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Black Gay/MSM and HIV/AIDS:
Confronting the Crisis and Planning for Action
Expert Panel
National Alliance of State and Territorial AIDS Directors
February 4, 2008

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TERRANCE MOORE: So I actually want to, I have the pleasure of introducing Jen Kates from the Kaiser Family Foundation. NASTAD has a long-standing relationship with the Kaiser Foundation on many projects that we've worked on, many of which you all have seen are Adapt Monitoring Report [misspelled?] which I think we've doing for over a decade now, right? And a recent project that is examining prevention programs across the country. So this is about the second or third time I've had to work with Jen and when we were deciding on who we wanted to moderate this panel, Jen's name kept rising to the top of the list. So here she is and we are thankful to have her as well as our other distinguished panelists this morning. And I am going to turn this session to Jen Kates. [Applause]

JENNIFER KATES, M.A., M.P.A.: Thanks, Terrance. I was sort of thinking, oh, it seems very obvious why I'm on this panel, just because I'm a good moderator. [Laughter] so hopefully I'll do a good job. No seriously, this is such a critical topic and one that anyone working on HIV and addressing the epidemic in this country today has to be focused on the impact on Black Gay men, and MSM. And if you're not, you're not focused on the epidemic in the United States. So it's so critical. It's an area of focus for a lot of our work

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at Kaiser. And when I was contacted by NASTAD and asked if I would moderate the panel I was so honored to be asked to do this.

So I'm just very humbled to be here, especially with all of these experts on the panel. And I also want to just commend NASTAD for taking this on. This is a tremendous undertaking and to devote so much thinking and energy to this issue, to the issues facing Black Gay men and MSM by an organization taking this on, working with health departments who are really at the forefront of receipt and management of public dollars and community. It's unprecedented.

So I want to commend NASTAD and Terrance and Patrick in particular for quite an amazing research effort. It's mind-boggling what you've done here. And I think a lot of us— we're here to talk today about technical assistance the and role of health departments in this response, but clearly there's so much here for so many audiences that will have all be taking a lot of time to really delve into these findings and try to understand what the implications are for all of our work.

So as I mentioned, and as Terrance mentioned, the real purpose of this panel is to hear from some of the foremost experts in the country working on issues affecting Black Gay men and MSM and HIV and their reactions, both based on their work and hearing the findings for the benefit of all of us

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going into more detailed discussions. How do we then take the next steps? How do you take the next steps to incorporate all the rich information, what we already know from the literature, from everyone's work, into a plan really?

So we're going to, the sort of order of the day is that I will briefly introduce everyone. I think everybody knows everybody here, but we'll just briefly say who we have. Then they'll each talk for three to five minutes on their own reflections and reactions based on their work and what they heard and then we'll go into a moderated discussion and then sum up. So hopefully we'll give you— everyone will need lunch because it will be such a heavy morning, but a good one. So I will briefly introduce everyone. You have full bios and there's a lot to say about each person so I'll just give the top line.

We have, and I'm going to do it in the order here so I'm not flipping around, Rashad Burgess from the CDC, who's the Acting Chief of the Capacity Building Branch of HIV/AIDS at the National Center for HIV/AIDS, viral hepatitis, STD Prevention. [Laughter] Yes, I'm- yes, the National Center at CDC. And as we know he's responsible there for nearly 60 programmatic and scientific staff providing capacity building assistance to all domestic health departments and community-based organizations. So today Rashad will be able to talk about that work and what

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these findings can tell us. And he also has a long history of working in the community on prevention programs and outreach efforts.

We also have Ernest Hopkins. Ernest is the Director of Federal Affairs at SFAF, San Francisco Aids Foundation, where he has been for 10 years. He's also the vice chair of the National Gay Men's Advocacy Coalition, a policy chair, he's done many, many different things on— not just on HIV but really focused on the impact on Black Gay men. He's served as the Ryan White HIV planning council chair for the Washington, D.C. metro area and many other things. So Ernest will be talking I think mainly from the federal advocacy perspective and how that is informed by this and also could be, you know, next steps in that regard as well.

We also have Jesse Milan who is a Senior Principal for Health Policy Promotion at SRA-Constella Group, a $1.2 billion health care consulting firm, where he oversees health programs for federal, state, and local agencies and for private foundations and has been at Constella for many, many years before it was purchased by SRA. And so all of us know Jesse from his work on the CDC HERSA advisory council for being outspoken as a person living with HIV and for being a personal hero of mine, providing lots of inspiration through his many talks and motivational singing and speeches. If you were at

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the CDC, the prevention meeting, you got to see Jesse do all of that.

And finally and definitely last but not least, is Greg Millett who is a Behavioral Scientist at the Division of HIV/AIDS prevention at CDC. He's the lead scientist on a large multi-state study investigating social and cultural factors associated with the high rates of HIV infection among Latino and black MSM. Many of us have used and valued the work he's done looking at the complicated factors that go into the impact on non-black MSM and why the impact seems so much greater and so his work is unique in the field and really at the forefront. And just on a personal note, Greg and I went to college together and have known each other for many, many, many years, and when we ended up in the same field it was really exciting. And we think this is the first time, though that we're actually on a panel together. So I'm very excited to hear from him and all of you.

So I will let our panelists shed some light on what we heard this morning and we'll just go— does anyone want to start? Why don't we start with, I think Jesse has a good idea. Why don't we start with CDC and Rashad and then we'll move to Ernest and get a better overall perspective

MALE SPEAKER 1: He has the typed notes.

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JENNIFER KATES, M.A., M.P.A.: And then Jesse and then Greg.

