



RISE Proud: Combating HIV Among Black Gay and Bisexual Men

an action plan to mitigate the impact of HIV and AIDS on black gay and bisexual men

 NATIONAL MINORITY
AIDS COUNCIL
Building Healthier Communities



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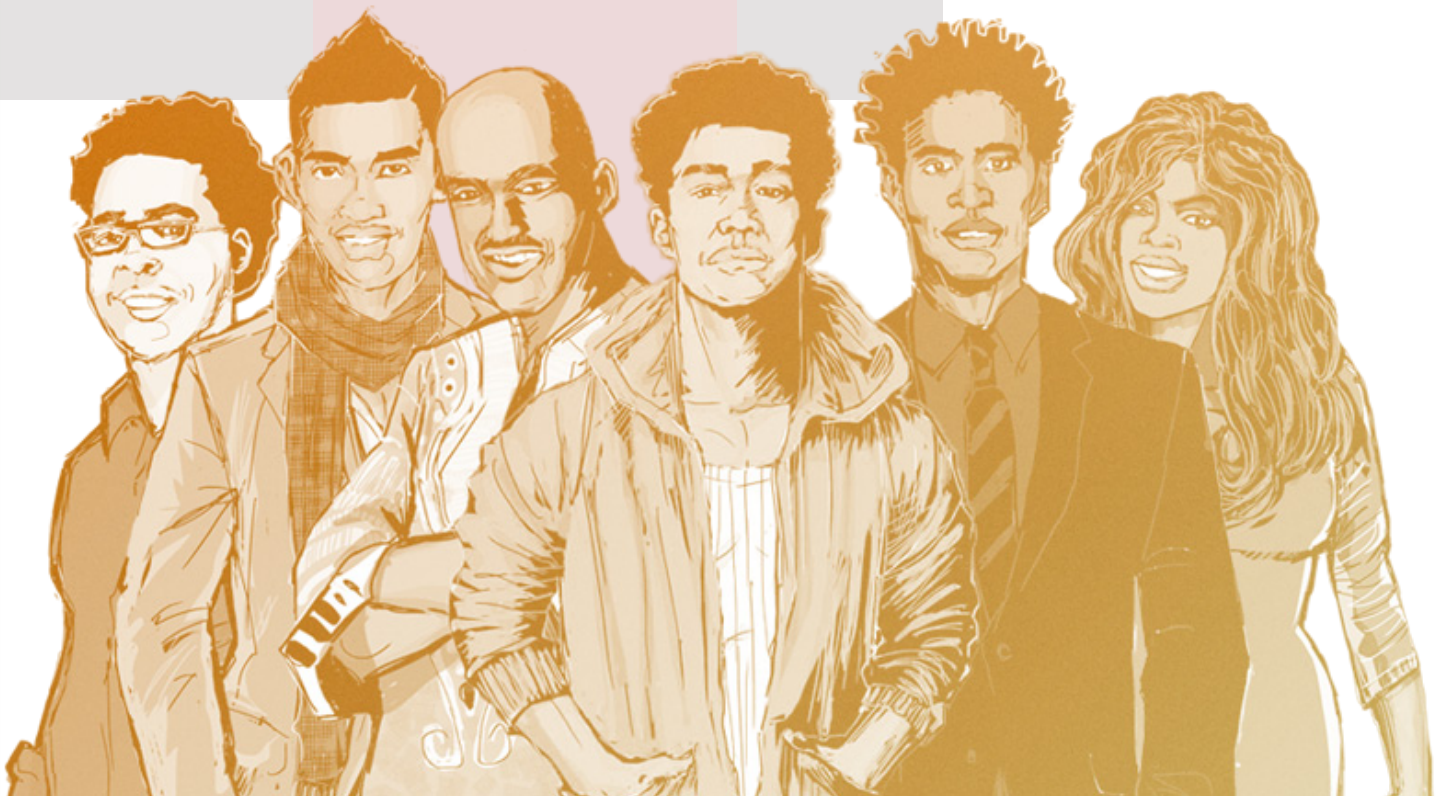
A report by the National Minority AIDS Council with support from the Ford Foundation.

“When new infections among young black gay men increase by nearly 50 percent in 3 years, we need to do more to show them that their lives matter.”

-- President Barack Obama, World AIDS Day, 2011

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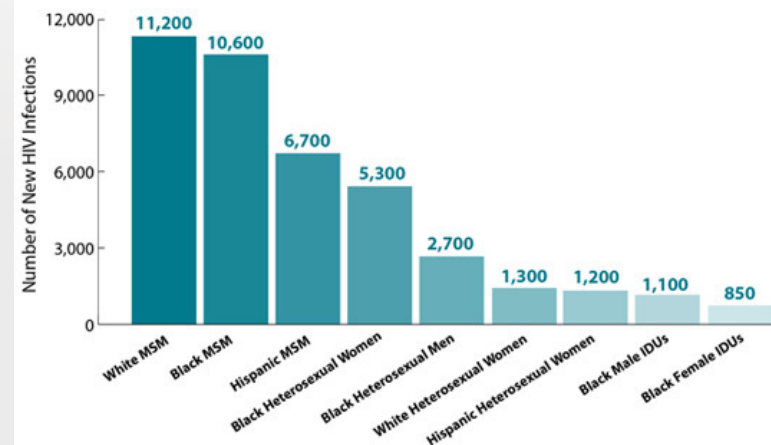
INTRODUCTION

Black gay and bisexual men bear the heaviest burden of HIV in the United States. Despite making up less than one percent of the overall population, they accounted for more than 22 percent of new HIV infections in 2010 (CDC, 2012). Between 2006 and 2009, young Black gay men saw a 48 percent spike in new infections, with those between the ages of 13 and 24 being especially hard hit (CDC, 2011). And for the first time in 2011, the estimated number of new HIV infections among Black gay and bisexual men surpassed that of their White counterparts (CDC, 2013). Same-gender loving Black men also experience significantly poorer health outcomes than their white brethren. This report and the recommendations made herein are the culmination of three years of work, supported by the Ford Foundation, to identify evidence-based approaches that must be prioritized to tackle the continuing and growing HIV crisis facing Black gay and bisexual men.

With the release of the National HIV/AIDS Strategy (NHAS) in 2010 there has been a renewed and reinvigorated focus on strengthening our national response to HIV. In 2011, then-U.S. Secretary of State Hillary Clinton committed America to realizing an AIDS-free generation. President Barack Obama reiterated this commitment several times, both in his 2011 World AIDS Day remarks and in his 2013 State of the Union speech. Indeed, in his World AIDS Day remarks, the President recognized the disproportionate toll this epidemic has had on Black gay and bisexual men by stating we must do more to show that “the lives of Black gay men matter.” And last year Executive Director of UNAIDS Michel Sidibé opened the International AIDS Conference in Washington, DC not by speaking about sub-Saharan Africa, eastern Europe, or South America, but rather by highlighting the urgent need to expand our efforts in the United States, especially among Black gay, bisexual, and other men who have sex with men (MSM).

Improvements in HIV care and treatment have transformed the disease for many into a manageable, chronic condition. The release of protease inhibitors and the advent of Highly Active Antiretroviral Therapy (HAART) rapidly reduced the number of individuals dying from AIDS-related illnesses, from its peak of more than 50,000 in 1995, to an average of about 16,000 by 1997 (CDC, 1997). Still, more individuals die from AIDS in the United States each year than are murdered by a firearm, another epidemic which continues to plague the Black community. HIV is only manageable if individuals identify their infection early; have access to sustained quality healthcare; and can effectively

Figure 1: Estimated New HIV Infections in the United States, 2010, for the Most Affected Subpopulations



manage adherence to treatment. For the most part, myriad social and structural conditions have resulted in less benefit for black gay and bisexual men in the United States from the advances in medical care and prevention research, when compared with their white and heterosexual counterparts.

At more than 25 percent, Black gay and bisexual men in the United States have the highest HIV seroprevalence of any group in the nation (CDC, 2005). As a population, Black gay men are more heavily impacted than that of South Africa, whose rate is 18 percent (UNAIDS, 2013). This should not be the case in a country with such immense resources as the United States. This startling trend persists in spite of the fact that Black gay and bisexual men typically engage in less risky sexual behavior – i.e.

lower rates of unprotected sex and fewer sex partners – than other gay and bisexual men (Marks et al, 2005; Koblin et al, 2006). What’s more, many Black gay men already have access to high quality health services, but feel estranged from the environments in which they are provided. Efforts to actively target resources proportional to the epidemic’s impact on this population are a relatively new development. As a result, it is imperative that we examine the context that gay and bisexual men access and manage their sexual health and do more to address the social determinants that impact their health outcomes.

