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**Black Gay/MSM and HIV/AIDS:  
Confronting the Crisis and Planning for Action  
Welcome and Release of NASTAD Targeted Interview Findings  
National Alliance of State and Territorial AIDS Directors  
February 4, 2008**

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[START RECORDING]

[Applause]

**TERRANCE MOORE:** My task this morning is to really kind of get us through, and if we could start the screen on the first set of slides here.

I just want to kind of walk us through our - a few kind of guiding principles for the morning, actually for the entire meeting, just a few rules for us to consider.

A lot of the information that you are going to get today is going to be very rich. There are going to be some things that you agree with. There are going to be some things that you disagree with. There are going to be some conversations that are going to be had that you're going to think are wonderful and you're going to think that someone that said something, they are right on target. You're going to disagree with someone, but I just want to have us kind of establish an open-mindedness throughout the course of this meeting. Be respectful of other persons' opinions and experiences.

Fully participate. There's going to be a lot of things, a lot of discussions happening. We really pulled together what we deem are the best and the brightest across the country in terms of really having their hands in the pot of everything that's happening, so we really want folks to be

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engaged in all of the discussions, the discussions this morning as well as the concurrent breakout sessions this afternoon.

It's going to be extremely important for state teams, and in these state team processes, for folks to really be involved in that as well.

In terms of engaging in solution finding, we all know that there is not enough money. We know that you don't have enough staff. We get that, and we're talking about how we're going to be able to present the funding sections without basically presenting the obvious information. We know that, and we really want folks to think outside of the realm of limits that you face in your own jurisdiction in terms of resources.

Kelly McKinsey [misspelled?], sitting in the back in the green sweater, has taught me lots of step up, step back, so I encourage everybody to step up, step back, meaning if you're a person that talks too much, Terrance Moore, step back. If you are someone that doesn't always engage, you sit back, be the first person to make a comment. Be the first person to talk in a second, so get outside of your comfort zones.

Try to minimize sidebar conversations. You'll probably hear some things during the findings that you'll want to talk to your neighbor about. Try to avoid those as much as possible.

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Getting to sessions on time is going to be critical, and last but not least is my favorite thing. If everyone could turn off their cell phones, put them on silent, that would be fantastic.

So I want to also walk us quickly through the agenda. You all have a meeting notebook. If you could flip through the meeting notebook with me, I just want to kind of give everyone a head's up of what's in it so that you are able to get what you need.

Most of the information I want to draw your attention to, and folks can read this at their own leisure, I want to really turn your attention to tab four. Tab four has all your information for this afternoon regarding the concurrent breakout sessions. It has the session descriptions, as well as the second and the third pages behind tab four have your actual tracked assignments.

There is a dedicated staff person on the NASTAD staff who will be assisting the experts under those concurrent breakout sessions this afternoon, so if you have signed up for a track in the registration process your name should be listed in there. If there's someone who is not listed in there, let one of the NASTAD staff know and we'll get you to the proper place, and just to let everyone know, everyone in the room got their first choice assignment of where they were wanting to go,

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so if you're wondering whether or not you got your first or second choice, everyone got their first choice.

The other place I want to draw your attention to is under tab seven. Tab seven is the state action plan template, and under that particular tab, that's going to be the actual tool you use this afternoon and also tomorrow to develop your state action plans.

The state teams will meet this afternoon at individually at tables and at various rooms on this particular floor, and so you should be able to engage in a dialogue throughout the course of the afternoon and the morning to really start to look at individual issues that impact your jurisdictions.

The presentation itself, and we can actually go there, the presentation itself is a rather lengthy one. You will all get copies of the slides here momentarily. It is literally 97 slides, okay? I say that we are not going through all 97 slides, just so that you know [laughter].

We do want you all to know that this information is so incredibly rich that there was no way that we could get it down to a standard 20 slides or 30 slides or even 40 slides, so what you will receive, you don't have yet, it's literally taken us days to photocopy these slides.

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You will have the slides that you can look at in your own time, to go through the quotes, to really take time to synthesize them.

We're going to give you the highlights this morning, and also, which is going to be very impactful, are going to be some rich sets of audio that accompany some of the, what we are deeming some of kind of the most profound quotes that came from folks, so that's going to be a real treat as well.

So, without further adieu, I'm going to kind of start us off here. Again, we're going to take some time to go through the background and the methodology of this work, and then the sections of this presentation are broken out as follows.

We're going to touch upon some of the barriers toward targeted interventions going on in health departments and programming. The facilitators; we're going to have a conversation, of course, about some of the funding issues and limitations, and then what we are calling unique issues, which are issues that are nothing but issues that are very, very specific to African-American culture, black gay norms, things that came up during these interviews that we want to share out with you, and then of course conclusion and next steps.

So again, as Julie mentioned, some of the things that really started this work in terms of the scope of this

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particular project, was the release of the data that many of you, if not all of you, know about that came out of CDC in 2005.

It's the data that came out of the behavioral surveillance study that essentially underscored the enormity of HIV among black gay men in a subset of jurisdictions across the country.

We had a conversation internally and also with our African-American Advisory Committee about how we might be able to address this as an organization who represents state health departments. We had several robust conversations with our Executive Committee and just determined that we really needed to have a response that's going to be overarching across all of the state and local health departments across the country. We felt that we really needed to know exactly what was taking place out across the country.

One of the first things that we did as part of this process was conducted a survey of state health departments. We felt that we really needed to know what types of funding were out there targeting black gay men. We really wanted to know what types of programming was happening, and specifically trying to figure out the level of activities, and what were folks able to do in jurisdictions across the country if you

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were a small incident jurisdiction or a large incident jurisdiction.