RASHAD BURGESS: Well, whoa. Wow. Okay. Well first let me begin by just extending an enormous amount of gratitude and appreciation for the work of NASTAD and particularly under Julie's leadership as well as under Terence's leadership through this process and Patrick being the great researcher that has helped pull this information together. This is just critical that we do this and we address this issue. I haven't, I don't think ever in the, since I've been in HIV prevention my entire career, and that it's probably longer than some of you may think, but needless to say I have never seen the kind of synergy around HIV prevention for Black Gay men like I've seen in the last year or so. So I want to just extend a bit of an appreciation.

But I want to speak to— I want to make four points and then I'll be quiet because someone told me I was a little long-winded sometimes. So I'm going to try to be a little measured so I can be respectful of my colleagues.

I want to speak a little bit about the barrier. And I particularly want to talk about, respond to the issues around capacity building And really the capacity of organizations that are charged, or who are charged with working with Black Gay men. I wanted particularly to speak to the issue of a

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workforce. You know, one of the things that I have seen, before taking this position I was a team leader at the Richland Program Branch [misspelled?] so I oversaw the project officers that had anywhere from six to 15 grantees, a combination of community-based organizations and health departments. And what we consistently saw was either these issues around turnover or these issues around being able to attract folks who were both culturally competent and had the skills to do the work and the ability to pay. I mean those were three issues that seemed to always be a major challenge for the organizations.

So one of the things that we are thinking, though many of you may know this, we actually are recompleting probably within the next 12 to 18 months our new program announcement for capacity building assistance providers, our CBAP Program [misspelled?]. And one of the things we're taking a look at is how is that— how do we better address these sorts of infrastructure needs as it results to staff? And is it just an issue of training a TA? So is it just about needing trained staff or is it about us nationally having a cadre of folks who are going through set trainings and that we are finding ways in which to either subsidize or partner with entities that can subsidize to really pay folks what they're worth so that agencies do not have such a difficult time keeping staff, particularly at the program management level. I mean that's

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what I would say oftentimes, you know, the key to a successful program and a program operationalizing itself with fidelity, really often exists at that program director's level.

So that's one of the things that I want to speak to that I want to really acknowledge as just a significant, significant issue. And they are issues above that level, the ED level, and issues below that, the outreach or the peer level or the group facilitator level, but I think there are some unique issues so that we need opportunities for us as we move forward to really address that level at the program director level.

The other thing I want to speak to is DEBI as I sometimes refer to internally as Miss DEBI at the office. I think it's important that we at CDC just acknowledge that there are real limitations with DEBI, I mean, there just are. And particularly there are real limitations with the fact that there are no behavioral interventions that are made through our PRS process, which is our Prevention Research Synthesis process which is basically this major analytical process that sort of funnels and determines which are the interventions that we believe to be the best evidence of promising evidence interventions. That our research primarily insuring effectiveness for Black Gay men. That is a significant, significant issue. And so part of what we're doing internally

at CDC is saying if PRS is not getting us interventions that speak to Black Gay men, what then do we do? And are there options and opportunities for doing some significant adaptations and tailoring of some of the interventions that we've now released as DEBIs. And so some of you might be aware that we are going to be diffusing this year DEE UP [misspelled?] which is an adaptation of the popular opinion leader. And we're doing a major adaptation and we're going to be putting a significant amount of effort and resources to really do all the modification work and all the adaptation work so that it can be significant and culturally appropriate and culturally specific for Black Gay men.

Well guess what, folks? Even our best efforts at adapting all these behavioral interventions, or even having interventions that, you know, are culturally appropriate, culturally specific, that even has some effect at behavioral change, the concern is that we are at such a place in the epidemic that if the 46 percent number is true or if the number from Linda Valleroy a few years prior, the 33 percent number is true, we're at a place in the epidemic where some, many, many, many voices or empowerments going on in a major city is not going to have the kind of epidemiological impact that's needed to turn the tide.

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So this is going to get to my third point around social networks. I think us in HIV, we have to do a better job of understanding social and sexual networks. And it's not about telling Black Gay men not to have sex with other Black Gay men. That's- that's- that's not the direction we're going, but really how it is that we develop strategies and utilize strategies to infiltrate those social networks. The other thing that's a part of that is we have public health strategies. You know, we have what starts to be called partner services, but traditionally was called partner counseling referral services, that in most major cities are significantly under-utilized.

And in part, you know, we all take our ownership, you know, part CDC has not pushed it enough and part health departments have had a tough time with community resistance. And so, and some places have not pushed communities hard enough to accept partner counseling referral services as an effective strategy. But that is a place where individuals test HIV positive. It is imperative that we follow up with their partners. I mean, that is a basic fundamentals of public health. And we are at a place in the epidemic where we can not sacrifice that strategy for many of the issues that surround it and the concerns. And they are real because sometimes the disease investigator is not the most sensitive. That's a- I

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don't want to pretend like that's not a real issue, but there are things that we can do to insure a more culturally appropriate response. But we don’t' throw the baby out with the bathwater. And I think that, you know, in terms of our partner services we have to do more of that. And I would really encourage and push health departments to push for CBOs and work with your community-based organizations and better yet, work with your own clinics to ensure that it's happening because so often in cities it's not, and particularly in our epicenters unfortunately.

Another thing I would say about that is that we have a real issue with Black Gay men not knowing their HIV status. And it's interesting because black folks get more than anyone else. But the issue is frequency. So we have to develop some national strategies to encourage folks getting tested annually. And while it's buried in our CDC recommendations, we have not really put the kind of resources behind developing a national strategy, a social marketing at really making it a norm that people get an HIV test every year.

And then the last thing that I want to speak to, which is not necessarily a CDC issue under my sort of specific domain, if you will, is I think that the oppressed [inaudible] that black gay men deal with oftentimes are so overwhelming to many of the providers. And out of the scope to many of our

specific programs that we have to think about how do we have community responses that creates the kind of support for black gay men to offset the issues around daddy not being there. Offset the issues around being called a sissy at 13, dealing with the rejection of faith leaders which is interesting. I didn't see much of that in the report, but I think that's a major issue.