As a community, lesbian, gay, bisexual and transgender (LGBT) Americans have made incredible strides in the struggle for equality. Twenty-one states and the District of Columbia, now have laws that prevent employment discrimination for LGBT individuals. Eighteen states allow gay couples to adopt children. Sixteen have passed legislation protecting LGBT students from discrimination, with another fifteen specifically protecting LGBT students from bullying. Gays and lesbians can now serve openly in the military. And as of June, 2013, 12 states and the District of Columbia have legalized same-sex marriage with more than half of all Americans supporting marriage equality, including the first-ever sitting president, also a Black male.

Indeed, within the Black community, perceptions around homosexuality are shifting more rapidly than ever. Not only has the first ever African American president come out in support of gay marriage, but so has the National Association for the Advancement of Colored People (NAACP). Hip hop music, which has historically been extremely hostile to gay men, has seen several leading artists come out in support of equality, including Jay Z and Macklemore & Ryan Lewis. Even the arena of professional sports, previously a stronghold of hetero-normativity, has seen Jason Collins, a professional basketball player come out, while Brendon Ayanbadejo of the Baltimore Ravens actively campaigns for marriage equality. Both men are also Black.

But while these advances are impressive, stigma around homosexuality – especially as it relates to HIV – remains a significant factor in the perpetuation of this epidemic. Both homophobia and a general emphasis on hetero-normative behavior remain strong in much of the black community, especially in America’s South, which has seen an explosion of new HIV incidence in recent years and continues to struggle with decades of insufficient health care access and poverty. Coupled with the wide swath of competing challenges facing Black gay men, including housing insecurity, lack of familial support and limited employment opportunities, the ability to effectively combat the spread of HIV and ensure positive health outcomes for those living with it becomes an almost herculean task.

Stigma around homosexuality - especially as it relates to HIV - remains a significant factor in the perpetuation of this epidemic.

As such, the National Minority AIDS Council (NMAC), with the support of the Ford Foundation, embarked on a multi-year project to examine the available research and existing interventions focusing on black gay and bisexual men to develop an evidence-based action plan to address structural and societal contributors to HIV vulnerability among this population. NMAC held a series of focus groups with Black gay men across the country, partnered with the Johns Hopkins Bloomberg School of Public Health and empaneled a group of black gay men with relevant subject matter expertise to help develop recommendations to best address the most critical needs of this community. This report and its accompanying recommendations are the result of that process.

CRIMINAL JUSTICE

In the United States, the criminal justice system must be referenced in any exploration of health outcomes for Black men and, moreover, Black gay men.

At any given time in this country, seven percent of Black men are confined within a correctional institution (BJS, 2011). Black men are more likely to be incarcerated than any other racial or gender group (Pew, 2008). Furthermore, 33 percent of Black men will be incarcerated during the course of their lives (BJS, 2011). For perspective, there is approximately the same number of Black men currently incarcerated as the number of Black men who attend higher education institutions (JPI, 2002). The disproportionate number of Black gay men entering correctional institutions at least once in their lives is an especially salient, and detrimental, phenomena. The BROTHERS Study from the HIV Prevention Trials Network showed that up to 60 percent of Black gay men in urban centers have a history of incarceration (HPTN 061, 2012).

A constellation of social and economic challenges, as well as structural racism endemic within the American criminal justice system, contribute to the over incarceration of both Black men and Black gay men (NMAC, 2013). It is well established that incarcerated males of any sexual orientation have suffered from childhood sexual abuse (CSA) at a higher rate than the general male population (Johnson et al, 2006; Weeks, Spatz, 1998). Trauma suffered from CSA for people with limited access to health care leads to undiagnosed or untreated mental health illness (Spataro and Mullen, 2004). Depression is the foremost mental illness facing Black gay men (Reisner et. al, 2009). Its symptoms, both inside and outside of prison walls, have been shown by behavioral researchers to be associated with increases in the number of sexual partners and unprotected sex yielding more frequent sexually transmitted diseases, including HIV (Reisner, 2009).

Many Black gay men experience social isolation, deprived of familial and community support (Stokes et. al, 1996). This is in addition to the

limited vocational opportunities available to these Black men, especially those who identify as gay or bisexual (Moodie-Mills, 2012). Gender non-conforming and effeminate men experience higher levels of unemployment than more masculine men (Sears et al, 2009). To provide for themselves, many of these men turn to commercial sex work or transactional sex to pay for food and stable shelter. Commercial sex puts a person at higher risk for HIV infection, due to increased sexual partners and decreased power to negotiate condom use (Johnson et al, 2006). Additionally, commercial sex work is a unique contributing factor in the over incarceration of Black gay men throughout the country (Fondacaro et al, 1999).

Black gay men who participate in commercial sex work often do not have access to

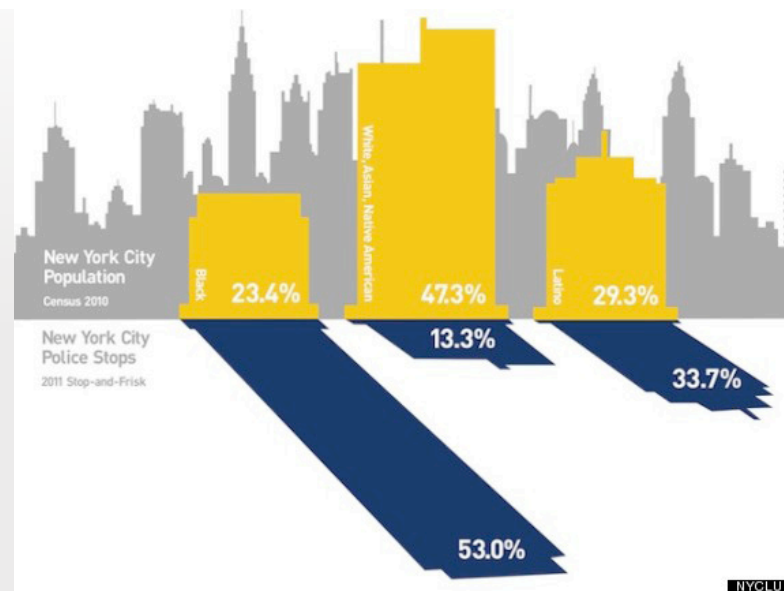
regular and routine healthcare (Jones et. al, 2009). For example, Medicaid is focused on assisting low-income individuals with specific disabilities, as well as low-income mothers and their children. Without access to private or public health insurance, many commercial sex workers do not seek medical attention until HIV or an STI has progressed and begins limiting activity or causes extreme pain (Olga et al, 2003). Due to limited access to employer-based or publicly funded healthcare for sex workers, initial contact with medical providers for HIV testing and treatment typically occurs within an incarceration setting (Olga et al, 2003). Such settings may be the first time a sex worker is educated on how to protect himself and his sexual partners from HIV infection (Olga et al, 2003). Hopefully, these barriers will cease to exist for this vulnerable population after the full implementation of the ACA, and accompanying Medicaid expansion.

Studies show up to 60% of Black gay men in urban centers have a history of incarceration.

Destructive and non-supportive life experiences are stressors faced by many Black gay men leading to higher levels of depression (Graham et al, 2011). These stressors may vary in scope and intensity in various regions around the United States. For example, Black gay men in the South may experience more structural and overt racism from Whites while also coping with social isolation from a familial perspective due to one's sexuality. Meanwhile, Black gay men in the Northeast may experience more stress from living in neighborhoods where simply walking down the street may evoke constant anxiety due to fear of physical violence. A team of social scientists concluded that there is no clear causality between mental illness and the HIV disparities of Black men versus White men (Maulsby et al, 2013). However, mental health acts as a contributing factor to HIV-risk behavior in concert with other sociopolitical challenges Black gay men face on a daily basis (Robinson and Moodie-Mills, 2012). For instance, hetero-normative valuation surrounding sexual orientation is the standard expectation within most cultural circles of Black America. The reduced self-image of being classified outside the accepted orientations and identities leads many Black gay men into destructive anti-social activities, such as the aforementioned commercial sex work and drug abuse that often lands them on the other side of a jail wall (Graham, 2012).

Furthermore, Black gay men are as susceptible, if not more so, to unfair, systemic, and racist policing practices. The Bureau of Justice details the plight of Black men and youth in this country. Black youth are arrested at a far higher rate than non-Black youth for the same infractions, and 58 percent of Black youth are sentenced to adult correctional institutions and receive longer sentences than their non-Black peers (BJS, 2010). When Black gay men do leave prison, they face significant challenges reintegrating into general society. These challenges are often exacerbated by limited employment opportunities available for men perceived as non-gender conforming, especially for men with a criminal record (Ramaswamy, 2012).