So these are the things that we sought to find in that particular scope of work, the initial scope of work in the survey. We did publish, as many of you may know, and you also have included in your folder on the left side of your tab, two issue briefs that were released, the first being the issue brief that really kind of encapsulates the issues that black gay men are up against in terms of health and wellness, the second being the findings from this survey that is mentioned here.

Now, after we got the surveys back, we got lots of quantitative data, lots of numbers, lots of information about [inaudible 8:54] and surveys of what you all were doing across the country.

We really used the survey as a tool to really dig a little bit deeper. We felt, while the quantitative numbers were important, we felt the stories that were happening out in the community were far more important, and so we really thought about a process that was going to allow us the opportunities to get in your work to talk to you, to sit down with health departments and find out what exactly is happening, what are the challenges that you're up against, and this is how this process evolved.

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We met one on one, Patrick and myself. We flew to multiple places across the country, 14 jurisdictions all over the place and here they are, and we sat down with either the AIDS director or prevention director or the senior person responsible for MSM work. We sat down with community folks. We sat down with these stakeholders, and at the end of the day these were all the places that we visited across the country.

We conducted semi-structured interviews with folks. These are some of the general questions that we asked. How would you describe the HIV epidemic among African-Americans among MSM in particular, in your particular jurisdictions? What problems or issues are particular to African-American MSM that promote risk behavior and hinder prevention efforts? What will your state or jurisdiction do to respond to the African-American MSM crisis?

And we really wanted to key in on what were the available testing, counseling, referral services in your jurisdictions as well.

We asked state health department staff how many and what types of contracts are out in your jurisdictions to support local HIV prevention activities.

Would you describe the support resources available to your jurisdiction as adequate or inadequate? Does your agency

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employ a minority AIDS coordinator? Why or why not? Does your agency work with a community planning group? Why or why not?

So as you can imagine, we got some really, really rich information from all over the country and, as you all know, many of you who participated in this process knows that our questions went out the window most of the time.

We got some very, very rich information from all of the jurisdictions that participated that were well beyond the scope of the questions that I just raised to you, and you will hear some of those this morning.

So this is the fun facts, the numbers of miles traveled, 7,429 miles, 71 people interviewed, 46.8 numbers of recorded hours of interviews and 1,140 pages of transcripts and we are here today to share out our findings.

And without further ado I'm going to introduce Dr. Patrick Wilson.

[Applause]

**PATRICK WILSON, PH.D.:** Good morning, everyone. Before I get started, I just want to get my two cents in, and first thank NASTAD, Julie and Murray for their support of this work and Terrance, because as he said, we have developed such a strong relationship as colleagues and as friends over this process of doing this work, and it's been so important to me to

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have his insight as a colleague and as a friend, so I'm really fortunate to have been engaged in this.

And I just also want to add, as someone who does research this has been some of the most fulfilling, if not the most fulfilling work of my career thus far, a career that's still growing of course, but it's so important, the findings that we have here we think are so rich.

You can really see, based on the slide that's up why we have 97 slides, because we have 1,140 pages of text that we were trying to condense, and I wanted to add that we are highlighting some of the exemplary quotes, some of the quotes that we think really drive home the theme, but we saw many, many different quotes, and there were profound quotes left and right, so we couldn't actually put everybody's in there, and you might say I remember saying something that really fits with that statement, and believe me it was coded and used, but like I said, we are focusing on some of the quotes and excerpts that we felt most reflected the common theme.

Speaking of common themes, one thing that's important to talk about is the methodology that we used. We didn't go into this process with blinders on. We did use a structured approach, and we basically found that we followed the principles of what's called grounded theory, and some of who have done research and those of you that have worked with

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qualitative data may have heard of grounded theory. It's just basically a way of letting the data speak for themselves. It's not imposing a structure upon the data, but actually letting the structure emerge out of the data, and this process includes reviewing transcripts and taking notes, creating a codebook which is refined and revised over time, and I'll show the one that we used momentarily, systematic coding of the transcripts using the codebook, and we had three coders, which was myself, Terrance and Germaine [misspelled?] and I have to say thank you to Germaine too, because he was and has been just so important to this process and to getting the work done.

And then we used a qualitative data analysis software program called NVivo to really help us explore the themes and to extract some of the common findings.

So in total, in doing this process, in total we amassed over 120 codes that were used to document and organize the data for the project, and they fell along six categories.

So this is our codebook, and I realize the text is somewhat small, so I don't expect you to read all the fine detail, but the columns themselves form our main themes, we call them really level one codes, and they also are the outline of the presentation, of course, so barriers, facilitators, interventions, funding, relationships, and unique issues.

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These were the sort of large, key categories that we focused on.

And now today in our presentation we're really going to focus on barriers, facilitators, and unique issues. Finally and to a lesser extent, we won't be talking about intervention specifically because it's integrated into a lot of the other areas, and relationships also because of time.

So I'm going to start with barriers, and I have to say barriers is the most lengthy and exhaustive section, so we may spend a little bit of time here.

This table, and I'm going to be coming back to tables that sort of reflect these key things the six that we have. This table gives us an idea of how the theme was represented within these interviews, so when you see the percentage of interviews column, that's basically the percent of interviews that had a particular theme come up, and under barriers we had several subthemes, including department of health or health department and policy related barriers, CBO related barriers and interventions, syndemics, the internet, structural factors and psychosocial factors, network, and community factors, stigma, racism, and religion, and you can see the percentage of time that these topics came up in the interviews and then the number of references tells you the number of times actually

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that people mentioned it within or across the interviews that we conducted.

We're going to focus mostly on the most talked about themes, or those that were talked about really in about two-thirds of the interview. So one of the first barriers, and this was stemming from the health department, had to do with a lack of capacity building efforts with minority serving CBOs and how that negatively affected the performance by organizations targeting the population.