You know, Black Gay men and church, you know, is a major— well this is being recorded so maybe I shouldn't say it— if people read Friday's Washington Blade, you will see that there is a major conversation going on in a major black church here in the D.C. area dealing with Black Gay men. And I don't want to take sides on that issue, but what it underscores is the fact that Black Gay men and the black church are not, sometimes we treat them as if they're separate and they're not. If any of you all have ever been to a community choir concert knows that, you know, they really can be one and the same. And it is important that as we think about our strategies and our comprehensive strategies that we are inclusive of our behavioral interventions, we're inclusive of our public health strategies, but that we're also inclusive of our community-level strategies, those that impact community norms, and not just community norms amongst Black Gay men, but also community

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norms in terms of African Americans. So with that, those are my points. [Applause]

ERNEST HOPKINS: Oh, it's already on. Good morning and thank you all for the invitation. Thank you, Julie. Thank you, NASTAD staff, Terence and everyone else for the invitation. And thank you all so much for meeting with the National Black Gay Men's Advocacy Coalition several years ago. The executive committee of NASTAD, and I believe its African American work group met with the fledgling National Black Gay Men's Advocacy Coalition, a group of Black Gay men across the country, who were brought together in reaction to the June, 2005 MMWR which I think all of you are familiar with that reported that the median HIV infection in Black Gay men as being 46 percent with little response from the CDC. We really felt like we had to do something.

And one of the things that we did in addition to calling on the CDC to create a consultation which they did, was to go to the states because we really knew when you look at where the dollars are at the federal level for the CDC, the vast majority of them reside with the health departments. And we knew that we could not be successful in having the kind of significant impact on HIV prevention in our community without partnership with the health departments. And so the study that's ongoing, the multiple parts of it that have been

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released, we really appreciate and feel like it's really going to go a long way to assisting us all in making a significant difference in how we deal with the epidemic in the black MSM communities. So I want to say that first.

I also really wanted to acknowledge some of the comments that I saw as sort of pull quotes from the study. And to that, that really I want to emphasize. The first being one of the members of one of the health departments that said that they really understood how important it was to expand the definition of what is your business as a health department. When I was planning council chair for this region, which goes- it's ridiculous how big it is, but for this region it goes all the way down to West Virginia.

One of the deep frustrations I frequently had in dealing with health department staff was the way in which they boxed and compartmentalized their role in making sure that the grants and programs actually were effective in the community. And the reality is it really feels to me like if you know there are a handful of Black Gay organizations in your community that have access to the population, but you know that they have any number of capacity problems, both internal around administration and the capacity to actually provide quality program, it feels like it has to be your business to take that on, to find ways to support those organizations so that they

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can be in this for the long haul, which is going to be essential for us. So I'm thrilled that that is like become understood by folks generally across the health departments. I think that's great.

And then where you do your work, sort of suspending the judgment of what the appropriate venue for public health intervention might be is also obviously critical and all the talk about the condoms being distributed at the sex parties and, you know, in the ballroom community. And there's so many levels to that process, to the ballroom stuff that that in and of itself could be someone's full time job. I'm just thrilled that that's where you're going. That's obviously where you need to go and we want to partner with you in doing that.

Let me just say also that when I was listening to the presentation having looked at it prior to coming here, the other thing that continues to strike me about working in the black MSM community is this syndemics issue, and the ones that-not necessarily all the co-morbidities, but the degree to which socio-economics and class play such a powerful role in our ability to get the work done in our community. So I'll give you some examples.

Back in 1990 when the Black Gay pride movement started here in Washington, it was started by myself, Wellmore Cook [misspelled?], Theodore Kirkland [misspelled?]. Theodore

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Kirkland was a former military guy. Very well-educated, had a good job. Wellmore Cook, older gentleman, retired from the military. His home and his social network being involved in the best of Washington and the Pinochle Club and Five plus Five and all of these organizations that if you go into what I hope is sort of the historical annals of black Washington, you would know.

Because these are the organizations, these were our social networks before AIDS decimated our community these were the infrastructures that we had in our black community that were so critically important to the social fiber of a Black Gay Washington. He was completely embedded in all of that and I was sort of the young whippersnapper at the time who had just come back to Washington and was getting involved in politics. And I was a part of the D.C. Coalition on Black Gays and Lesbians. And so between the three of us we felt like we had the ability to sort of cover the waterfront of the Black Gay community and bring people together for HIV philanthropy. We were all also members of an organization called Best Friends of D.C. that between a network of maybe 30 Black Gay men were able to raise annually maybe $25,000 that went to paying people's utilities, paying their funeral bills, buying them food, keeping their rent paid. I mean that was the kind of things that you did back in the '80s and early '90s before the red and

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white carrot. That was how we showed up in community. And I say that because we wouldn't have been able to do any of that had we not been well-educated and employed. And I think that when you talk about the variability of community and how to find the venues and there's no black community per se, I don't think you can really dismiss the fact that there's not a lot of Black Gay men who have the wherewithal to weather the variability of the vagaries of gay club life.

I mean, the fact is as a gay man I want to be in the club before any of you all know about it and then I want to be out of it by the time you all come. That's just the way it is. And that is the kind of— that kind of investment is very challenging for a lot of people. And I think more so even in the Black Gay community. I raise that because that's one of the challenges that we're going to continue to face.