In some cities, specific policing policies such as 'Stop and Frisk' and 'Condoms as Evidence' contribute greatly to the criminalization rates of Black gay men (HRW, 2012). The 'Stop and Frisk' program, originated in New York City and Philadelphia, allows police to stop, question and frisk a person when a police officer feels that person has committed a crime (Weir, 2013). In practice, over 90 percent of those that the police choose to 'Stop and Frisk' are Black or Latino (CCRJustice, 2012). Currently, the program is under judicial



review in the federal courts due to alleged 5th and 14th Constitutional amendment violations (Floyd v. City of New York, 2011). Other jurisdictions are considering implementing the same policy (Costantini, 2013).

Of further concern to many LGBT youth and young Black gay men, is the fact that police employ these 'Stop and Frisk' and 'Condoms as Evidence' policies to arrest many individuals and charge them with prostitution based on the fact that the person was carrying multiple condoms (HRW, 2012). The assumption is that someone carrying multiple condoms is intending to engage in sex work. Quite often, those youth who are stopped not only are racial minorities, but are LGBT-identified or non-gender conforming (Center for Constitutional

Rights, 2012). This practice undermines safer sex public health initiatives to improve health outcomes through condoms. It is well documented that condom use, especially by youth, lowers the transmission of HIV and STIs (CDC, 2013). As with ‘Stop and Frisk,’ the practice of police using Condoms as Evidence for prostitution is facing court challenge (Center for Constitutional Rights, 2012).

Both law and law enforcement continue to have a direct role in society’s perception of HIV and fueling stigma associated with the disease. Laws criminalizing HIV non-disclosure and exposure vary widely between states. For instance, having sex with knowledge of one’s positive serostatus can result in misdemeanor charges in some states, as well as felony charges in others. Moreover, the United States has prosecuted more people for alleged HIV transmission or exposure than any other country worldwide (UNDP, 2011). Statutes criminalizing HIV transmission and exposure perpetuate outdated public health information and contribute to the continued stigmatization of HIV-positive people (UNDP, 2012). In some states, if a person with knowledge of his or her positive HIV status engages in sexual activity without disclosing, then criminal liability may ensue.

The requisite criminal intent element of HIV transmission laws is predicated on knowing one’s HIV status. This creates a correlative incentive to not learn one’s HIV status in the first place, limits individuals’ willingness to disclose their status, and additionally increases stigma for people living



with HIV (PLWH). HIV criminalization laws were created to force PLWH to disclose their status prior to consensual sex. The conjecture is that a person who knows that he/she is HIV-negative or status-unknown may decline sexual contact with an HIV-positive partner. These laws do not receive universal support throughout the United States, with 14 states not having specific HIV criminalization of transmission and exposure statutes (UNDP, 2012).

While HIV-specific transmission and exposure statutes contribute to the over criminalization of Black gay men, incarceration settings present an additional challenge to the health and HIV vulnerability of these men. It is estimated that at least 1.5 percent of prisoners are HIV-positive, which is four times that of the general population (BJS, 2010). For incarcerated Black gay men aware of their sero-positivity, a new set of issues arises around disclosure to medical providers in detention facilities. Due to the nature of the prison setting, prisoners often do not have privacy, even from other prisoners, when they speak to clinicians. And many non-clinicians such as law enforcement and guards often have access to medical records and may share this protected health information with other prisoners or coworkers. Being outed about one’s HIV status can lead to ostracism or the threat of harm from an inmate from other prisoners. Furthermore, some prison systems segregate HIV-prisoners from the rest of the inmates, which exacerbates the trauma already associated with being incarcerated (Jeffries, 2013). South Carolina and Mississippi currently maintain this practice while the state of Kansas is currently assessing whether it should. A federal judge in Alabama stopped HIV-positive population segregation in that state, stating it violated the protections afforded from the Americans with Disabilities Act (Henderson et al v. Thomas, et al, 2012).

Notwithstanding, many prison systems do attempt to ensure a full complement of care for incarcerated individuals, including Directly Observed Therapy (DOT) for inmates with medication

adherence problems (HRSA, 2011). Mental health consultations also help identify when depression and other illnesses are more prevalent among inmates, which can lead to medication adherence problems (HRSA, 2011). Furthermore as inmates reintegrate into society upon release from jail or prison, some incarceration systems ensure that the patient is appropriately linked to HIV care outside of the prison and provide a temporary supply of antiretroviral medication to avoid treatment interruption (NYSDOH, 2008). This is an especially critical protocol for Black gay men, who face tremendous challenges with stable housing, poverty, and access to regular healthcare. These programs are not uniform throughout the country so many newly released prisoners may reintegrate into the public without this support, suddenly responsible for maintaining their health status in addition to daily priorities (Stephenson and Leone, 2005). Again, this is a salient issue for Black gay men who face a landscape of poverty and social challenges beyond the prison wall.

An additional concern about HIV in prison settings is access to condoms for sexually active inmates, which are banned in many correctional setting. Rep. Maxine Waters (D-CA) has introduced the Stop AIDS in Prison bill in numerous sessions of Congress to make condoms available in federal prison settings. Rep. Barbara Lee (D-CA) has repeatedly submitted bills to Congress that would ensure that prisons provide condoms to men in federal prisons and faced considerable opposition. Opponents of the bill believe distribution of condoms will encourage prisoners to have sex, an act forbidden in many state systems, while supporters contend it is another tool to curb the spread of HIV both within prisons and the communities that prisoners return to upon release. Condom distribution in jails is decided upon by local jurisdictions; therefore, there is no set national standard that must be followed. To date, there have been no documented negative ramifications from allowing access to condoms in prison settings (WHO, 2007).

RECOMMENDATIONS

Address the role that the Criminal Justice system plays in impacting the rate of HIV infections for Black gay, bisexual, and other men who have sex with men

- I. HIV-specific statutes criminalizing transmission and exposure must be eliminated to reduce HIV-related stigma and to support best public health practices, which encourage knowing and disclosing one's HIV status
- II. Policing procedures, such as Stop and Frisk and Condoms as Evidence, must end to reduce the amount of undue stress on Black gay men that also discourages carrying prophylactics necessary to prevent HIV/STI infection
- III. Department of Corrections must review statutes and sentences of laws that disproportionately affect Black Americans to reduce the stigma and stressors experienced by Blacks with no actual improvement to public safety
- IV. HIV screening during intake into state prisons must be enacted and routinely repeated every six months during incarceration on an opt-out basis to help identify undiagnosed inmates who will benefit from treatment before disease progression
- V. Condoms must be made available to inmates to prevent HIV/STI transmission
- VI. Compulsory HIV education courses need to be prepared for correctional officers and for prisoners to reduce HIV-related stigma and to better understand the actual routes of HIV transmission
- VII. A program must be created to enroll low-income prisoners in Medicaid who do not have, but desire, access to healthcare
- VIII. Prisoners should be granted greater privacy for their health related information to improve

healthcare engagement and reduce isolation within the prison walls

IX. Department of Labor must examine and eliminate, when unjustified, policies that ban felons from various vocational opportunities

X. Department of Education must eliminate the preclusion of certain felons from receiving federal aid to attend post-secondary institutions

SOCIAL DETERMINANTS

For Black gay and bisexual men, the HIV/AIDS epidemic is predominantly characterized by social, political, and economic challenges that contribute to a heightened vulnerability to HIV infection. These challenges — also referred to as social determinants — impact the trajectory for an individual’s education, employment, housing security, health outcomes, and intrapersonal quality of life. Social determinants are defined as “relevant broader social structural forces [that] influence health through their effects on individual characteristics” (Martikainen et al, 2002). The role that any specific social determinant serves as a proximate cause to HIV vulnerability varies by individual, but when aggregated, these factors lend a causal and correlative explanation to health-related behaviors and accompanying health outcomes for targeted demographics. Dr. Perry Halkitis evidences this point articulately: “HIV cannot be considered in isolation. The HIV epidemic is inextricably tied to other health and social conditions including, but not limited to, psychological comorbidities, substance abuse, poverty, and discrimination. It has been posited that HIV and other health problems overlap and ‘fuel’ each other and create a mutually reinforcing cluster of epidemics, known as a syndemic, that results in higher rates of HIV infection and AIDS” (Halkitis et al, 2013). Consequently, to effectively reduce new infections for Black gay men, and improve health outcomes for those men already living with HIV, a detailed examination into the role that social determinants play in HIV prevention and intervention must proceed. The charge of this section is to recommend

interventions to social conditions for Black gay men to reduce HIV vulnerability.