So this participant said "I don't think we have invested enough in developing the capacity of some of our community organizations, particularly indigenous organizations, in responding to those needs and think they're fairly complicated, and I think we need to be more creative than we've ever been."

Here's another great quote that really defines this lack of capacity - it was working earlier. Okay, sorry about that.

[Audio Playing 18:23 - 19:13]

So that's the good example of the efforts or lack of efforts, or not so much a lack of effort but really the effort that it takes to build a workforce of black gay men or black MSM that can tackle the challenges that CBOs are trying to tackle.

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Another theme that came up had to do with the representation of black people on health department staff and how that linked to cultural understanding and the competency of the health department, so this person said, "One of the first issues we had was that there were no people of color."

I remember this person asking an AIDS director one time, how many black people do you have that work here? And so the AIDS director starting counting on his finger and he was up to about 12, and the person went that's not - who are you talking about that's not either a secretary or working in some capacity like that?

And then he went, so you don't have that reflection, and this came up frequently across the jurisdictions as needing representation on the health department staff from black gay men, black MSM, black persons in general.

Another key barrier had to do with competency on the part of CBOs, but really more the interventions that were being disseminated and delivered to black MSMS, so this is another great example of that.

[Audio Playing 20:48 - 22:25]

And that came up, again, quite frequently from the people to the people, as being very important, and of course it links to health department staff having representation of people of color on their staff, and I think one of my favorite

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parts of that quote is seeing beneath the Kinta cloth, and I think that's really the point here is the need for interventions that are really not just in a patina of focus on African-American men or African-Americans in general, but that are really to their core about the issues affecting those populations.

Another quote, and many of our health departments don't go out into the community or don't really have access to our high risk populations, and so CBOs that do, they have the credibility, and those populations that are in the community, and many of them really did not have the infrastructure, the administrative capacity, the board capacity to continue to survive as a successful agency in this highly competitive time.

So again you have this dichotomy of the agencies that have the ability to reach the populations are many times the ones that are underfunded or that don't have the infrastructure to be able to effectively reach the population or intervene.

I'm going to continue to go up past some quotes, and this is again in an effort to allow you guys to read and sort of dissect, as you will. Another barrier for CBOs had to do with high turnover among CBO staff, so a couple of quotes from participants in California, "I think burnout has contributed to a workforce that is revolving. Certainly not - it certainly isn't longevity with our HIV prevention workforce in L.A.

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County and in particular some of the communities of color whose work, I think, is a little bit more intense."

Another participant said, "And I think the fact of the matter is we don't pay. We don't value this enough. Whether it's HIV counseling or the people that do outreach or risk reduction, we don't pay them enough. It's ridiculous, you know?"

Interventions were also frequently brought up as barriers, and one of the key barriers, or intervention related barriers, that were talked about had to do with the DB [misspelled?] interventions, and people had positive things to say about the DB interventions, but they did note that they weren't always practical in the field and they weren't always relevant to black MSM, so one participant noted, "We can't afford to do intensive interventions like that, because we can't deliver interventions in a practical - in a field setting the same way that they're delivered in a research setting, so oftentimes," and this is a way that this jurisdiction is unique, "because we have a particular expertise within the health department and available to us to pick out pieces and parts of the DBs our contracts with the CDC say do evidence based programming, and that's what we do, evidence based programming."

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So in this situation, the folks in the jurisdiction were able to build their own evidence-based intervention by taking pieces of DBs and putting them together and evaluating; however, we talked to many jurisdictions that were trying to implement DBs as they were packaged, and had trouble doing that, partly because of the lack of field applicability.

Again we focus a lot on DB interventions, which are hugely, in my view, important, but they're also expensive and labor intensive.

CDC holds to the microscope about that evaluation and the data. We're all perfecting this stuff.

Now, I want to move to a different category of barriers, and this is really more about psychosocial factors and I think you will all find that these things come up throughout the slides, whether it be specific to psychosocial practice; we're talking about communities. We're talking about stigma.

It seems to always come back to self-concept, self esteem and loneliness, and how those are really related to internalized homophobia and even self hatred among black gay men and MSM, and so this is a pretty good quote that I think exemplifies the issue.

[Audio Playing 26:55 - 27:15]

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And so, again, we thought this was a pretty profound statement, and it does actually - it's very consistent with the findings that we have here.

It wasn't an issue that black gay men didn't know how to use condoms or didn't understand HIV, but many times the latter, at least in this statement, that there wasn't a value, the same kind of value that we see in other populations in terms of saving one's life.

This participant mentioned, "For those people who you said so accurately earlier may have never received any other kind of nurturing anywhere else in his life ever, ever, and so to be able to spend an hour and a half with a doctor who is nurturing you, caring about you and taking care of you is the first step in healing."

Again, a lack of nurturance, a lack of connectedness in one's, in the past for many black MSM or black gay men is going to affect where they are today.

Another participant, "I think those guys may have some degree of internalized homophobia, and because of that they haven't achieved that level of self acceptance. I think that those are the guys who, because of that, wouldn't necessarily associate with an openly gay man for fear that the fact that they may implicate them in their interaction, so I think they do have unique needs."

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Here's another quote, and again I'm going to move on, but again psychosocial factors continue to pop up and they are extremely important, I think, to our prevention efforts for black MSM. Substance use, another issue, but I'm going to move to social networks.

Another theme that we saw come up so frequently had to do with a lack of venues and social spaces, and the idea that there were hidden communities, though there was a strong desire on the part of black gay men for connectedness with other men.