And from a federal perspective what is the role of the federal government in all of this, you know? I think that more and more what we at the National Black Gay Men's Advocacy Coalition are realizing is that it's really got to be our job to really clearly delineate the federal resource responsibility and the community resource responsibility. And in partnership with groups like NASTAD identify what can be done with local and state resources because they don't always have to be completely consistent. There are things that we probably

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shouldn't do with federal money that need to be done. And that's what keeps coming up for us. Maybe I was out of the room when we talked about the research, but that for us is becoming critically sort of where we're honing down on and not just sort of long-term behavioral and biomedical research, although we're also pushing for that.

But the kinds of research that these reports represent where we can actually get on the ground quickly and get critically important information back that can be useful to us in formulating policy. And so I know there are a number of members of the National Black Men's Advocacy Coalition in the room and also members of the Black Gay Research Group, which is another group that has been created all in an effort to focus attention on the Black Gay community. So those are some of my thoughts and I just appreciate being able to be here. Thank you. [Applause]

JESSE MILAN JR., J.D.: Good morning. I'm Jesse Milan and in getting the invitation from NASTAD and from our good friend, Terence, who works so hard, where's Terence? Terence, it's on tape. You work really hard and we appreciate all you do. And the opportunity to be in conversation with you and all of you is very important. When we got this invitation to talk my mind automatically went to the policy issues because I think that's what I was asked to speak about.

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But coming here, actually not just seeing the PowerPoint with the language, but hearing the voices on the tape took me to a different place. And it took me to a very deep and dark place because— and I can't believe I'm going to tell you this on tape, but I have only been beat up, and I mean beat, once in my life. And that was by a Black Gay man who was my college roommate my freshman year at Princeton.

Now Princeton was newly integrated and so black people had black roommates, which kind of surprised me. And my roommate, I knew, was developing in his freshman year, a strange relationship with another gay, black man. Neither one was out. And I let it be known just this much that I knew what was going on, being a Black Gay man myself. I let just this much be known to him that I knew what was going on. He waited and lurched for me on a Sunday night when I came back from the library, turned out the lights and beat me. That's how deep this is. Do you really think that the Secretary of HHS even has a clue as to how deep this problem is? How the homophobia and the internalized homophobia that we have to deal with is fueling this epidemic and where's the research that shows it?

So we have a lot to do. We have to appreciate NASTAD for doing this, but without that documentation where does the policy go? How do you even begin to address where the funds should go without that deep information that in an objective

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way tells us where we need to be. I assure you that Michael Levitt doesn't have a clue. And I can tell you he doesn't really care. It is too easy for him to go to— George Bush is getting on a plane next week to go take his wife to see an HIV/AIDS program. I was with Prunessa Seal [misspelled?] two weeks from the Bombagilead [misspelled?] when she got the call from the White House that George and Laura were going to go to Tanzania to see an AIDS program in Tanzania. He ain't going to Tennessee to see us and he's certainly not taking Laura with him, but we have to help them understand why they should be going to Tennessee.

So we're at a pivotal point in history and I think this presentation today gives us a sense of that pivotal point. And maybe we should put it in a better historical perspective because for those of us who have lived for long enough to have experienced the HIV/AIDS as adults in the 1980s, we saw that white, gay men did something that was meaningful but we haven't put it in an historical context beyond the fact that they created programs that are still getting funded and people are getting mad about that, are still mad about that.

Because we simply would not be talking about gay marriage, which is mostly a conversation among white homosexuals and not black homosexuals, we would not be talking about gay marriage had it not been for HIV/AIDS. And do you

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know why? Because it forced white, gay men to take ownership of their relationships and get to decide publicly who sat on the front pew in those funerals, because if you didn't get to sit on the front pew in those funerals and memorial services, your relationship was not valued publicly.

Now, 25 years later, we in this room are accountable for the next generation of Black Gay men so that they are not going through what I went through in that deep, dark night, and what we hear in the conversations in this research is still going on today. You know, coming just two weeks after Martin Luther King, he knew what he had to sacrifice in order to make the future better. And we've got to look at it maybe beyond just is my agency getting funded today as opposed to what should we be doing for the future?

You know, I've already gave my money to Obama. I even gave him a draft of what I thought the HIV plan should be. But the change that we're looking at, whether it's him or somebody else, has to be taken to the next level. We can't simply be stuck with epidemiological profiles and CPGs and complain and complain and complain. We should be demanding something higher. A national plan for HIV/AIDS could not possibly be written or exist if it didn't address 46 percent. But I think people are afraid to ever write it down and say there should be a plan because then we'd have to look at historic black

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colleges. We might even have to look at correctional institutions. We'd have to look at all levels of society that impacts the black community and that is of the black community in order to make that change. If we're not going to get it within the next 11 months, we should be making the charge now, setting the plans, so that it gets started 11 months from now. [Applause]

GREG MILLETT, M.P.H.: You know, one of the worst things about being invited, I'm not sure if this is on. One of the worst things about being invited to be on a panel is being on a panel with people who are so incredibly terrific about everything that they're saying. One thing that I do want to say before I get started with some of my comments is, I also want to thank Terence as well as Patrick for the incredible work that they've done. And bringing this type of data is absolutely crucial.

So often we see a lot of quantitative data, a lot of statistics, and they don't really give us what the meaning is behind the 46 percent, what the meaning is behind the high rates of HIV. And what was particularly important about what we heard this morning is that they were able to bring back the voices of the community to us, to researchers, policy makers, to people who can perhaps effect some sort of change. And that is what is critically important. In many ways, you know, the

people who are sitting here at this table are not the experts. The experts are the members of the community and what we hear from the community. And that's something that we have to keep in mind consistently.

There are a couple of things that I wanted to discuss. And I heard from the discussions, not only from the people here on the panel, but also what I also heard this morning, most of my work really deals with stereotypes. And stereotypes that have been leveled among black MSM for researchers for years. The first stereotype being that black MSM have high rates of HIV infection because we engage in greater rates of risk behavior. That is categorically false. We do not engage in greater rates of risk behavior, but we still have high rates for HIV infection. And the research has fallen short in explaining exactly why. I think one of the problems that we dealt with, and I'm speaking as a researcher and specifically from what I've seen in the research over the last 26 years of the epidemic, is the fact that we are consistently talking about disparities, disparities, disparities.