The American public education system poses a significant structural and institutional challenge that contributes to a cascade of negative social, economic, and health outcomes for Black gay men that increase their vulnerability to HIV infection. Attained education level is a strong predictor of poverty, with poverty being perhaps the most significant environmental correlative of HIV infection (Denning and DiNenno, 2013). Race-based inequality is deeply rooted in the fabric of America’s public school system, beginning in the Reconstruction era and exacerbated by Jim Crow laws. And while schools were integrated almost 60



years ago, following the 1954 Supreme Court ruling *Brown v. Board of Education*, significant disparities remain. Black youth continue to report high school graduation rates and enrollment in higher education that are below the national average. Black men have the lowest high school graduation rate in the country at 47 percent, which is 11 points lower than Latinos and nearly 28 points lower than that of non-Hispanic white men (Schott, 2012). High school dropouts earn \$17,000 annually, whereas people who earn their diplomas earn \$27,000 per year (U.S. Bureau of the Census, 2006).

Black gay youth are more prone to drop out of school than their counterparts, partially due to the lack of support at home (Dunn and Moodie-Mills, 2012). Black gay men experience “high rates of rejection, violence, and discrimination within their families and churches,” resulting in instability that

interrupts or ends engagement in the educational process (Moodie-Mills, 2012). "Many ethnic minority communities strongly reinforce negative cultural perceptions of homosexual orientation," exacerbating stigma for young Black gay men at home and jeopardizing school attendance (Advocates for Youth, 2002).

Sexual orientation is a salient factor in the academic performance and success of young Black males. Students who identify as gay dropout at a rate of 33 percent and are 4.5 times more likely to skip school because of safety concerns as compared to other students (Lambda Legal, 2013). 44.7 percent of LGBT students of color face harassment based on both their sexual orientation and ethnicity (Lambda Legal, 2013). This research demonstrates that schools do not consistently foster environments conducive to achieving academic success.

Additional research demonstrates that gay youth of color who are bullied at school earn a GPA at least a half point lower than their non-bullied peers (Diaz and Kosciw, 2009).

Not only is our public school system failing America's black youth in terms of their educational success, but it is also failing to empower them to make positive sexual health choices. Schools have the ability to provide students with knowledge about effective ways to prevent acquisition of HIV and other sexually transmitted infections (STI) through direct education. Youth, under the age of 25, represent 25 percent of sexually active persons in the US; as well as half of all new STIs, which are higher among racial/ethnic minorities (CDC, 2012). Moreover, young Black gay men account for approximately 10 percent of all new HIV infections, despite making up less than 0.5 percent of the total U.S. population (CDC, 2012). There has been a long-standing debate regarding the type of education youth should receive in schools related to their sexual health, such as abstinence-only education versus comprehensive sex education. Systematic reviews of research on the topic have shown that the benefits of "abstinence-only programs on sexual behavior have been minimal, and that initiation

of sexual activity is not hastened by receiving instruction about measures for safer sex" (Kohler et al, 2008).

Depending on the jurisdiction, many schools offer comprehensive sex education to students. However, comprehensive sex education initiatives typically are heteronormative, devoid of material related to anal sex and safer sex activities keyed to younger gay men. There are "virtually no studies [that] have looked to assess the experiences of such a curriculum for gay and bisexual male youth" (Fisher, 2009). Young gay men of color have voiced the need for educational programming that addresses dating, intimacy, self-esteem, sexual identity, and inclusion of sexual practices (Seal et al, 2000). The importance of educating these men is underscored by the fact that Black high school students report having engaged in intercourse at a rate of 60 percent compared to 49 percent for Latinos and 44 for Whites (KFF, 2011). This describes an opportune environment for age and culturally appropriate sexual health education.

Knowledge of safer sex practices is not independently sufficient to reduce the rates of HIV/STI acquisition. A secure home environment is also an incredibly important factor in achieving positive health outcomes. Unstable housing can often lead to higher-risk sexual behavior and increased risk of infection (Rew et al, 2005; Ebner & Laviage, 2003; Gangamma et al, 2008) and unstable housing disproportionately affects the Black community – over 50 percent of people utilizing emergency shelters are Black (SAMHSA, 2011). Furthermore, in large urban centers, the proportion of chronically homeless individuals who are Black and male surpass 90 percent (SAMHSA, 2011). Additionally, LGBT youth are overrepresented in the homeless population, estimated in the range of 11 to 35 percent (National Coalition for the Homeless, 2009). Newly homeless LGBT youth have been shown to have greater sexual risk behaviors, including higher numbers of sexual partners, decreased condom use, and greater rates of participation in transactional

sex compared to their stably-housed counterparts (Solorio et al, 2008).

For individuals living with HIV, homelessness is a real-threat to livelihood and can begin a long downward cascade reducing quality of life. People living with HIV (PLWH) “risk losing their housing due to compounding factors, such as increased medical costs and limited incomes or reduced ability to keep working due to AIDS and related illnesses” (HUD, 2013). Homelessness becomes a catalyst towards progression to an AIDS diagnosis since adherence to an antiretroviral therapy (ART) becomes more difficult. Non-adherence to ART often leads to advanced HIV disease and ultimately AIDS (Bangsberg et al, 2001). For HIV-positive persons on ART, the paramount goal for optimal health outcome is to attain viral suppression (such that viral copies remain under 35 per milliliter). Considering that only 21 percent of HIV-positive Blacks are virally suppressed, and constitute over 50 percent of shelter patrons, the issue of housing is especially salient for HIV prevention and improving health outcomes for Black gay men already living with the disease (CDC, July 2012). Access to stable housing allows a person to store their medication properly and maintain consistent communication with a medical provider. And most importantly, stable housing means that the daily pressure of procuring housing will dissipate and transitionally-housed individuals will be able to better focus on health maintenance.

To specifically protect people with AIDS, the U.S. Department of Housing and Urban Development (HUD) created the Housing Opportunities for Persons with AIDS (HOPWA) program to assist people infected and affected by AIDS. The HOPWA program assists people with AIDS in procuring emergency transitional housing, as well as long-term housing when resources for the individual or caregiver are insufficient to meet the cost of stable housing (HUD, 2013). Congress has considering legislation, specifically the Housing Opportunities Made Equal Act, which would indirectly assist Black gay men through provisions that explicitly prohibit

discrimination in the sale or rental of housing and related services based on sexual orientation gender identity, race, and marital status.

Fostering or maintaining a stable living situation is most easily attained through substantial and consistent employment. In the United States, the “average unemployment rate for Blacks in 2011 was 15.8 percent, compared to 7.9 percent for Whites, and 11.5 percent for Hispanics” (DOL, 2012). Blacks are also less likely to find employment once unemployed “with a median duration of unemployment of 27.0 weeks (compared to 19.7 for Whites and 18.5 for Hispanics)” (DOL, 2012). The Department of Labor attempts to combat unequal hiring practices through affirmative action enforcement by the Equal Employment Opportunity Commission (EEOC), which now recognizes gender identity as a protected class and discrimination against the class as sufficient to bring a claim (Macy v. Holder, April 2012).

As with education, housing, and employment, race and sexual orientation play major roles in creating the social and economic conditions that make one more vulnerable to HIV infection. Black gay and bisexual men must overcome the myriad of aforementioned social determinants, which are often magnified for racial/ethnic minorities, since an individual may “experience stigma and discrimination not only due to their sexual orientation but also due to multiple intersectional identities” (Halkitis et al, 2013).

The stigma that Black gay men face presents itself in times of greatest need as well. Gay and bisexual men are often more likely victimized by sexual partners. “Approximately 1 in 3 gay men (32.3%), 1 in 5 bisexual men (21.1%), and 1 in 10 heterosexual men (10.8%) reported experiencing unwanted sexual contact during their lifetime” (Chen & Breiding, 2013). Abuse between males often goes unreported due to the assumption that law enforcement personnel “are unknowledgeable, unsympathetic, and perhaps even hostile toward them” (Herek & Sims, 2008). Moreover, victims of intimate partner

violence (IPV) often experience re-victimization after the event. Since the majority of IPV criminal statutes are written for opposite sex state-sanctioned marriages or common-law relationships, there are no written protections for men in relationships with other men. “Consequently, male victims of IPV from a same-sex partner often are unable to find appropriate assistance [making] it difficult for gay and bisexual male IPV victims to seek help, receive treatment, and leave abusive relationships, thereby exacerbating the extent and severity of their abuse and complicating their recovery from it” (Herek & Sims, 2008).

For some members of the Black community, faith-based institutions provide a critical support and buffer to the institutional biases in the larger society and help foster a sense of community for members around societal challenges. For many in the Black community, “Christianity guides religious expression and worship. Many African Americans participate in religious worship or are affected by what is known as ‘the black church’” (Miller, 2007). Often times, the Black Church is at odds with effective HIV prevention messaging and holistic support for HIV-positive individuals. Tension exists between perceived scripture and the Christian sentiment to aid those in need (Fullilove & Fullilove, 1999). As an institution that typically provides support and care for the Black community, the Black Church may ironically hinder a person from seeking out or receiving quality medical care as perceived “external stigma can be internalized by PLWH, resulting in negative self-image, feelings of shame or guilt, and other manifestations of internal (or felt) stigma... [which may manifest by] poor access and adherence to HIV medical care, and high-risk sexual practices” (Wolitski et al, 2009).