So this participant said, "One of the challenges we have consistently found with working with African-American MSM is the venue. The venue is constantly changing. Either the club goes out of business, they switch to a different venue, or because usually the way the clubs work for African-Americans, the African-American clubs around here work a lot different." And that I should say is a North Carolina participant. That's not New York.

But there was this idea of not being one place, one outlet, whether it be a community center, whether it be a nightclub, that black men can go to consistently, but that the venue was always changing. It was moving from place to place.

Another exemplary quote on a lack of venues and social spaces.

[Audio Playing 30:04 -30:43]

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So again, loneliness comes up, and it came up over and over again as the key issue.

Also fractures and division within the black gay male community was something that a lot of our participants talked about, and these fractures were often by age or class or SCS.

One participant from D.C. said, "But the fact of the matter is I think we all deal with class issues in our community and the black MSM community. I think that is a barrier for us."

Another participant in Illinois said, "Even in the gay community, those kinds of specific divisions about where you can be and who you are, are very prominent."

North Carolina participant, "There's not an organized black gay community. When you start looking into it deeper and sectioning it off, yes there is an organized community, but you have the black MSM who'll go out to the white clubs because maybe that's their interest. You have the groups that the younger ones, who will travel to Raleigh and to Charlotte from the different clubs and stuff there, who are just there to have fun, and then you've got the ones who are also part of the houses or the house and ball scene." So you have, again, a community that, in many ways, is divided and made it hard to target the whole community.

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Social networks weren't the only barrier. Sexual networks came up quite frequently in the work, and sex parties and how they are potentially risky context in which black gay men hook up, so this participant says, "So there are no lights, you know. You are bent over for three hours, four hours. You don't know what's going on. Again, I keep saying there are other issues. I believe that some people are using condoms but I don't think the majority are. The thing is it's just the whole silence."

And another quote, and I personally really love this quote because I think this is what people in CBOs have to deal with, "It's not about drugs and alcohol. It's not always about drugs and alcohol. It's about pleasure. I mean, some of it, that's driving it, it's about passion. How do you do prevention around passion?"

And I think that that's a really great way of putting it. It is about passion. It's about that connection. That's what our participants told us, and it is very difficult to prevent that and to do prevention around passion.

Another very interesting finding, and we're so fortunate to have great researchers like Greg Mulette [misspelled?] here who have looked at sexual networks among black MSM, but a lot of our participants also brought it up in

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talking about it as a reason for high rates of infection, and they really talked about it as pools of infection.

So this participant says, "And so we'll have, like, in our case management we'll have ten or 12 clients that got infected by the same person. They keep identifying that same person every time. They come in, that same name keeps popping up, and, but that person is not case manageable. They're known on our caseload, but they never will come. They never comply. They never want to talk about things. They never want to be open and discuss those issues."

So again, the networks, the ties between men often are ties that are allowing HIV to be transmitted from partner to partner. Here's another participant who really talks about there's less room for error when you are - when black men are having sex with each other.

And then a very interesting and provocative statement here that I think many people will react to.

[Audio Playing 34:24 - 35:22]

So here you see a lot of different factors coming into play, but the key here is the sexual network, but of course it's about testing. It's about treatment and getting people into care and again, another very important, I think, quote and theme when it came to the barriers around sexual networks.

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Stigma, of course, is an enormous barrier that we face in mounting effective prevention efforts targeting black gay men, and stigma stems from multiple characteristics, not just being gay. It's also being out. It's stigma around HIV and AIDS. It's stigma around sexuality in general, and it's stigma around femininity.

So one of our participants in San Francisco mentioned, "Because I think one of the core issues is self value, that we are struggling with deep seated internalizations of a whole range of oppressions that converge.

It's internalization of racism, internalization of homophobia, internalization of misogyny. All of these things converge and you are then seeing how the epidemic, the stigmatization of it and the prevention and treatment thereof gets internalized as well, and these are the things that are undergirding all of the kinds of behavior that we are engaged in."

Another great stigma quote, and it really sort of highlights how stigma is not just a personal level phenomenon. It's something that's the characteristics of communities as well, of neighborhoods, of organizations of entire geographic areas, "But you see we are still dealing with fear, real or imagined, and I keep saying that because that fear, that shame

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that we go through sometimes is just - it's just imagined.  
It's not real.

Many of us don't come out because we're so scared of coming out, but we don't know what's on the other side of coming out. We just assume that oh, our families are going to turn their backs on us. I mean, in some cases that's true. In many cases it isn't."

Here's another great quote that highlights how stigma really exists as a function of a geographic area, "But basically in this town, to be honest, for gay men that are out, it's still you have the closet mentality even if you're out. You just feel like there are certain places you can go and there are certain things they can do, and it's just really, God, I can't find the right word for it, but it's just - feel like you're restricted, extremely restricted."

Stigma, one of the themes that came out frequently, and as it related to stigma, was how it impacted HIV testing and health seeking behaviors, and that might be the real kernel of information that we need to focus on in thinking about how we deal with stigma in this population.

So here's a quote, "But you know, people are still doing that whisper thing. He got the monster. You know how those girls are, so internally we have stigma, so we have to work on that internal HIV stigma within the black gay

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community. I mean, I think that's the key for people willing to get tested; not feeling that they're going to be ostracized."

Another participant, and this is a very interesting quote because I think it really ties to how stigma is a barrier to health safety behaviors, "I see us black gay men who are HIV positive, who are insured, who are seeing doctors who are infectious disease specialists, but they're not HIV specialists, and so I think that hinders or slows down the progress of their treatment and the success of their treatment because they're seeing infectious disease doctors, but they're not HIV specialists, so they don't want to go to an HIV specialist because they don't want to be identified as HIV positive. They don't want to show up in a clinic or a medical setting where there's just no question about why you are here."

