed, communities will inevitably struggle. The competition for whatever resources that remain will become intensified, and this competition will eventually strain family, neighborhood, and community family and friendship ties. Once unified neighborhoods in which neighbors could count on neighbors can dissolve into a state of disunity in which an “everyone for him or herself” ethic will prevail.

These stresses, he suggests, exist in almost every facet of the life. In this study these stresses might be used to explain the extraordinary lengths to which some Black men will go to hide the nature of their sexual behavior. These stresses also describe the environment in which HIV/AIDS service organizations that serve the black community function. As the disease burden on the community increases, so does the demand for services. In many instances services are not allocated to meet the need, but are instead the object of intense competition among providers.

Organizations that should, in principle, be collaborating to improve the community's health are, instead, competitors for a dwindling resource pie. Their inability to work together imposes greater stresses on those who depend on them for services, particularly those who are infected and affected by HIV/AIDS. Sadly, at this point in the 21st Century, those infected and affected often comprise a very significant portion of the African American community.

The sexual behaviors that we have described in this study are, we would argue, partially a reaction to these stressors. So too are the responses of the CBO's that are striving to serve them. We noted earlier that the findings we have reported would generate few, if any, surprises to HIV/AIDS prevention specialists and service providers. Although there are many questions about the "why" in Black male sexuality, the "what" – which is to say the list of behaviors that must be addressed in order to create effective HIV prevention and service campaigns – has been well understood since the early days of the epidemic.

In a 1999 study of the ability of the Ryan White Care Act to meet the needs of minority women living with HIV/AIDS in five US cities (Fullilove, Fullilove, Stevens, and Green, 1999), we noted that "In all five cities, the structural inequalities of American society were a significant factor in the local AIDS response. Race, ethnicity, gender, sexual orientation, and poverty contributed to every HIV-related interaction that researchers observed or participants described." We also reported that in many cities we observed evidence of services that approached the ideal for meeting the needs of the target population. We observed as well, however, that there was a significant level of unequal distribution of resources that had a negative impact on clients and providers alike. We concluded that there was not a lack of understanding of what to do as much as there was a lack of resources with which to do it.

The same might be said of the situation that confronts CBO's in the City and State of New York that must minister to the needs of Black males in general and of Black men who have sex with men in particular. The responses of providers demonstrated a significant level of understanding of this population and of its needs. We observed, as well, an almost universally expressed awareness of what might be done if these organizations had access to funding and assistance in building organizational capacity.

Recommendations

As we noted in the introduction, this paper is a follow-up to the 1999 report "Working Together to Save Our Lives: A Call to Action for Black Gay Men." That document provided a framework for our analysis of these two studies. Our findings strongly support a number of themes that emerged from that document.

Collaborations. The Call for Action urges public and private funders to develop strategies for resource/funding allocations that foster collaborations, perhaps by giving monetary incentives for service organizations and programs to work together on a common problem. It notes: "Given the severity of the HIV epidemic among African American gay men and the paucity of resources targeted to this population, pragmatism requires that stakeholders devise strategies for working together to respond to the crisis."

In this paper we suggest, as noted earlier, that a failure to generate such funding strategies has resulted in an unequal distribution of resources and the creation of an environment of competition. Such competition is divisive and has been cited by many providers with whom we spoke as the principal reason for a lack of continuity in many of the programs and services in the

HIV/AIDS field. “We live from grant to grant; if one of them isn’t refunded, we lose staff and we lose contact with our clients. Many of my staff have never worked in one agency for more than 18 months. It’s nuts. It guarantees that we will never have any long term impact on resolving the issues and problems that dog our community.”

Mental Health Services. The Call to Action notes that: “It is critical that the mental health issues of black gay men be examined and addressed in a comprehensive fashion. Racism, homophobia, classism and sexism are stressors that adversely affect the well-being and health outcomes of black gay men.” The findings that we have reported here confirm the existence of these stressors and the role that they play in sexual risk taking, in maintaining the dual identities of men on the “down low”, and in the anguish that many of our respondents expressed at being the objects of racism, prejudice, and community rejection. The pressure that many men described to maintain the appearance of being heterosexual emerges in our studies (and in a host of others) as one of the primary factors in the decision of many men to adopt a *down low* lifestyle. It also prevents many gay-identified Black men from engaging programs and services where they perceive there is a likelihood of being rejected or treated with scorn and contempt.