As with other social structures, the perception of the Black Church, other Black faith institutions, or generalized Black American culture as extensively homophobic is a proximate, rather than a direct, cause to heightened HIV vulnerability for Black gay men. Black gay and bisexual men also face other forms of stigma such as double standards that require

Black gay men to deny their gay identity in a Black context or have gay identity affirmed in the midst of racism within the gay community and beyond (HPTN 061, 2012). “Historically, black gays have received harsher treatment from society than white gays for being gay. Disparities in society’s treatment of black gays and white gays are reflected through the media, the legal system, as well as through the treatment received in health and mental health care. Charles Hughes commented as early as 1903 that, ‘the names of black gays, their feminine aliases and addresses appeared in the press notices of their arrest, while the names of the white consorts with them were not given’” (Icard, 1986). These types of double standards from culturally external sources coupled with adverse treatment from within their own racial/ethnic community can lead to a cascade of poor health behaviors and accompanying health outcomes.

The impact of social determinants on one’s health outcomes will vary by individual. Although, the full effect of stigma on Black gay men can be “described as ‘fragmented’ owing to denial of traditional opportunities for masculine affirmation (education, employment, property ownership) by institutional and personal racism” (Malebranche, 2003). Despite these challenges, Black gay men actively work to overcome their sense of oppression and isolation. At a community level, the coping strategies and resiliency of Black gay men to combat stigma have been tested at a very high level leading to chronic emotional stress (Meyer, 1995). The intersection of mind, body, and spirit encompasses the effects that education, healthcare, and familial interactions may have on health outcomes for an individual. These social determinants, affecting one’s health, should not be addressed individually, but must be addressed simultaneously in order to improve the health of any person or demographic.

RECOMMENDATIONS

Address the structural community-driven social determinants that lead to HIV infection and subsequent poor health outcomes for Black gay, bisexual, and other men who have sex with men

I. The media must be encouraged to better showcase supportive faith-based leaders who affirm Black gay men to encourage stronger relationships between the leaders and Black gay men

II. Encourage community support for churches that specifically address the holistic needs of Black gay men within their respective congregations to encourage the reduction of queer-related stigma

III. The Department of Education must be fully funded and empowered to enforce comprehensive sex education, inclusive of a discussion of gay sexuality, in public schools that gives students information to protect themselves and their partners if they choose to be sexually active

IV. The Department of Education must develop an objective measurement tool to assess the success of sexual health programs, such as a comparison of HIV/STI incidence before and after a program has begun, to provide the most effective and evidence-based harm reduction trainings

V. Resources must be available to provide workshops for the facilitators who teach sexual health to students to raise the level of cultural competency to better relate to students

VI. Community-based organizations should receive additional funding to build their capacity to teach and reinforce sexual health to community members

VII. Community-based organizations should receive additional funding for programming to help young Black gay men foster community with peers and mentors in order to reduce emotional distress and social isolation

VIII. Online social networks must be utilized to help

disseminate information to Black gay men in rural settings related to sexual health needs and affirming community support

IX. Legislation must be enacted to protect young Black gay men in public schools from abuse based on their race, ethnicity, or sexuality

X. Legislation must be enacted to support the victims of intimate partner violence with shelter, food maintenance, and available counseling

XI. Peace officers must be trained in proper responses to situations of intimate partner violence to ensure the victim is not re-victimized by the legal system

XII. Funding must be provided to LGBTQIA-serving community-based organizations to build capacity to support social workers who interact with gay men who are victimized by their intimate partners

XIII. Safe and stable housing options must be made available to transitionally housed individuals to avoid spiraling health outcomes

XIV. Homeless shelters must be supported to create safe spaces for young Black gay men to discourage transactional sex work

XV. The Department of Labor must promote the use of proactive diversity and inclusions language in hiring applications to expand awareness of employee rights and discrimination protections

XVI. Legislation should be enacted to protect LGBTQIA workers, including Black gay and bisexual men from discriminatory employment and hiring practices

ACCESS TO HEALTH CARE AND TREATMENT

African-American men, including Black gay and bisexual men, access health care at a significantly

lower rate than any other demographic in the United States. At the same time, they have higher rates of infectious disease, hypertension, cancer, diabetes, stroke, and cardiovascular disease as compared to other racial/ethnic groups (CDC, 2011). Blacks and Latinos are “less than half as likely as Whites to have a regular doctor” (NAACP, 2013). There are a number of factors that impact the lack of access to and utilization of health care services by Black men, including Black gay and bisexual men. One such factor is the system of employer-based health care coverage that has existed in the United States for many years. As employers are the primary provider of health insurance in the U.S., the higher rates of unemployment experienced by Black Americans means that many are locked out of the primary mechanism for coverage. Additionally, they report higher levels of discomfort with traditional healthcare settings, higher rates of incarceration, homelessness and also have more untreated mental illness. All serve as barriers to health care access for Black gay and bisexual men (Robinson and Moodie-Mills, 2012). In order to improve health equity among Black gay men, it will be necessary to change the structural dynamics/forces, beliefs, and behaviors that prevent them from accessing health care.

Perhaps the most significant opportunity to improve health care access for Black gay and bisexual men is the Patient Protection and Affordable Care Act (ACA), which was signed into law by President Obama in 2010, and will be fully implemented in 2014. The ACA is the largest reform to our nation’s health care system since President Lyndon B. Johnson signed the Social Security Amendments of 1965 that created Medicare and Medicaid. When fully implemented, the ACA will expand access to health insurance for more than 30 million Americans, including thousands of Black gay and bisexual men.

The ACA expands requirements that employers provide health care coverage to their employees, but also provides other avenues for accessing coverage, including insurance marketplaces for individuals to purchase coverage, with tiered subsidies up to 400 percent of the Federal Poverty Level, and expanded

Medicaid eligibility for individuals making up to 138 percent of the Federal Poverty Level. Providing access to health insurance alone is a critical step in improving health outcomes for Black gay and bisexual men. Research shows that uninsured Black men who have contracted an STI or HIV are less likely to seek care prior to the onset of complications from advanced HIV disease (Krawczyk et al, 2006).

The ACA also requires health insurance companies to cover all applicants at the same rates, regardless of gender, race, or sexual orientation, and outlaws denial of healthcare based on pre-existing conditions such as HIV (White House, 2013). For Black gay men living with HIV, the law guarantees access to health insurance by preventing insurance companies from placing lifetime spending caps on their coverage, as well as banning the practice of rescission, or dropping individuals from coverage once they are diagnosed with an illness. In 2010, only 13 percent of HIV-positive American residents had private health insurance (KFF, 2012). Now, Black gay and bisexual men both living with and vulnerable to HIV will have a real opportunity to obtain quality health care and treatment, improving their individual health outcomes, but also helping to prevent onward transmission.

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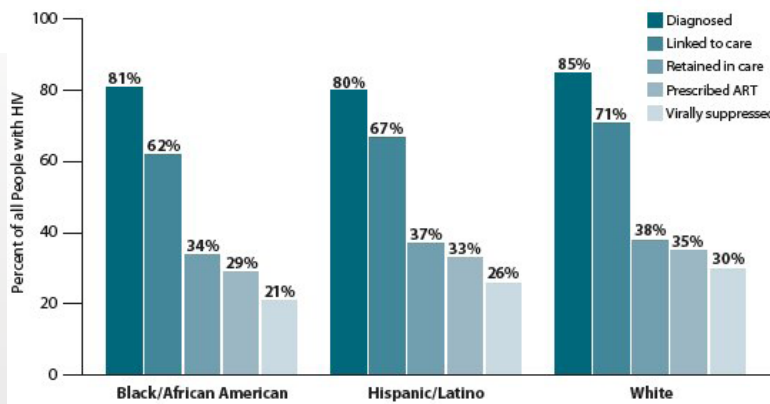
The ACA will also help people remain negative by increasing access to preventative health care. According to the CDC, Black gay men have an HIV infection rate almost 8 times higher than White gay men (CDC, 2012). Through expanded health coverage, both private and public, Black gay and bisexual men will be able to access preventive STI and HIV screenings at little or no cost. Specifically, the ACA will cover HIV screenings

for all individuals without co-pay. This provision is especially critical given that the CDC estimates that 1 in 5 HIV-positive individuals in the U.S. do not know his/her status (CDC, 2012).