Another participant, and again this is stuff that came up over and over again. This isn't just unique to these jurisdictions or to these people, "I think that a lot of people feel that, and if there's anything we have heard a lot, it's that if somebody uses a condom then there's something wrong with you. You know, it's why is he using a condom? Does he have something?"

Again, sometimes we might think is this data coming from the late 80s or the early 90s? No, this is data collected

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last year from a very reputable person working on the front lines talking to clients day after day.

Again, stigma related to preventing health seeking behaviors also prevents ownership of HIV and a lack of a face to the epidemic.

This is a great quote as well. You'll hear me saying that a lot, "The one thing you said that I kind of feel differently about from a community perspective is that not enough people have died. What I think the statement should be is not enough people have died who were openly positive.

I have buried personally a number of folk; brothers, cousins, sisters or friends who died of anything but HIV and everyone knew they were positive. That's not what the community was told.

So there's a difference. There's a quantitative difference between saying not enough people have died, but not enough people are admitting that they're dying from HIV. I have a girlfriend now who still tells me that her brother died of pneumonia. The boy had AIDS. Everyone knows and you can't tell her honey, but we really know it was AIDS."

Structural factors represented also significant barriers, and this was really across the jurisdictions as well. One quote here is about locating an intervention program on a mass transit line. Another one has to do with trying to bring

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people into one facility but they're from all over the place, and it's hard because there's not transportation.

Another one that was prominent had to do with the use of highway corridors to link communities of black gay men and HIV epidemics across counties and states, so here's a quote from a Texas participant, "But outside of there some of the features from rural Texas, if you're a gay man or a man who has sex with men, you've got a lot of traveling to the larger cities or the big cities on the weekend."

Another one here from North Carolina about men traveling to go to Atlanta or D.C., "Even though they're in Greensboro, Raleigh or Charlotte, which are fairly large cities in North Carolina, they didn't have the type of access to social venues to other men as these larger cities did."

Structure also has to do with history. It has to do with institutionalized racism and homophobia and here we have a participant who says, "I think the major problem in the city of Chicago, and I do call it a problem, is you can be black on the South and the West Side, but you cannot be gay, but you can be gay in the North Side, but you cannot be black."

And I think again, another profound statement here that has to do with stigma, but it also has to do with structure. It has to do with neighborhoods and how you can or cannot be.

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Another one, "Baltimore has this consciousness of it was a southern occupied city during the Civil War. There's memory around that and it's memory from many generations of families that have been here for along time. The social networks are very confined by race. They're very confined by that sort of social level."

And now another participant in North Carolina talks about being gay in Charlotte.

[Audio Playing 43:27 - 44:40]

I think again, it's the being gay in Charlotte. It's this context that makes it difficult, and that came up quite frequently again, across our jurisdictions. And to end out barriers, syndemics came up not quite as frequently as some of our other barriers, but it was a quite important one.

And for those of you who are unfamiliar with the term syndemics, it's basically about the intersection of different epidemics, so you have an HIV epidemic. You also have a substance use epidemic. You also have an epidemic of homelessness and poverty, and when those things intersect you have a syndemic.

And here's a great quote from a participant from New York who really talked about needing to address all of these things in order to be effective in addressing HIV among black gay men.

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[Audio Playing 45:32 - 46:08]

So we're talking about barriers, and that was the lengthiest presentation, but let's move to facilitators and again, our table showing us sort of the representation of themes.

One thing I want to highlight is that in every interview we did, facilitators were brought up. This wasn't just about the negative. It was very much about the positive as well, and those facilitators existed on multiple levels; the department of health, CBOs, interventions, the Internet, structural factors as facilitators, psychosocial factors as facilitators, networks and community, and religion as well.

Health departments serve as facilitators, particularly in their capacity building efforts, so here's a quote from a person in D.C. who says, "And so we help those organizations get to a place where they can be competitive and at a place where they can deliver high quality services to residents in that ward.

The \$600,000 that's directly out of the director's office exclusively funds capacity building, training for these organizations." And so you can read, so on.

Another quote that has to do with capacity building.

[Audio Playing 47:23 - 48:42]

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So again, and I see people shaking their heads, it's about having an investment in the CBO, and we found that the health departments that were not just financial invested, but also invested in the health of the organization were the ones that were more effective at having CBOs and funding CBOs that could be competitive in getting funding, that could reach their target populations more effectively.

Communication also a key factor, and I'm going to move to this slide, because I think it really gets at the core of communication, particularly from the health department to CBOs.

[Audio Playing 49:30 - 50:36]

So again, it's really being open and transparent about the process and approaching CBOs and the other organizations that the health department intersects with, with respect and openness that really serves a key facilitator.

Related to communication, good staff in the health department is important. So this participant said, "But after that, though, I felt like whenever I've been in a quandary, need some guidance in this area, I've been able to call this AIDS director and it's been really valuable for me, because something about what to do, what choices to make, where to go, how to respond, what to say, what not to say, you know what I mean? It gets tricky sometimes."

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Facilitators from the CBO perspective had to do with many CBOs were finding black gay men where they were and working to promote creative ways of reaching folks, so this participant in Illinois says, "Because the things is when I was testing I wouldn't hand you off to somebody who I knew was going to be a complete ass or who was not going to relate to you, but I knew who could relate to who in what way.

If you were a female, then I knew this person would be more likely to relate to you."

Here's another participant from Illinois who did something really incredible, which is basically develop his own prevention program by going to a sex party that he had more or less infiltrated and also infiltrated with condoms, so he says, "When they see that bag, they know I'm in town. I had that bag. I came in the door and I said I want to do something special. He said," This is the sex party promoter. "What's that? I said would you be upset if I wanted to give out some condoms or some of these, because some of these people may want condoms. He said it's funny you say that because I would normally have a box and within a half hour I would have none left, and I thought it was stupid going to the health department and ask for a sex party.

