

# HIV Risk Reduction

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## Reaching African American MSM

The year was 1993. University of Chicago undergraduate student Rashad Burgess was attending the funeral of a friend.

A strange secrecy cloaked his death. As Burgess looked around the sanctuary of the African-American church, it was apparent that a number of those in attendance were HIV positive. At the time, wasting was a significant symptom of the disease, and the popular treatment AZT delivered its own telltale signs, impacting the color of one's skin and changing hair texture.

Speaking about the deceased man, who had been a member of the church's gospel choir, the minister mentioned an AIDS organization for which the man volunteered, disguising the term AIDS by spelling it. "A. I. D. S." The clergyman seemed afraid to give voice to the acronym while in the house of God. The individual letters lingered in the air – and in Burgess' mind.

"The minister was unable to speak about the very disease that killed the man for whom he was performing the service," he recalls. "I was struck by that. Clearly this problem was impacting African-Americans, yet no one in the church was talking about it." The event was so remarkable, Burgess decided to study the role of AIDS in his religious community and was selected as an Andrew Mellon Fellow in recognition of his research. It led to a career where he is still working to change cultural behavior, perceptions, and dynamics.

Early in his professional life, Burgess worked for Chicago's Department of Public Health, creating MOCHA, a federally funded program dedicated to fighting rising HIV infections among black and Latino men. An article in *The Preventionist* reported the following about his endeavors: "My goal was to build a new information and prevention infrastructure in the



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black community,' said Burgess. 'I always understood that black gay men experience sexuality and life, including HIV, differently than (stereotypical white gay characters) on TV.' Burgess' insights have infused MOCHA with innovative grassroots ways to connect with black and Latino men, including those on the down low who might not identify as gay."

Today, Burgess serves as Chief of the Capacity Building Branch, Division of HIV/AIDS at the National Center for HIV/

AIDS, Viral Hepatitis, STD and TB Prevention at the Centers for Disease Control and Prevention (CDC) and his work has a much broader reach. Yet many of his responsibilities revolve around dealing with the same issue, which is now captured by a different acronym: HIV in BMSM (Black men who have sex with men). And the statistics are alarming.

A study of MSM conducted in five U.S. cities between June 2004 and April 2005 found that 46 percent of BMSM tested were HIV positive, and 67 percent of these men were unaware of their status (HIV Prevalence, Unrecognized Infection, and HIV Testing Among MSM).

“African-Americans are still disproportionately impacted by HIV; we represent over half of new HIV infections and more than half of all cumulative cases,” says Burgess. “The African-American community is really devastated by this disease.” He compares the situation to sub-Saharan Africa. “The disease is so prevalent, it is becoming the norm among African American MSM,” says Burgess.

It is not uncommon for the public – and some health professionals – to assume that HIV prevalence within the African American MSM community must be high because of high risk behavior. In fact, as a group, African American MSM have a lower rate of high risk behavior than white MSM.

There are numerous interlocking issues that contribute to the high prevalence rate, but none more central than the fact that African-American

MSM tend to have very small social/sexual networks which means that disease, once introduced, spreads rapidly. Among white MSM, the background prevalence is lower, yet, “it’s interesting because white MSM actually have higher risk behaviors,” says Burgess.

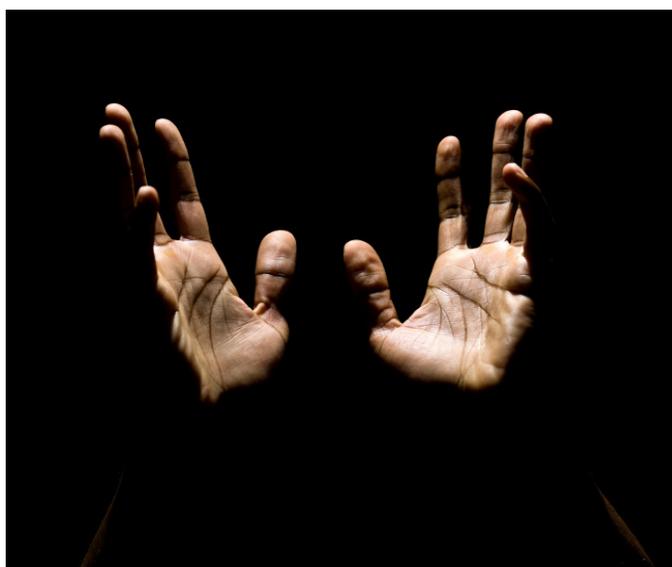
To look at it in terms of probability, in a network of four people, if one person is HIV-positive, the odds are far greater that a single act of unprotected sexual contact will lead to infection than in, say, a network of 50. As a result, explains Burgess, “The pool has become so infected that even if members rarely engage in risky behavior, there is a very high probability that they will contract the disease.”

As a result, the CDC recommends that sexually active MSM be tested annually. While the rate of African American MSM

tested for HIV at least once in a lifetime is reasonably high, given the extraordinary prevalence rate, as a group they are not testing frequently enough. Scientists know that people are rarely able to achieve a 100 percent rate of safe sex over extended periods of time and “because the background prevalence is nearly 50 percent, just one exposure can lead to an infection,” says Burgess.