Routine HIV screenings, which are now officially recommended by the US Preventive Services Task Force (USPSTF, 2013), will also help reduce barriers to HIV testing based on perceived risk determination by the physician. Physicians often miss opportunities to diagnose Black gay men due to reluctance to offer a screening, thereby delaying the initiation of treatment (Millett et al, 2011). These opportunities may stem from provider bias, cost, stigma, homophobia, or poor training of providers who perform sexual health screenings (Millett et al, 2011). Knowledge of one's HIV status and engagement in treatment, especially during the acute period immediately after sero-conversion, has a huge benefit not only on individual health outcomes, but also to public health as the newly-infected person can take immediate steps to reduce the risk of transmission through safer sex practices, as well as initiate antiretroviral therapy, which reduces viral load and risk of onward transmission. Undiagnosed individuals represent 20 percent of all HIV-positive Americans yet account for at least 50 percent of yearly transmissions.

Even with the expanded health insurance coverage that will accompany ACA implementation, significant barriers will persist that may limit the willingness of Black gay and bisexual men from accessing care. Black Americans, especially those of lower socioeconomic status, have historically higher levels of distrust for the healthcare system than the general public, and often delay necessary care or treatment as a result (Armstrong et al, 2011). For Black gay and bisexual men, this distrust also manifests itself in a pervasive unease with disclosing one's past sexual behaviors and orientation with their physicians. This challenge is further compounded by physicians' general discomfort with discussing sexual health and sexual orientation during examinations (Millett, 2012).

Over 63 percent of all HIV infections in the United States stem from male-male sexual contact, which correlates to 78 percent of all infections among men overall (CDC, 2013). Open and honest communication between health care providers, especially nurses, and Black gay and bisexual men is critical in successfully diagnosing HIV and STIs, as well as counseling around risk reduction strategies. Distrust of health care providers, including real



or perceived experiences of homophobia within traditional health care settings can reduce frank and honest interactions between Black gay men and their physicians (Klitzman, Greenberg, 2008). It is critical that medical practitioners are accessible and affirming with their patients and create an environment conducive to disclosure.

Black gay and bisexual men also face significant challenges in accessing care due to lack of transportation, food insecurity, mental health challenges, unstable housing, and inability to pay for services even with insurance. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was created by the US Government in 1990 to address the medical needs and supportive services of HIV-positive persons with limited resources by providing last resort direct client services for HIV treatment and related health completion services to ensure continual care such as case management, psychosocial support, treatment adherence, temporary housing, nutritional services and transportation for medical appointments. The Ryan White CARE Act also supports the health

service system through technical assistance and research support.

In practice, the legislation ensures HIV-positive individuals with no other means of paying for treatment have access to medical services and/or medication. As the ACA is implemented, and Black gay men gain access to health insurance coverage, the Ryan White program will remain critical in ensuring that necessary health completion services are available to assist Black gay and bisexual men engage in care. While the ACA may cover some of these services under its essential health benefits, many will remain uncovered, demanding a continued role for Ryan White (HHS, 2013).

Another provision of ACA that will help improve healthcare outcomes through centralized client-centered service is the medical home model. Patient-Centered Medical Homes aim to enhance primary care by building stable relationships between the health care provider and client, where the clinician directs prevention and chronic care management (Abrams & Stremikis, 2011). Black gay men could potentially partner with a healthcare group to alleviate anxiety from perceived stigma from unknown providers related to their race, ethnicity, and sexuality. These objectives could be met by the development of ‘health homes’ that “are similar to medical homes, but tend to emphasize the integration with public health” (Abrams & Stremikis, 2011). Medical homes may help improve the health outcomes for HIV-positive individuals who fall in and out of care due to lack of housing or vocational stability.

By law, the Ryan White CARE Act is a payer of last resort. As, it is unknown the final level of coverage each state will make available to its citizens after the full implementation of ACA, Ryan White funding will continue to be necessary to supplement any uncovered needs for PLWH. For instance, the ACA will not offer any healthcare for undocumented immigrants and subjects legal permanent residents to a five year waiting period. For HIV, STIs, and any other infectious diseases, public health departments

will struggle to control and prevent advanced consequences of infections for significant segments of the American populous. Finally, the drug formularies that will be covered in each program is only starting to become public. There will be an ongoing need for the AIDS Drug Assistance Program to fill any gaps that may occur due to prior authorization requirements or incomplete coverage.

While ACA implementation will expand much needed health coverage to Black gay and bisexual men, more attention and resources must be directed to outreach and navigation services to increase insurance enrollment and health care engagement. What’s more, given the reluctance of many Southern states to implement the ACA, many Black gay and bisexual men living in that region, which is already plagued by dismal health care infrastructure, will not benefit from its reforms.

RECOMMENDATIONS

The Patient Protection and Affordable Healthcare Act and other public health programs must be fully integrated into the plan to reduce HIV incidence for Black gay, bisexual, and other men who have sex with men through utilization of medical prevention and intervention resources

- I. HHS must prepare, in advance, to create Duty Stations in areas with high rates of HIV incidence in the South that may not fully implement ACA to ensure that all Black gay and bisexual men benefit from having increased access to quality healthcare
- II. Interagency coordination of federal bodies must continue to improve in order to foster transparent communication, pooling of resources, and best practices to benefit Black gay men
- III. Health & Human Services (HHS) must form a plan to specifically address enrollment of Black gay men into the ACA to help build the capacity of Black gay men to manage their own health

IV. HHS and the Department of Labor (DOL) must partner to ensure that PLWHA are made fully aware of the employment protections extended to all HIV-positive persons

V. HHS and DOL must engage state and federal prisons to create a program for released prisoners to gain employment as health navigators into ACA, which would assist with the ACA registration within their respective communities while also offering a source of income to the former incarcerated

VI. Oversight of the placement of Federally Qualified Health Centers and Federally Qualified Behavioral Health Centers must be implemented to ensure areas of high HIV incidence have an increased health provider density per capita to ensure accessibility to physical and mental health clinicians

VII. The National Institute on Minority Health and Health Disparities (NIHMD) must expand its mission to also focus on individuals who possess both racial/ethnic and sexual minority status to help reduce provider distrust and improve provider cultural competency through appropriate training on the needs of dual minorities, such as Black gay men

VIII. The NIHMD must develop appropriate trainings for physicians and other staff in Patient-Centered Medical Homes (PCMH) to competently engage with Black gay men on their holistic health needs to foster trust between the physicians and their respective patients

IX. Current PCMHs must be fully funded and subsequently expanded to all regions that have an increasing rate of HIV/STI acquisition among Black gay men

X. Opt-out testing should be implemented for all federally funded clinics and hospitals to reduce any missed opportunities to engage any undiagnosed HIV-positive individuals in appropriate care and treatment

XI. Formal reauthorization of the Ryan White CARE Act should be delayed until a thorough review of the changing needs of HIV-positive persons after full implementation of ACA

SUMMARY OF ACTION PLAN RECOMMENDATIONS

The National Minority AIDS Council, in coordination with the RISE Panel, developed a series of recommendations to reduce the impact of HIV/AIDS in the lives of Black gay and bisexual men. These recommendations were rooted in a comprehensive review of the best available behavioral and scientific research. The panel convened four times to discuss selected papers on salient topics directly attributable to the increasing incidence of HIV for Black gay and bisexual men. These discussions focused on formulating concrete recommendations for reducing the impact of HIV and AIDS, specifically for Black gay, bisexual, and other men who have sex with men (MSM). The proposed action items below are aimed at enhancing recommendations from previous public health task forces charged with confronting the disproportionate rate of infection for Black gay and bisexual men.

Due to the disproportionate numbers of incarcerated Black men in the United States, it would be shortsighted to not focus our attention on a system that holds over 33 percent of Black men captive at some point during their lives (BJS, 2011). While the panel's recommendations are focused on Black gay men, it acknowledges the extensive work that must be done to reduce the unjustifiable incarceration rates for Black men. As Attorney General Eric Holder acknowledged in April 2013, "Too many [Black men] go to too many prisons for far too long for no good law enforcement reason." Laws do shape public opinion.

The societal impact of HIV criminalization laws, for instance, specifically stigmatizes sexually active HIV-positive individuals as enemies of the state. They discourage HIV testing because knowledge of an HIV-positive status constructively forbids

sexual activity which is detrimental to public health. Research has shown that high-risk sexual behavior is much lower for people aware of their HIV-positive status than for those of unknown HIV status (Marks et al, 2005). Therefore, the public health benefit of eliminating HIV Criminalization laws demands immediate action, a position supported by the most recent resolution from the President’s Advisory Council on AIDS (PACHA). PACHA explicitly stated “that all U.S. law should be consistent with current medical and scientific knowledge and accepted human rights-based approaches to disease control and prevention and avoid imposition of unwarranted punishment based on health and disability status” (PACHA Criminalization Resolution, 2013).