You know, I really get tired of hearing that black folks have higher prevalence of HIV compared with other populations. Tell me something new. Frankly we need something new. We already know from epidemiological research that those disparities exist. What we need to know is why? And that's

what was so important about some of the information that we heard this morning is because people are telling us exactly what may be happening that researchers need to be following.

So some of the things that I heard that I know that we could supplement with some of the research that's been done is looking at issues of self esteem and depression. There is certainly research out there that shows that depression and self esteem is associated with sexual risk taking as well as greater rates of HIV infection among gay men and specifically among Black Gay men. Other things that I heard this morning from the community is that we also know about are social and sexual networks. They are also associated with greater rates of HIV prevalence in our community.

When you are having sex with somebody who is from a community that also has a higher background prevalence of HIV, then you're more likely to become infected. If you are having sex and you're a young, Black Gay man with somebody who is older than you, then you're more likely to become infected. And we find those patterns over and over again in our research data. We're less likely to know about our HIV status compared to other populations. Exactly as Rashad said, you know, we get tested frequently. Perhaps we get tested more frequently than any other populations in the United States. But we're still less likely to know whether or not we're HIV positive so

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there's all sorts of policy implications there as to the frequency of testing, that we might have to get tested more frequently than perhaps once a year. Perhaps it has to be every six months for us to really know what our status is.

And even when we know that we're HIV positive there are far too many Black Gay men who are not in care. We're not accessing antiretroviral therapies. And without those life-saving therapies we're more likely to transmit HIV to our partners and to our friends.

Another issue, and it's something that unfortunately is a huge gap in the research area, is issues dealing with religion and spirituality. We know that there's all sorts of issues dealing with stigma, religion, and spirituality. We do not know how that affect HIV risk on Black Gay men. And quite frankly, 26 years into the epidemic is really late to start that type of research. We should have been doing this research earlier.

We also need to do more research on social support. We heard very poignantly this morning that men really need that social support. They're missing that social support and they may be engaging in greater risk behaviors. And there's actually a paper that we're working on right now where we ask those questions about social support and surprise, surprise. Those men who did not have social support were more likely to

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engage in greater risk behavior, they're more likely to be HIV positive, and they are more likely to have unrecognized HIV infection. So we are hopefully going to be coming out with that information soon on Black Gay men.

Another thing that came up this morning is just how in some ways fragmented the community might seem in terms of age, in terms of class and many other issues. And again you see that borne out in the data.

When you take a look at the epidemiological data and see who is becoming infected in our community, it's usually men who are younger, where the higher rates of infection are. And you also find class differences too. And you've seen this in at least three or four huge epidemiological studies, is that Black Gay men from lower income levels are more likely to become infected than Black Gay men from higher income levels. This is something that we really need to take a look at seriously and figure out exactly what dynamics are happening there. And the dynamics are fairly obvious.

I mean, people have talked about syndemics before. If you are marginalized, if you have a lower income, you're less likely to have housing, you're less likely to have access to health care, is it really a surprise to us that we see higher rates among men who have lower income? I don't think it is.

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So what implications does that have for interventions? Obviously we need to be moving forward in interventions that deal with some of the structural issues, structural inequalities that take place in this society that impact HIV infection in our communities. We can't keep looking at individual level interventions that just look at behaviors. That's not going to get us what we need to reduce HIV infections among Black Gay men. We need to look at issues of employment. We need to look at issues of racial discrimination. We need to look at issues of incarceration and many other issues, to see if we can figure out whether or not that might help reduce the overwhelming disparity that we see today.

I have a couple of other quick points and one of them, I have to admit, I'm still dismayed over the fact that how much we concentrate on men who don't identify as gay. And I'll say that for two reasons. One, just because men in our community don't identify as gay doesn't mean that the people that they hang out with and the people that they have sex with are men who only have sex with men and men who are gay-identified or go out to clubs. So this whole issue of this separation between gay-identified, meaning that you're potentially bisexual or you're not connected to the gay community is really a false statement. There are many men in our community who don't

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identify as gay, but they're very much connected to a Black Gay community.

Another thing that I want to point to is that the data are overwhelming when you take a look at HIV infections and sexual risks among men who are gay-identified and men who are non-gay-identified. And you see this irrespective of race or ethnicity is that men who are non-gay-identified have fewer male sex partners, they engage in less sexual risk with men, and they're less likely to be HIV positive.

We have surveillance data going back from the 1980's which have found this among Black Gay men all the way through to data that we have from national behavior surveillance, which is finding exactly the same pattern. And I just published a study two months ago where we found that Black Gay men who were bisexually-identified, were 60 percent less likely to be HIV positive in a sample of over 200 Black Gay men. And Black Gay men who were heterosexually-identified were 91 percent less likely to be HIV positive compared with gay-identified men.

So when we talk about our prevention programs and where we need to be going I get really worried that for some reason out, Black Gay men or even men who are just out in some ways, are always overlooked for the last 26 years. And I don't understand why we keep overlooking them. This is where nexus of infections are. This is where most of the sexual risk is

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taking place. And we're not doing enough work with men who are easily reachable.

One other comment that I want to make is we really need to do more integration of research and program. There has been so much separation. I mean we even see the separation at CDC and on many levels where researchers are not working with members of the community. And community members feel they can't contact researchers for very different reasons. That has to stop. We need to make sure that we have all the resources available to make sure that community members have access to the research and that researchers are also listening to what community members' concerns are.