Organizational and Community Capacity Building. The Call to Action states: “The ability of Black gay organizations and the Black gay community to respond to the dual epidemics of HIV and substance use, and to develop and sustain health promotion behaviors and strategies must be strengthened.” The CDC (2000) has made technical assistance to community-based organizations that serve Black men who have sex with men a significant part of the Prevention Priorities in its Strategic Plan. However, funding for this initiative has been woefully inadequate. Thus, the demand dramatically exceeds the supply. Survey responses to the NYSBGN, as noted earlier, repeatedly underscored the need for such assistance in all areas of programming and management.

Program Evaluation. Many federal agencies and private foundations are demanding evaluation studies. They point out, as do many in the HIV/AIDS world, that there are a host of programs and services that have never been assessed to determine their effectiveness in meeting needs, changing behaviors, and improving health outcomes for their target populations. Many interventions that are currently in place are intuitive approaches to providing services to their clients. While there is often a great deal of anecdotal evidence that such programs work, eventually most, if not all, will be compelled to demonstrate their effectiveness using quantitative evaluation methods.

At present, the cost of creating a rigorous evaluation study is rarely included in the funding for a program. If dollars are provided for such a purpose, they are rarely sufficient to produce studies with the sophistication that is increasingly being demanded by funders and policy makers. HRSA’s Special Projects of National Significance (SPNS) was a step in the right direction because that agency invested considerable dollars in creating programs that were specifically designed to undergo thorough, rigorous evaluations. More SPNS programs – or better more programs based on the SPNS model -- are needed.

In the current funding environment, we cannot afford to pay for programs, services, and prevention interventions that are not having a significant impact. We are recommending, therefore, that the funding for program evaluation studies be made available as soon as possible. Moreover, we are recommending that those programs that have claimed success in meeting the

needs of Black men and which are hoping to be adapted by other organizations be given top priority for such funding.

Finally, as part of an effort to increase the organizational capacity of AIDS service organizations, we are calling for the creation of a core group of evaluation specialists with experience in working with communities and agencies of color. These specialists would be involved in the design and management of evaluation studies that are tailored to fit the needs of small CBO's.

Understanding the Social Contexts of Black Men Who Have Sex with Men. Our findings support the Call to Action's contention that "Environmental factors, including racism and homophobia, combine to create a propensity for unsafe and unhealthy behaviors among Black gay men. Estrangement from social institutions in the Black community, such as the church and family, and alienation from white society, also adversely impact on the health and mental health of these men."

One of the constants in the 22 years that this nation has been confronting the HIV/AIDS epidemic has been its impact on communities of color. In report after report, in study after study, a frighteningly similar pattern is observed. The gravity of the crisis is underscored in the statistics, in the findings of researchers, policy makers, and, it goes without saying, the men and women living with the virus. In the introduction to this paper we noted that the issue before the nation and its leaders is not what must we do, but when?

Table 4
Summary of Recommendations for Improving Programs
and Services to Men of Color Who Have Sex with Men

Collaborations

Create strategies that foster collaboration among CBO's that serve the HIV prevention needs of Men who have sex with men. Reduce competition between agencies that should be working together.

Mental Health Services

Develop programs and services to reduce the stressors that promote HIV risk behavior in Black men

Organizational and Community Capacity Building

Assist organizations that serve this population to increase their resource base and the organizational capacity to respond to the epidemic of STDs and HIV infection that are increasingly prevalent in Black communities statewide

Black Male Sexuality Study

Create a multi-focal study of Black male sexuality and sexual behavior. Sample populations should explicitly include the full range of sexual behavior in the Black community and as broad representation of ages as possible

Increasing Evaluation Capacity of CBO's

Provide CBO's with the resources to evaluate the many types of programs, services, and strategies for doing community outreach to men who have sex with men.

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