Policing procedures such as Stop & Frisk must also be discontinued. That practice disproportionately targets Black men, adding to the chronic stress experienced by Black gay men which is associated with high-risk sexual behavior (Meyer, 1995). Furthermore, the utilization of Condoms as Evidence to be cause for arrest for commercial sex work is a direct assault on public health initiatives that encourage condom usage to prevent the spread of HIV. It is imperative that laws reflect the best interests of the public. These police practices are detrimental to public health.

It is estimated that up to 60 percent of Black gay men have been incarcerated at one point in their lives (HPTN, 2012). Since one of the goals of correctional institutions is rehabilitation of individuals so that they may be productive members of society, prisons must encourage healthy behaviors within and beyond their walls. Upon entry into state prisons, HIV testing should be universally implemented, unless the person explicitly states that they do not want to be tested, a practice which already exists in federal penitentiaries. Furthermore, condoms must be made available to all prisoners to protect themselves from HIV and STIs; with HIV/STI screenings offered regularly to ensure that a newly-diagnosed person receives treatment early in the course of infection to avoid

poorer health outcomes and possible transmission. Viral suppression has been shown to reduce HIV-associated mortality and reduce the ability of an individual to infect their sexual partner(s) (Nakagawa et al, 2012; Fisher et al, 2010). These recommendations not only protect the health integrity of individual prisoners, but also the communities that they return to upon release.

While in prison, it is necessary to reduce the amount of prisoner-experienced stigma, as it is a confounding factor to the real stressors from losing one’s freedom. HIV-related stigma increases when HIV-positive prisoners are segregated from other inmates. That practice must end, but it must be done in coordination with increased education to prisoners and correctional officers regarding routes of HIV transmission— infection is impossible from sharing toilets, food, or through spitting. Education for both inmates and correctional officers will reduce fear from misinformation and misunderstandings about infection routes, while also helping to prevent infection from real transmission routes.

Correctional settings provide a critical opportunity and have a public duty to help newly released individuals reintegrate into society. Assistance with enrollment into a stable healthcare network is essential for PLWHA to maintain adherence to medication (HRSA, 2011). With the full implementation of the Patient Protection and Affordable Healthcare Act (ACA) in January 2014, there is an opportunity to help released prisoners who reintegrate into society maintain their healthcare by enrolling them into the program. Prisons must be mobilized to assist released inmates in enrolling in ACA programs for the benefit of general public health, as well as for the former inmate and his respective family and sexual network.

As stated, Black gay men face many academic achievement challenges. These challenges are compounded for men who have a felony on their record. For example, it is forbidden for some felons to receive federal aid for college grants and

felons are restricted from applying to jobs such as educators, peace officers, and sanitation officers. Access to work directly affects access to housing, improved quality of life, and healthcare maintenance. These vocational restrictions or laws on employment should be examined and eliminated wherever possible.

The charge of the panel was also to explore the root causes for the increasing rates of HIV infection experienced by Black gay men. The panel's diversity of members was geographically and vocationally diverse, and included men in their twenties, thirties, forties and beyond. They examined the social determinants that may explain why young Black gay men continue to have an increasing incidence (CDC, 2012). Conventional wisdom states that since Black gay men report less high-risk sexual behavior than they should have a lower incidence of HIV infection, but that is not the case (Millett et al, 2006). Therefore, the panel reviewed the contributing societal factors that may contribute to higher rates of infection.

The faith-based community and the public school system were identified as the two largest entities that directly affect young Black gay men's health-preserving and health-seeking behaviors. Faith based institutions such as the Christian church and the Nation of Islam have received considerable media attention for not being supportive of young Black gay men, despite the fact that many offer HIV/AIDS support ministries. The panel noted that the media should do more to highlight faith-based leaders who provide affirmative environments and encourage community support for gay men, especially those who are living with HIV. Continued engagement of the faith-based community is necessary to foster a better relationship between its leadership and Black gay men who are part of the congregation.

It is also vital to address the challenges faced by Black gay men in school settings. First and foremost, students must receive comprehensive sex education; and a mechanism of enforcement must

be developed to ensure it is delivered properly. The teachers who facilitate the coursework should also be trained on how to deliver preventative messages confidently with inclusion of all forms of sex, including anal, with public funding tied to reducing HIV/STI acquisition for school youth. Education is vital to Black gay men who reportedly engage in anal sex at an earlier age than White gay men (KFF, 2011).

Community-based organizations must continue to receive public funding to deliver and reinforce safe-sex messaging. These centers should offer courses for parents of gay and bisexual youth so that they may be more reaffirming during their child's development years. Stronger and more supportive schools and community centers will help offset any negative messaging that students may receive from their racial/ethnic communities that often lead to poor school performance (McCready, 2004).

Schools, gay-friendly sports clubs, and community-based organizations need to receive community support to help create space for the development of peer mentors, as well as experienced mentors. Additionally, an online system must be developed to support students who reside outside of urban centers that have typically had less than supportive systems in place. These relationships will help solidify a sense of community for young Black gay men who often feel excluded due to their racial, ethnic or sexual identity.

Support systems within public schools are strongly needed for Black gay men, as they report higher levels of emotional distress and feelings of isolation (Resnick et al, 1997). The panel supports the development of legislation that will combat bullying and other forms of discrimination within schools based on race, ethnic origin, sexuality, and gender identity. From the HIV Prevention Trial Network's Brothers study, we learned that Black gay men report feeling discriminated against based on their racial/ethnic identity as well as their sexuality, contributing to more high-risk sexual behavior (HPTN, 2012).

Black gay men must also receive better support after experiencing abuse from strangers or from intimate partner violence (IPV), whether sexual or physical in nature. Approximately one third of gay men report experiencing unwanted sexual contact during their lifetime (National Intimate Partner and Sexual Violence Survey, 2010). Due to the lack of marital or common-law recognition, victims of same-sex IPV are often unable to escape due to lack of economic stability and housing (Herek & Sims, 2008). Peace officers need to be appropriately



trained on ways to fairly handle alleged perpetrators of same-sex IPV or sexual abuse and their alleged victims. Greater protections and culturally-sensitive communication need to be available to the victim in these situations. Furthermore, the law must recognize the validity of male-male intimate relationships and the protections that accompany full recognition in order to protect the victims of IPV.

Young Black MSM are at a higher risk of homelessness as compared to other gay men due to higher rates of family rejection and lower levels of academic achievement that often yields lower levels of employment that can result in homelessness. Stable housing is a significant factor in an individual's ability to maintain his HIV-negative status. Thus, safe housing must be created for non-gender conforming youth to reduce the likelihood that young Black gay men do not find themselves in situations where they may have to engage in transactional or commercial sex in order to access housing. Commercial sex puts Black gay men at an

even higher risk for acquiring HIV and/or an STI (Fondacaro et al, 1999).

In order to accomplish the recommendations listed above, greater coordination of institutions is necessary. The panel acknowledges and applauds the greater coordination between government agencies, such as the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), Health & Human Services (HHS), Department of Labor (DOL), Department of Education (DOE), and state and local public health departments to reduce the impact of HIV/AIDS on vulnerable populations, especially Black MSM. The panel recommends that HHS formulate an action plan to engage Black gay men around ACA enrollment to help foster a stronger culture of preventative sexual health utilization. Additionally, HHS should partner with DOL to increase knowledge about expanded employment protections available to PLWHA as a protected class. DOL should also consider an avenue for released inmates to become health navigators to help enroll the general public in ACA. For example, released inmates who have enrolled in ACA, thereby gaining knowledge of how to enroll in ACA, could be well prepared to become enrollment health navigators. There will be a large need for health navigators for ACA enrollment in the general public especially during the early years—and these released inmates could already possess this knowledge.

HHS must be proactive in preparing for the needs that Black Americans will have to fully utilize ACA. Approximately 60 percent of Blacks reside in the South (15 states composing the southeast region of the United States) (Census, 2006). It has been noted that Blacks are moving to the South at the “highest level in decades” (USA Today, 2011) and only six of the states in the South did not attempt to block the full implementation of ACA in one form or another. In order to prepare for the likelihood that the other nine states do not create a robust insurance marketplace to increase access to healthcare or expand their Medicaid eligibility, HHS must begin making steps to safeguard Black Americans from

not receiving the more extensive ACA benefits afforded to citizens in other states.

Under the auspices of HHS, the United States Public Health Service Commissioned Corps has the authority to create centers that provide healthcare and related services to medically underserved populations, called Duty Stations. Duty Stations must be considered as a temporary solution to serve Americans in states that chose not to fully expand Medicaid and associated health-related services. Notwithstanding, the placement of Federally Qualified Health Centers and Federally Qualified Behavioral Health Centers must be reviewed carefully to ensure vulnerable populations will be able to access affordable healthcare. The healthcare providers and other service employees within these centers must receive appropriate training to improve cultural sensitivity for Black gay men seeking care.