And in many ways that's a false dichotomy because many of us who are sitting here are not just policy makers. We're not just government workers. We're also members of the community. And I can say specifically that the only reason that I'm sitting here is because of community-based organizations. From GMED [misspelled?] when I was a kid in New York as well as the National Task Force on AIDS Prevention that was also funded by CDC, in helping me in the career path that I needed. So it's critical that we fund these black organizations and CBOs, because in many ways, exactly as Jesse was saying, that's really our ticket to the future. We need to make sure that there's a pipeline of more black MSM who are

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coming into many of these positions and many of these places, because I know there's many of us in this room who don't relish being the only ones that we see who are doing this type of work. And not seeing any more individuals who had the same opportunities that we had. We need to make sure that those opportunities are created, and we need to make sure that those opportunities are secure for our future to stem the infections in our community. [Applause]

JENNIFER KATES, M.A., M.P.A.: Thank you all so much. That was actually much further along in, I think, leading the next steps than we had anticipated. I wanted to just sum up a couple of things that I heard from each person, and then ask a couple questions. We are— we're still doing okay with time.

Two observations that jumped out at me from all the information and the qualitative, rich qualitative data that we saw, and we heard some of it here. There were two quotes that really struck home for me as just so powerful and big challenges. One was around this issue of how do you do prevention around passion, which is, I think such a challenge, and one that I think for health departments it's really one to grapple with. And the second was this issue of self worth. And we heard a lot about that, self esteem, self worth, sense of future, how do you instill a greater sense of self worth and future into an individual who's part of many communities so

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that risk taking is not seen as an important option— an important thing to undertake, or just no choice in the matter?

And so just quickly in some of the summary points, if I had to sum up what each person brought to this, although I think there was so much overlap, Rashad reminded us of the workforce challenges and capacity building that CDC has engaged in but community's really have to be engaged in. Ernest focused on syndemics and how that critical intersection of all of the issues is just so fundamental and it can be overwhelming to a health department, but how to expand the view to really take some more of that on.

Jesse, I really thank you again for of course being inspirational and finding a way to bring a personal perspective to such a— to really help guide policy I think. But this issue of the future and how do you create that future, different sense of future for a generation of people. And then Greg, actually I'm glad you went last because you summed up all of the research and you asked a question early on about so much focus on disparity, but why the disparity? I think your research has done more to help people understand why than anybody else's research and it's such a critical— it's what I use to inform our work. It really is. Now I'm going to use this work, too. So between the two I think that the body of work has grown significantly.

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So now I'm going to ask a couple questions and I'm going to do it from the perspective of all of you, in a sense, if you're health department, health department representative and you have to kind of take all this information and figure out what to do next. Let's start with this issue of self worth and future.

And if you are a health department facing some of the budget limitations that people heard, DEBIs that, sort of structure you can do this, you can't do that, how do you take that concept— and these are not easy to answer questions, but how, does anyone on the panel have a suggestion for what would be a good way to take that challenge. And as a health department staff, sit down and find a way to work toward that, towards raising someone's sense of self worth in a community? And ultimately I think the challenge too is multiple communities. An individual sits in multiple communities every day. So I don't know if anyone wants to take that on first?

ERNEST HOPKINS: I'm reminded of an organization, and I've been at a few conferences recently to sort of think about this, but there was an organization in Washington that used to be called I CAN, Inter-City Aids Network. It was an organization established by and for Black Gay men. It was HIV prevention funded. I don't think it had any federal money so it was all D.C.-based money. It provided HIV testing. It had

group counseling. It had individual counseling. It had its own building which provided space for Black Gay community to convene and any number of Black Gay organizations convened there. It also had some additional office space for other organizations to come in. It was like a Black Gay community center.

And what it allowed to occur, this was maybe late '80s, early '90s, was to, in a really smart way I thought, bring [inaudible] into the game of supporting Black Gay community with an HIV overlay. And so today, that kind of a structure could also include job placement and all sorts of other kinds of training. It wouldn't have to, but all of the HIV components could still exist within the same framework. I just think that when you continue to hear that there's no sense of community and people don't have a place to land and that's a way for them to self-identify and feel valuable and feel more connected. You just have to respond to that. And I think that's an example for me that I offer up as a thing that I wish that both D.C. and other communities would have done.

RASHAD BURGESS: One other thing that I would add to that, and it's always difficult having this conversation in the context of dealing with resources, you know, there have been every year--prevention budget since 2001 has been cut almost every year. And so health departments have felt it in a very

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real way. And health departments, you know, when you first start cutting you can sort of cut some of the fat. But it gets to a place where you start to cut the body and you sort of really get the budget cut things that are even most important.

But given that we are [inaudible] I'm going to put something on the table. Every health department has in their prevention portfolio as comprehensive program; one of the areas is capacity building. And I'm struggling— a couple of weeks ago many of you in the room were at a conference that was on open African American and leadership conference. And that was held by NASM.

And they did something, you know, it was one of those things that I've even thought about or participated in, but it just struck me as a moment of truth. They had 17 to 24-year-old Black Gay men in the room and they had a leadership institute. And I thought about, you know, what would it mean if health departments put together some local leadership institutes? You know for many of them, I mean these were really top tier guys and with the major application process many of them college graduates, but what would it mean at a local level to do that for workers or even volunteers or organizations that were interested in Black Gay men and HIV in developing that sort of cadre of leadership.

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Another thing that I was reminded of, recently I— we fund the institute for HIV prevention leadership which we do in partnership with UNLV, and in speaking I realize that over half of the folks that were walking across that stage had never graduated. And so what would it mean if we did— if health departments did leadership programs where they actually had a little graduation ceremony and validated someone's work and effort and their training and gave them a certificate in hand. And I think that some of those things that— sometimes us in our bureaucratic offices whether it's CDC or our health department, doesn't realize the power of our influence and our name on an individual.