For three weeks in a row when he had the next parties I went with a box and that had almost 1,000 condoms, and went

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through four sex parties and that was going on the same night and came home with two condoms left, so don't tell me about preventative work not working. A little idea turned into a big theme if you're serious."

So again, sometimes it takes creative, very grassroots type efforts to get your prevention program out there. Effective and competent CBOs are crucial to achieving good outcomes. Here this participant talks about, and these are black gay men, or black serving CBOs, where he says, "I mean there are some people who are very focused on making sure every single financial piece in the system is tight, every deadline is met, every monthly report is submitted, even amongst the small CBOs. It's very strong leaders. They've been in place for seven, eight, ten, 12 years. They don't have the staff turnover. They have strong recruitment and retention patterns."

So it's certainly not that every CBO, minority serving CBO out there is incompetent or lack infrastructure or lacks the ability. That's certainly not the message. In fact, we have seen throughout our jurisdictions that several CBOs did have great leadership and great organizational capacity.

Interventions, holistic interventions seem to be the greatest facilitator across the board when we spoke to participants.

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And I'd like to play this quote, which I think gets at how it's important to sometimes focus on more than just HIV when you are tackling HIV with black gay men.

[Audio Playing 54:33 - 55:44]

So again, approaches that tackle the whole person were very - were found to be effective among the participants in our interviews.

Psychosocial factors as much as they were barriers, if you think of just the opposite, when they were in place, when you saw men who had a great sense of self, they were very comfortable with themselves that truly facilitated their engaging in healthier behaviors.

And it wasn't just, as I said, about education and awareness, but sometimes skills building and harm reduction approaches were important for this population.

A positive sense of self, again, as a major facilitator and here, I'm not going to read the quote. I'm going to paraphrase. This is a person who mentioned a younger person coming into his office saying he wanted an HIV test knowing that he was HIV negative because he had just had a test weeks earlier and it came out negative and he hadn't had sex, but he was just so afraid.

And the director said, you know, I don't want you to take this test right now. I want you to go out there and stay

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HIV negative. I want you to know that you are a valuable person. I need you to stay HIV negative.

And promoting that message seemed to be extremely effective, particularly for the younger black gay men that this person interacted with.

Here's another one, another quote, "In our curriculum we talk about self esteem. We talk about positive black role models. We talk about church. We review scriptures and what we call the Claver [misspelled?] scriptures.

A lot of men don't understand that there are certain interpretations that are a little different than what they've been taught.

We do three month follow-ups and we have health parties where we bring the graduates together."

Social networks also serve as a facilitator, and here it was creating spaces and building and utilizing existing spaces. This quote has to do with the use or participation in black pride events, and this person says, "I think black pride is an important key, and I don't say that because I've actually seen or been told, but people who've gone home and they've gone home and they've told their families they were gay because they went to pride and they felt a kindrance there with the people there.

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They feel it was a positive thing and they felt uplifted. I think we need to continue finding ways to uplift each other," and he continues.

Now that's not to say black gay pride is going to work for every black gay man, but it certainly does promote community building and fosters a sense of pride in the community and oneself, and that's what this participant was really getting at.

Peer led approaches also seem to be the most effective approaches. Here this participant says, "We have gone to universities with primarily large African-American student populations and do the ambassadorships as well as work with the Hellenic organizations, all the sororities and the fraternities, to get them to have ambassadors so that they can do training statewide.

It's all peer modeled. It's all peer modeled. We believe that peers are the best way of doing HIV prevention work."

Another participant talking about the importance of peers and incorporating club promoters and party promoters into delivering HIV prevention messages.

And here a quote about the importance of engaging youth into the conversation, and this participant noted, "But people of our age also discount the enormity of the ballroom. It's

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something that sissies do. It's something that little kids do." And the interviewer says, "Or it brings the community down."

"It brings the community down, and there are some things that are not so good that go on in ballrooms, right? But everything, it has a good and bad, and I can think of, as a practice, as a cultural practice, as a practice that can also be put to use to help reduce the impact of this epidemic on an entire community, it has to have some sort of recognition, which is in some cases it's beginning to get that recognition, but clearly not as much as it needs to."

House and ball came up quite frequently across the jurisdictions and it's not just New York. It's not just California. It was very much a part of North Carolina, Texas and Illinois as well, and people had different feelings about the house and ball community, but one thing did seem clear is that it has to be a part of the conversation.

It is a great way of engaging and finding younger black gay men and younger ethnic minority and sexual minority populations as a whole.

Internet based approaches were also important. I'll let you read these quotes yourself.

So we're almost to the home stretch. I just want to talk briefly about funding issues, and briefly because, as

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Terrance said, we know that there are issues and there's a lot of things going on with the jurisdictions.

Here's our table of codes or themes, and you see that there were several different subthemes to the funding issues code. They included creative funding, heeding priorities, program destabilization, efficiency in using funds, limited resources, the use of epidemiological profiles and then finally politics.

So we have an example of how limited resources and decreasing funding trends erode not only programs, but also innovation.

[Audio Playing 1:01:40 - 1:01:52]

The interesting thing is the second part of that quote. The same thing happened across the country in Michigan. Here's a participant that says, "Well, we have not a choice. We're working with what we have, but yeah, because of the rescissions, we've lost about \$300,000 in our prevention funds over the past few years." "And why is that?" the interviewer says.

"In the rescissions we've lost about \$300,000 of our CDC prevention funds in the last two or three years, so we're doing more with less. It's an issue. We certainly have a lot more need than we have resources to address that need, and I think that every single state will tell you that.