As stated above, elevated levels of distrust of the healthcare system lead to delays in treatment and subsequent poorer health outcomes (Armstrong et al, 2011). The NIMHD must explore ways to improve health outcomes for dual racial/ethnic and sexual minorities, i.e. Black gay men. This will best be accomplished through partnership with established Patient-Centered Medical Homes provided through ACA. The goal of these centralized medical units is to enhance “patient access to a regular source of primary care, stable and ongoing relationships with a personal clinician who directs a care team, and timely, well-organized health services that emphasize prevention and chronic care management” (Abrams & Stremikis, 2011). This provision would prove most beneficial to Black gay men if the lead physician is properly trained to address not only their medical needs, but also the cultural and sexual health needs, of the client and help the patient attain the best health outcome possible.

Diagnosing HIV infections as early as possible is a public health priority to reduce transmission potential while helping a person on antiretroviral treatment (ART) attain viral suppression (Nakagawa et al, 2012). Therefore, all states should adopt an

opt-out policy for HIV testing to routinize HIV screening that already align with the guidelines set forth by the U.S. Preventive Services Task Force. Policy and guideline implementation will reduce the number of missed medical opportunities for diagnosis since the physician will not be required to assess risk (Millett, 2012). Thereafter, a person infected with HIV can work with a physician to choose the best treatment course.

The federal government must maintain the integrity of the Ryan White CARE Act. Since the bill does not include a Sunset clause, Congress should wait until the ACA has been fully implemented to reauthorize the program so that a proper, examination of service gaps for PLWHA can be conducted. If health outcomes under the ACA are not ideal, then revisions to the Ryan White Program during reauthorization can include more specific and evidence-based updates. A thorough review of how well people currently using Ryan White services are transitioned into ACA insurance plans, and their subsequent care needs, must be reviewed extensively. Furthermore, the wrap-around services, e.g. transportation, supportive housing, and meal service, are an integral part of HIV care and will need to be continuously supported as well.

The recommendations of the panel are in no ways meant to be exhaustive. They are meant to add to the dialogue surrounding the current needs of Black gay men and the struggle to end the HIV/AIDS epidemic. The panel would like to acknowledge the previous work and support of amfAR and Trust For America’s Health; Black AIDS Institute; National Alliance of State and Territorial AIDS Directors; Black Gay Research Group; Young Black Gay Men’s Leadership Initiative; National Black Gay Men’s Advocacy Coalition; National Black Women’s HIV/AIDS Network; Heterosexual Men or Color Coalition; Dr. Kenneth Jones of the Office of Veterans Affairs; Dr. Sheldon Fields of the University of Rochester; Dr. David Malebranche of the University of Pennsylvania; Drs. David Holtgrave and Cathy Maulsby of Johns Hopkins

Bloomberg School of Public Health; Mr. Gregorio A. Millett of the Centers of Disease Control and Prevention; and Drs. Beryl Koblin, Ken Mayer, and Darrell Wheeler of HPTN 061

FULL RECOMMENDATIONS AND ACTION ITEMS

A) Address the role that the Criminal Justice system plays in impacting the rate of HIV infections for Black gay, bisexual, and other men who have sex with men

I. HIV-specific statutes criminalizing transmission and exposure must be eliminated to reduce HIV-related stigma and to support best public health practices, which encourage knowing and disclosing one's HIV status

II. Policing procedures, such as Stop & Frisk and Condoms as Evidence, must end to reduce the amount of undue stress on Black gay men that also discourages carrying tools necessary to prevent HIV/STI infection

III. Department of Corrections must review statutes and sentences of laws that disproportionately affect Black Americans to reduce the stigma and stressors experienced by Blacks with no actual improvement in public safety

IV. HIV screening during intake into state prisons must be enacted and routinely repeated every six months during incarceration on an opt-out basis to help identify undiagnosed inmates who will benefit from treatment before disease progression

V. Condoms must be made available to inmates to prevent HIV/STI transmission

VI. Compulsory HIV education courses need to be prepared for correctional officers and for prisoners to reduce HIV-related stigma and to better understand the actual routes of HIV transmission

VII. A program must be created to enroll low-

income prisoners in Medicaid who do not have, but desire, access to healthcare

VIII. Prisoners should be granted greater privacy for their health related information to improve healthcare engagement and reduce isolation within the prison walls

IX. Department of Labor must examine and eliminate, when unjustified, policies that ban felons from various vocational opportunities

X. Department of Education must eliminate the preclusion of certain felons from receiving federal aid to attend post-secondary institutions

B) Address the structural community-driven social determinants that lead to HIV infection and subsequent poor health outcomes for Black gay, bisexual, and other men who have sex with men

I. The media must be encouraged to better showcase supportive faith-based leaders who affirm Black gay men to encourage stronger relationships between the leaders and Black gay men

II. Encourage community support for churches that specifically address the holistic needs of Black gay men within their respective congregations to encourage the reduction of queer-related stigma

III. The Department of Education must be fully funded and empowered to enforce comprehensive sexual education, inclusive of a discussion of gay sexuality, in public schools that gives students information to protect themselves and their partners if they choose to be sexually active

IV. The Department of Education must develop an objective measurement tool to assess the success of sexual health programs, such as a comparison of HIV/STI incidence before and after a program has begun, to provide the most effective and evidence-based harm reduction trainings

V. Resources must be provided to provide workshops for the facilitators who teach sexual health to students to raise the level of cultural competency to better relate to students

VI. The Department of Labor must promote the use of proactive diversity and inclusions language in hiring applications to expand awareness of employee rights and discrimination protections

VII. Community-based organizations should receive additional funding to build their capacity to teach and reinforce sexual health to participants

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X. Legislation must be enacted to protect young Black gay men in public schools from abuse based on their race, ethnicity, or sexuality

XI. Legislation must be enacted to support the victims of intimate partner violence with shelter, food maintenance, and available counseling

XII. Peace officers must be trained in proper responses to situations of intimate partner violence to ensure the victim is not re-victimized by the legal system

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XIV. Safe and stable housing options must be made available to transitionally housed individuals to avoid spiraling health outcomes downwards

XV. Homeless shelters must be supported to create safe spaces for young Black gay men to discourage transactional sex work

XVI. The Department of Labor must promote the use of proactive diversity and inclusions language in hiring applications to expand awareness of employee rights and discrimination protections

XVII. Legislation should be enacted to protect LGBTQIA workers, including Black gay and bisexual men from discriminatory employment and hiring practices

C) The Patient Protection and Affordable Healthcare Act and other public health programs must be fully integrated into the plan to reduce HIV incidence for Black gay, bisexual, and other men who have sex with men through utilization of medical prevention and intervention resources

I. HHS must prepare, in advance, to create Duty Stations in areas with high rates of HIV incidence in the South that may not fully implement ACA to ensure that all Black MSM benefit from having increased access to quality healthcare

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which would assist with the ACA registration within their respective communities while also offering a source of income to the former incarcerated

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XI. Formal reauthorization of the Ryan White CARE Act should be delayed until a thorough review of the changing needs of HIV-positive persons after the implementation of ACA

CONCLUSION

Many of the recommendations made in this report are being done by a number of dedicated

organizations across the country. Indeed, this report itself would not have been possible without the efforts of researchers like Greg Millet and Dr. David Holtgrave, as well as the HIV Prevention Trials Network, which published the largest multi-site study of HIV and Black gay and bisexual men ever conducted in the United States. Organizations like the Black AIDS Institute, amFAR and the Trust for America's Health have also been at the forefront of efforts to raise the profile of the epidemic among Black gay men. The Black Gay Research Group, the Young Black Gay Men's Leadership Initiative, the National Black Gay Men's Advocacy Coalition, National Black Women's HIV/AIDS Network, and the Heterosexual Men of Color Coalition are all doing incredible work in this arena.

At the same time, many government entities are working diligently to improve coordination and direction of resources to address the critical needs of Black gay and bisexual men, including the White House Office of National AIDS Policy (ONAP), the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Housing and Urban Development (HUD), the Department of Labor (DOL), the Department of Justice (DOJ) and the Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) at the National Institutes of Health (NIH). Much of this work was the direct result of the National HIV/AIDS Strategy released by the White House and ONAP in 2010.

The task laid before us is to build on the amazing work these organizations and individuals are doing to scale up our national efforts to mitigate the impact of HIV on America's Black gay and bisexual men. NMAC is committed to engaging in this fight and will continue to push for full implementation of these recommendations in the years ahead. From its headquarters in Washington, DC to communities across the country where Black gay men require services, NMAC will work to develop strong collaborative relationships with allies and leaders

from within the community itself. The CDC has named HIV a winnable battle. But this war cannot be won without addressing the persistent toll the epidemic has taken on Black gay men. NMAC is committed to doing just that.

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