And that could have a major impact on just helping communities develop a sense of self esteem and leadership. And they're small things, it could be small, it could be big depending upon the scale in which you did them, but they are very meaningful. And they really speak to building more self esteem concepts, but also building folks' skills. So…

JENNIFER KATES, M.A., M.P.A.: I think— Jesse, did you want to say something? Well one thing that I just wanted to add and what I think is so interesting too about all of those concepts that we just heard about, that's an approach that's increasingly being taken in developing country context about looking at the larger context in the future, economic

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opportunity, job opportunity, the other things that create livelihood for an individual in a community. So I think there's a lot of synergies there.

JESSE MILAN JR., J.D.: Actually, that's a lot of what I wanted to say. As a former AIDS director, I was AIDS director in Philadelphia, when you get people coming to you asking for dollars it's a much bigger issue than just getting funding. It becomes this whole empowerment of our lives. And I just think we can't allow ourselves in the day and age and in this quote, unquote environment, to allow us to buy into that. The dollars for HIV/AIDS that are in health departments are the only dollars that will empower black people at risk or especially Black Gay men. They're not. They may be the only dollars we know of, but they may not be the only ones available and so maybe we need to start looking at a larger approach because I think that one person who was interviewed who said they're working in collaboration with hypertension and diabetes and prostate cancer, a bigger holistic approach.

Collaborations, coalitions, collapsing issues together, I think is where we're going to have to go in order to have a greater sense of self worth. And when we look at it in that way, we can start reaching into FBOs which is so critical for the self worth for gay men and black people period and to larger NGOs from the Deltas and the Kappa's all the way down.

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To engage them in a way that helps this issue not be so difficult.

JENNIFER KATES, M.A., M.P.A.: I actually have a question for Greg and Rashad about the connection between this research that Greg does, that Greg's teams are doing around, you know, all the factors that do seem to play a role in higher rates, the factors that don't play a role. How does that then translate into the capacity building programming efforts that CDC undertakes? And then on a related note since the research that's been published in journals has so much information, to what extent is CDC taking that information and packaging it for health departments so that those individuals sitting here can really use it more accessibly? And these are just thoughts that are striking me now.

RASHAD BURGESS: Greg is so kind. This is, I mean, and I'm going to explain it in a very nuts and bolts way so that everyone in the room can have an appreciation so folks don't have to do any sorts of linguistics gymnastics, if you will, to try and figure out what I'm saying.

This is how it works. Basically we at CDC in our division HIV, the prevention research branch, which is actually where Greg is at, they have a team that is a research synthesis team. And every so often they go through the process or they go through literally thousands of research articles, journal

articles of all published research. And they have a whole series of words that they're looking for to see if the research will speak to those respective issues. And they come up with which— and they have a whole set of criteria around these behavioral interventions. And at the end of it they arrive at— basically there are four tiers, but the top two tiers is what we diffuse, which are the best evidence and promising evidence interventions. These are the interventions that we believe to be the most effective in communities.

Now remember it's important to understand it's what's been researched and published. So these are not necessarily interventions that was researched, published and tested in community-based settings. That's not the case. These are interventions that were taken straight from the research, straight from the journal article that was published. We didn't have a process in which the, in Greg's branch where they do a [inaudible] rep process, so they basically they develop a package. And this is the work with their researcher and they get all the materials of everything that it took for the researcher to implement the intervention or research the intervention to develop a package.

And in between there, once that packaging process is done, they hand it off to capacity building and say okay, now that you have this package, they hand it to us and say, okay,

now you guys diffuse it. We take a look at the package and we say, okay, what in this package can we immediately take as is and what needs to be changed? Oftentimes we get packages that are not, that are suitable for a academic environment but not suitable for a community-based organization or even a health department for that matter. So we go through and we create the curriculums that many of you who have been to any of our trainings you know there was a facilitator that had a curriculum. There was the participants that had a curriculum. And then you were given materials that would help you implement the intervention and evaluate the intervention and the participants had materials.

So needless to say there's an enormous amount of material development that we in a capacity building bridge that we embark upon. Then from there we do a series of trainings. And we do— we're trying to concentrate on more training of trainers, so we're working with health departments and training their staff as opposed to training the facilitators, which we do do some of that. It was a TOF [misspelled?] basically the folks who were implementing the intervention in and of itself.

So that's the process— I mean I've skipped a number of steps, but that's the big picture stuff that happens. But I think the challenge that we face at CDC is that when we look at the challenges and the issues that come up in the research that

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Greg does and others, and we look at the interventions that are coming through that PRS process, there's a real disconnect. I mean I think at the end of the day we're challenged because we are wanting to do interventions that we believe will work and have proven to be effective and are scientifically sound. And you should all want us to do that. We don't want to put stuff out there that we don't believe are workable or that it's not confident. The challenge is, is that oftentimes that research and those interventions there are many issues that they don't address. And so we find ourselves in the situation having products and having tools that speak to some of the issues, but not all of them.

And so the challenge we have is what do we do and how do we support organizations addressing the other stuff? And I think that that oftentimes, where you may feel the disconnect and the challenge and because we want you to maintain fidelity to the interventions, but you're not going to— there's all this other stuff.

Well we know there's other stuff, but we're trying to maintain scientific fidelity and be accountable to both Congress who gives us money to ensure that we're doing interventions that are effective. So we're working internally on strategies of how it is that we can have a real win-win. How it is that we can maintain scientific fidelity. How is it

that we can do interventions that work, but how does also we have strategies that speak to these other issues? And so internally we're working on a number of processes and looking at a number— I shouldn't say processes— a number of options that we have so that we can close some of the gap. We may not be able to eliminate it, but we can attempt to close some of the gap.