“And the reason testing is such a big deal is because we know that when a person is newly identified HIV-positive, they have a 30 percent reduction in risk behavior within the first 6 to 12 months,” says Burgess. “That rate of behavior change is as high or higher than what is achieved in our most successful interventions.”

Additional factors that influence rates of infec-



tion in this community include substance abuse, which plays a key role in escalated risk behavior; a higher rate of STDs, which increases the risk of transmission; and a level of stigma that can prompt those most in need to avoid any association with HIV-related services.

While these factors are not limited to the African-American MSM community, they are compounded by racism and cultural divides. Compared to white MSM, BMSM have higher rates of poverty and joblessness and are less likely to be insured. Therefore, they do not have access to healthcare at the same rate as other populations. So those who contract HIV have more limited access to care and, as with African Americans in general, lower compliance with medical regimens. “So,” concludes Burgess, “What do we know about HIV medications? We know that when people are not compliant, it increases the viral load which in turn increases the likelihood of transmission when participating in risk behavior.”

Another way in which African American MSM are set apart is that the stigma of their sexual preference carries greater weight than that of white MSM. For example, a white MSM who chooses not to reveal his sexual preference is said to be “in the closet;” an African-American man who does not disclose that he has sex with men is referred to as on the “down low” or DL. Men on the DL have been widely - and falsely - blamed for the HIV epidemic among African-American women.

And while the subject is no longer completely taboo, there is still a level of shame associated with MSM behavior in the African American church. It



is common now think in terms of “loving the sinner and hating the sin,” which, though far from an embracing message, is one step closer to respect for human dignity. At same time, says Burgess, “They are still wrestling with what that looks like in practice.”

This same struggle occurs with healthcare professionals and others who provide services to at-risk populations. “Many people are trying to reconcile their faith or belief systems with their job requirements,” says Burgess. “In the past, we’ve tried to

change people’s belief systems. I’ve evolved to where I no longer think that’s the answer. We need to focus on how we engage with and treat clients.”

One African-American MSM reported that when he entered a counselor’s office, he saw a Bible prominently displayed and open to Leviticus 20:13, which, as quoted on godvoter.org reads:

If a man lies with a male  
as he lies with a woman  
both have committed an abomination

For an HIV Early Intervention Services counselor, such a display would be considered highly unprofessional -- not because of any personal belief that a worker may hold but because a non-judgmental attitude is key to working effectively with consumers. Creating an accepting environment is particularly crucial for professionals who serve people at the intersection of drug treatment and mental health care. For those who may be challenged by this professional requirement suggests Burgess, “Make a decision that your personal beliefs and convictions are strong enough that you don’t have to visit them on someone else.”

## Reaching African-American MSM *continued*

Asked what health professionals can do to create an environment where African-American MSM feel accepted, Burgess notes that subtle behaviors often make a difference.

- Personal bias is revealed when an HIV worker treats some clients differently than others. In contrast, a receptionist who smiles and greets each consumer with the same warmth and respect is sending a powerful message of acceptance.
- Avoid making assumptions about sexual orientation or labels. African-American MSM may identify as heterosexual, bisexual, or homosexual.
- Avoid telegraphing judgments with body language. For example, when a client says something that you were not expecting to hear, maintain a receptive expression.

Burgess assures readers that “being clear about what these clients face is a major step.” Additionally, many of the approaches that HIV EIS workers already use with other populations apply:

- Maintain a non-judgmental attitude. Find ways to make sure that African American MSM are clear about their risks without further stigmatizing this already marginalized group.
- Take a holistic approach. Encouraging clients dealing with substance abuse issues to stay in treatment can help to decrease their chance of engaging in risky behavior. Mental health treatment is important to this population. There is a high rate of childhood sexual trauma and abuse as well as the threat of rejection by family and friends.
- Support HIV-positive clients’ efforts to adhere to medical treatment.

And finally, African-American MSM clients may need to reconcile their own beliefs around sex to see themselves as worthwhile. At a 2008 meeting of National Alliance of State and Territorial AIDS Directors entitled, “Black Gay Men/MSM and HIV/AIDS: Confronting the Crisis and Planning for Action,” one participant put it eloquently:

It’s not a question of them not knowing how to save their lives.

It’s a question of knowing whether their lives are worth saving

To slow the growth of HIV in the African-American MSM community, “there are so many layers to deal with, all working in concentric circles,” says Burgess. “It’s difficult to wrap your mind around all of the issues.” And yet, there has been progress. If he were attending his friend’s funeral today, Burgess is certain the minister wouldn’t hesitate to pronounce “AIDS” aloud in a house of worship. And many churches are taking a leading role in educating their congregations about the problem and its challenges. The pulpit is one of many venues available to reach this hidden target audience, because many of those who need the information are sitting in the pews.

## *HIV Risk Reduction*

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