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We actually lost some state funds in 2002 because, I don't know if anyone else has told you, our economy is in horrible, horrible shape in the state. After Louisiana we are the worst economy in the nation and it's not getting better.

Right now we are looking at \$800 million deficit for this current fiscal year." So again, limited resources having a huge effect.

Use of epidemiological profiles is something that also came up a lot, and navigating multiple epidemics with limited resources as a huge challenge, so this participant in Maryland said, "To me prevention works, but then you look at the numbers we have now among MSM and you see we haven't been doing much with MSM and look what happened.

It's like that game that you play as a kid when you knock down the one and then the other one comes up. As much as this graph sort of argues to move resources away from injection drug users, I'm like wow, we could do that, and then in five years we will be like hmm, look at our numbers among IVU.

It's just we need more resources so that there's stuff going on with all the populations all the time, like you just said. So it's again trying to match resources to what's going on in the FE [misspelled?] is not always an easy task."

And then efficiency and use of funds another key issue when it came to funding and here's an exemplary quote,

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"Everybody seems real comfortable, you know, saying there's increasing numbers, and how many African-American MSMs are living with HIV, but when you start talking about the money and the response and the need to focus your dollars there, then everyone kind of got vague and weird, because we all know the pot is only so big.

It wasn't increasing, and so whenever you start talking about a focused response, the underlying thing is you're really saying we're going to have to start redirecting dollars, because everyone with a function in blame knows that as much as we'd like there to be more money, there isn't.

So there's that undercurrent that says if we are going to acknowledge that we need a focused response, that money's going to have to come from somewhere and barring any new resources it's going to have to be redirected."

Okay, so again efficiency in using funds a key issue, so we're finally at the last major theme, but I would say that Terrance and I would agree that almost the most important and personally just interesting had to do with the unique issues that came up.

And they underlie the barriers, the facilitators, even some of the funding issues that we just talked about, but they were these things that we didn't think fit into any other category outside of being unique.

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They're not necessarily unique only to black gay men. You might see some of the same kinds of things come up for white gay men, Latino gay men, et cetera, but in the black context, which is what we're really focusing on here.

And there were four main categories. I'm going to focus on three today, norms, the DL phenomenon, which as you see came up in about half our interviews, research and then also interracial sex.

So black gay norms, one of the big issues had to do with what is the meaning of being gay and coming out as a black gay man or a black MSM?

We know that it's important to self concept, or many folks said it's important to self concept, and we heard a slew of quotes about facilitators and psychosocial factors that sort of increase self esteem and self concept.

And coming out can do that, but then what's the incentive? So we have two quotes, one audio, that I think get at this debate.

[Audio Playing 1:07:37 - 1:08:36]

So again, we're hearing the importance of coming out, and then sort of the alternative and here a participant says, "I think there needs to be a conversation within the larger African-American community about what incentives exist in the black community for black gay men to come out."

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So we have this balancing act that we're trying to achieve, and I should just note - this is coming about 90 slides too late. We're trying to give the picture, the full picture, and you can, you may have heard, we're presenting some information that counters other information that we've said, but it's to really give the full perspective here, and so of course Terrance and I don't know the right answer, but hopefully that's something that we can work on and discuss over these next two days.

Body image issues were also something that came up and the need for positive and realistic images of black gay men and black MSM, so this participant says, "You may be fat. You may be, you know, bald headed, but we have the perfect image of what we want our lover to be, you know what I'm saying? So I mean, if we just really start focusing on the relationships that can work, I think, I love Noah's Ark.

I think it's real. It's something positive. It shows that you can have relationships, but if you do cheat on each other are you going to be able to make this work. You know what I'm saying?

So once we start to see more of ourselves on TV and the media that we can have relationships, I mean, you have guys that have been in relationships for five and six years and they

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don't go anywhere, so nobody really knows them unless they are really small. They usually have a small clique of friends.

So we don't - a lot of people don't see that you can have a house together, a car note, be in a monogamous relationship. All of these things need to come to the forefront for black gay men to have a better self concept and image of themselves."

Here's another participant that talks about body image issues.

[Audio Playing 1:10:40 - 1:11:36]

So again, here we've got an issue that's probably relevant across men, not just gay men, but I think the key that might make it somewhat unique has to do with the last statement that the participant said, that we've been so emasculated that we overcompensate a lot more, so sometimes the body becomes even more important. Sometimes the no fats, no fems becomes even more important.

Black male norms formed another pretty prominent unique issue in the importance of understanding what goes along with black masculinity.

So this participant said, "I think there's such a sense of shame and guilt with being gay, especially for black people. I think that comes because black children, black little boys

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particularly, never get to be little boys. You're always little man from the time you can walk.

You become little man, and you become, in a lot of families, there's no father there so you become de facto father. You have all these responsibilities. If you fall down you can't cry. You have to learn how to do man things.

The one thing that you cannot ever be is ever let - you can be a murderer, a rapist, anything, but you cannot be a sissy.

We can justify anything you do, but just don't be that. By the time you hit your sexuality you're like, oh God, I know what I like and oh my God. You're filled with self-hatred.

If I don't care about me, why would I definitely - why would I care about you?"

Another quote, "But I think along with the black pride movement you have some folks who don't want to be associated with that, almost the flamboyance of that movement. There's not a lot of balance as far as the different subgroups that make up African-American MSM.

So it's like, like I said, it's a very obvious group and because of that, folks aren't necessarily going to participate, especially in this city, because we are still, although there are a lot of folks coming in from other places in the country, we are still very much a Southern city.

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There's a lot of emphasis on just being a man, you know? Being a Southern black man," and the interviewer asks, "And what does that actually mean?"