GREG MILLETT, M.P.H.: I agree with everything that Rashad is saying. And in many ways to let people know that a lot of the frustrations that we hear from the community are exactly some of the same frustrations that we sometimes voice amongst ourselves at CDC. I think that people really need to realize that, that there's a lot of echoing of some of the same issues on multiple levels.

And one of the ways that we can deal with it is exactly what Rashad has said, you know, talked about the DEBI process. But there's some other things, too that I think people need to be aware of is the fact that CDC is very well aware of the fact that we need structural level interventions, that we need interventions that are going to impact the community in a wider scale than compared to just individual level intervention or group level intervention. The epidemic among black MSM has gone so far at this point that we need multiple tools at our disposal. We need not only HIV

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prevention messages, we might need biological interventions. We might need community level interventions as well as group and individual level interventions, as well as structural interventions and network-based interventions. So CDC is moving forward with a full slate of research that is really trying to step away from just doing individual level interventions and seeing what other ways we can impact what's going on in the black community.

So for instance CDC just finished a study looking at— that they did with Housing and Urban Development— to see the degree to which providing housing may influence not only access to antiretroviral therapy and being adherent on meds, but sexual risk among people who are homeless, many of whom are African American. So obviously there is a structural component to it. And obviously we found that people who were provided housing were engaging in fewer risk behaviors and were more likely to be adherent to their meds.

CDC also has another project looking at micro-finance measures and the degree to which they can provide, you know, micro-finance ventures to African American women to empower them. And to see whether or not being empowered economically may change some of the risk behaviors or even some of the partnerships that some women might be in for issues that are very real dealing with income.

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CDC also has two new projects that we're dealing with African American MSM, and one of the projects is trying to figure out ways of finding men with the highest rates of unrecognized HIV infection, which is incredibly key. That's something that we don't know about yet. And it's something that we'd like to disseminate to the health departments so we're taking a look at differences between providing HIV testing in remote places, satellite offices, versus PCRS, which is the standard of care in most health departments versus social networks.

What happens if you just tell a bunch of guys to just bring in a bunch of your friends and sexual partners to come in and get tested? Are we going to find more guys there who are HIV positive with unrecognized infection than with some of the other conventional means that we already have at our disposal? That information is crucial for us. It's very crucial for the Black Gay community. And that's something that we'd be able to disseminate really quickly to health department.

We're also working on community level interventions for Black Gay men because as I said before, when you're just looking at the individual level and you're looking at the level of just interpersonal relationships, it's not going to be able to reduce the high infection rates that we're seeing here. We

need something that's going to really reduce things at a much higher level than that.

And last, we're also considering interventions that just don't focus on a deficit approach and a deficit model. I mean, too often as public health professionals, we're always telling people what they're doing wrong. We're always focusing on their risk. We're defining them in many ways that are just reductive and really turns people off to our messages to be quite frank. And we're also interested in taking a look at ways that we can deal with resiliency. There's 46 percent of us who are HIV positive, but that means that there's 54 percent of us who are not. Of those 54 percent, what are they doing to keep themselves from getting HIV? We really need to do more work with those men in our community. And we need to see whether or not we can harness any of those strategies and utilize them in any of the interventions that we put forward. So CDC is looking at each one of these different options to see how they can be incorporated, and the best way to disseminate it not only to the health departments, but also to some of the community-based organizations.

JENNIFER KATES, M.A., M.P.A.: Wow. I was— I thought I was going to wrap [applause] this up- I thought I was going to just wrap this up since we're just about out of time, by saying part of the frustrations, the disconnects or how complex

the issue is, is amidst everything else that we struggle with. You know, funding issues and how programs are organized, but it's really just so complex. On the other hand I think we've heard so many ideas and tools that can begin to help, you know, with the rich information presented with what was already in the literature, to begin to help structure a response. Before we send you on your way, or I guess lunch would be the next thing, is there anybody on the panel who wants to make any final comments or put forth a charge to the group? Suggestions, or say one final word?

ERNEST HOPKINS: Personally I don't buy into no new resources. We're finding money to take care of the mental health problems of returning veterans with new resources. This epidemic has been here for 27 years. If we need new resources to take care of America's HIV/AIDS we need to go get them. And we need to advocate for them, make them happen, not just with the federal government but with the city councils and with our state legislatures. And stop waiting for the dollars to come to us. [Applause]

JENNIFER KATES, M.A., M.P.A.: Well, on that note, I think Terrance is going to take over and tell us all what's next. But I just want to thank our panelists. Everyone should give them a round of applause. They have just— [Applause] It's amazing how in a relatively short period of time we have

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got out on the table so many of the quote the challenges and the cutting edge potential responses that really exist there. So I just think it was a wonderful discussion. I hope you all can use that information and I just thank you so much for your insights. [Applause]

TERRANCE MOORE: I want to echo what Jen has said. I really appreciate this panel and being able to take some very dense information and distill it very quickly. So that was definitely our home here this morning. And some of you are probably asking why we haven't given you the opportunity to ask questions yet? That's been very intentional. [Laughter]

Here's what we're going to do next. We would like folks to break for a working lunch for the course of the next hour or so. We would like you all to meet as state teams and start to take some of the information that you've heard this morning in both the presentation as well as the panel, and start to have conversations amongst you teams about some of the key themes that struck you. And how you might link some of the- particularly some of the barriers and the facilitators to individual programming that's taking place in your jurisdiction.

Patrick and I will be floating as soon as we get something to eat amongst the tables to give you some more down the next level of information that we saw, in particular

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jurisdiction. So we'll be around to do that and to answer any kind of specific questions. I encourage folks, the panelists who are going to stick around for a few minutes are going to be here this afternoon for folks who feel free to come up and ask questions as well. And again I want to thank everyone and there's a wonderful little spread of food out in the lobby. And thanks to our panelists again. [Applause]

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