"I mean, it just means you're expected to go forth and provide for your offspring and be macho and do manly things and just all the bravado that comes along with the South."

Another person talked about how younger black gay men are emulating black heterosexual youth culture, and particularly when it comes to the idea of engaging in raw sex, and you can read the quote for yourself there.

Sorry, I know. Well, when you get your slide packet you can read the quote for yourself.

The DL phenomenon, it's - we almost didn't want to talk about it because we do hear it so often, but we got some interesting findings and you all talked about it, so it's important for us to share it that one thing that seemed consistent, people agreed, yes, there are men on the down low, but non-gay-identifying MSM are not unique to the community. Greg Mulette [misspelled?] has done research showing us that. We know that.

This participant said, "I think the DL phenomenon is overstated. We have white gay men who are in the closet. We don't call them DL. People are on the DL for many reasons;

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safety, discrimination on the job, discrimination in the community."

Another participant said, "Because African-American women now feel that this is something that is unique to only black men, which we all know is not true, that's a big fallacy, but they think oh, now this is the new thing about men down low and they really think this is something new and really unique to only black gay or black men, and that's not true."

Most of the conversation around DL had to do with how it contributes to hostility toward black gay men and black MSM notably as vectors of HIV transmission, and how it then thwarts openness among black gay men.

So one participant said, "The down low thing gets on my nerves and I'm like what incentives," Again the incentives, "What incentives - what's in it for a black gay guy to come out into this level of hostility, so that means people want to rag on down low guys, but you're like well if it wasn't compulsory to be heterosexual maybe they would."

So, another audio quote that's getting at the demonization of black gay men.

[Audio Playing 1:16:22 - 1:17:16]

Well, I think that speaks for itself. The DL phenomenon also came up as something that now is emerging as an identity and even a culture of resistance as one participant

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put it, for black gay men, and this is particularly younger black gay men, so this participant said, "I'm telling you. Go on Adam for Adam. It's all there. It's all on. The first thing they'll say is DL.

This is what's funny. You've got to ask yourself, because what's DL mean now? You're DL, right, but you have a picture of yourself on a sex site, [laughter] [applause] looking for another man on the Internet?

So how DL could you really be? What does that - to answer that question what does DL mean? I think that it's an identity in itself now."

Another quote getting at this DL as a culture.

[Audio Playing 1:18:14 - 1:19:03]

So the final theme, and possibly the most provocative had to do with interracial sex, and particularly the sexual objectification of black gay men, black MSM by white gay men.

This is an area that's interesting to me as a researcher, and I've done some work, burgeoning work looking at this.

One participant said, "I don't think our white gay male community is any different than what we see. The characteristics and the dynamics, interracial dynamics that happen are not different than in other communities. We see it's not about where did you go to college or what's your

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goals? What's your dreams? What are your aspirations or what's your hobbies? No, it's how big is your dick, point blank, and if you don't have a big dick you're in trouble because I'm going to go to the next brother, or it's how much money you have. We all know those kinds of dynamics exist in the gay community."

Again, a provocative quote, but something that did come up frequently is black men being looked at as sexual objects by white gay men.

Another quote, and I'm going to temper this one a little bit, "As far as sort of what I see anecdotally in my own experiences that there's an ongoing fetishism. I think it's really linked to devaluing and I think it's around class too, of black gay men that is quite persistent in that after the sex is done, the possibilities for equal partnership and value go down.

I think what happens is as guys try to socialize in some of these more traditional venues they're accepted, but they're accepted for their bodies and for what they can do with a white person.

So you end up with a real persistent racism and acceptance only for what you can do for the white man and not for what you can do as a whole person.

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We're just going to meet just through certain venues, whether it's cruising areas, whether it's the bathhouse or multiple Internet sites, we'll connect with you for that, but you're not good enough to be with us on our white circles or our white events."

So it's not the best way to end it, probably, but it does, I think, leave a striking example of some of the issues that black gay men are facing, health departments and community based organizations that are intervening with black gay men are facing.

Self concept, self esteem underlie a lot of this, but it's so hard to develop those in a context in which you're being wanted for only your body, or a context in which your community is telling you that you're an abomination against God, or a context in which DL is an identity and being gay may not be even what's cool or in.

So just to conclude very briefly, and then I'll turn it over to Terrance, we covered and uncovered a lot of different things here, as you hopefully have seen, and I think it's just important that we understand both the utility and the limits of the data presented.

Like I said, we're not able to say that we know there's a relationship between self esteem and condom use. We didn't do a statistical analysis in which we got significance tests

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here, but we actually value this data much more than that kind of data, because it actually is giving a voice to the participants.

And that is, I think, the main point here is to actually hear from you and be able to give that back to you in a way that we hope will be effective as you go forward and engage in your programs and outreach efforts.

[Applause]

**TERRANCE MOORE:** Thank you, Patrick, so we've had a marathon morning, and I just wanted to quickly summarize the end of this presentation by saying that we really do want this to be the backdrop for your conversations that you'll be having over the course of the next two days.

We do have copies of the presentation, so as folks start to have their discussions in state teams they can really go back to some of the data points and some of the research to be able to use that in your conversations.

In terms of the technical assistance piece that you see in bullet two, this really is why you're here. You're here to develop these plans to have discussions amongst your teams and to really pull together something that you will deem meaningful in your own jurisdictions however the scale may be.

And so we are going to be here to assist you in that, and this begins what we like to call a one year technical

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assistance relationship with NASTAD to be able to provide you with some of the tools that you need to be able to be successful.

So I'd like to take a brief break. Folks can get up and stretch, and if we can get back here in ten minutes or less we're going to have an opportunity for our expert panel to respond to the findings.

So if folks can get back here—

[END RECORDING]