Men Who Have Sex with Men of Color in the Age of AIDS: The Sociocultural Contexts of Stigma, Marginalization, and Structural Inequalities

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Introduction

Current State of the AIDS Epidemic in MSM of Color Communities

Nearly three decades since the onset of AIDS epidemic in the United States (U.S.), men who have sex with men (MSM) have represented a significant disproportionate number of cases of HIV and AIDS.[1] Within this context, MSM refer to gay, bisexually, and heterosexually identified men who engage in sexual behavior with other men. With the advent of HIV antiretroviral therapies (e.g., HAART or highly active antiretroviral therapies), AIDS-related morbidity and mortality in MSM initially decreased during the 1990s.[2] Yet, recent epidemiological data have demonstrated that there has been an accelerated increase in rates of HIV and AIDS, as well as other sexually transmitted infections (STIs) in MSM.[1] For instance, in 2005, MSM represented 71% of the overall HIV infections among adult and adolescent males in the U.S.; MSM also accounted for the highest HIV transmission category, 67% of male infections, compared to 15% for heterosexual transmission and 13% for injection drug use.[3]

MSM of Color (identified as Asian/Pacific Islander, black, Latino, and Native American/Alaska Native men) have been significantly impacted by the AIDS epidemic in the United States.[4–9] Much of the HIV epidemiological data have demonstrated that black and Latino MSM – in particular – have experienced substantial disproportionate rates of HIV and AIDS in the U.S., with the rates among black MSM comparable to some of the highest rates observed in some resource-limited countries.[10] By race/ethnicity, of the 207,810 MSM cases of HIV/AIDS in 2005,

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32% represented black MSM, compared to 50% for white MSM, 16% for Latino MSM, 1% for Asian/Pacific Islander MSM, and less than 1% for Native American/Alaska Native MSM.[3] However, incidence and prevalence rates of HIV/AIDS have been underestimated in specific racial/ethnic groups, including Asian/Pacific Islander and Native American communities, due to inadequate methodological approaches (e.g., research design, measurement, and sampling procedures) including but not limited to misclassification of racial/ethnic groups, surveillance systems not collecting data on specific groups, and failure to disaggregate within-group data to assess specific HIV-related health disparities.[8,11,12]

In a large-scale epidemiological investigation of MSM ($n = 1{,}767$) in five urban, U.S. cities (Baltimore, Los Angeles, Miami, New York City, and San Francisco), 46% of black men tested positive for HIV when compared to men from other racial/ethnic groups (white men = 21%; Latinos = 17%; Multiracial men = 19%; Asian/Pacific Islander, Native America/Alaska Native, and Other men = 13%).[13] Significantly, in this study, 67% of black men were unaware of their HIV positive status when compared to the overall sample (white men = 18%; Latinos = 48%; Multiracial men = 50%; Asian/Pacific Islander, Native American/Alaska Native and Other men = 50%).[13] Moreover, in terms of younger MSM (YMSM), in a large-scale cross-sectional, multisite, epidemiological study (e.g., Young Men's Survey) of 3,492 YMSM between the ages of 15 and 22 from seven urban cities in the U.S., HIV prevalence rates were higher among blacks (14.1%), Latinos (6.9%), and men of mixed race (especially those respondents of black racial backgrounds) (12.6%) than among whites (3.3%).[10] Based on the findings from Phase Two of the Young Men's Survey that enrolled 2,942 MSM (aged 23–29), HIV prevalence rates were as follows: black MSM (32%), Latino MSM (14%), and white MSM (7%).[14]

Significantly, according to the CDC,[15] current surveillance trends for 2001–2006 indicated that overall rate of HIV/AIDS diagnoses for MSM in the U.S. increased by 8.6%, although there was a decline in HIV/AIDS diagnoses in other HIV transmission categories (e.g., high-risk heterosexual contact, injection-drug use (IDU), and MSM/IDU). By race/ethnicity, the surveillance data showed that: (1) the overall rate of HIV/AIDS diagnoses increased by 12.4% for black MSM; (2) the rate of HIV/AIDS diagnoses for younger black MSM (aged 13–24) increased by 93.1%, which was equivalent to a twofold increase when compared to white MSM within the same age group; and (3) the rate of HIV/AIDS diagnoses for Asian/Pacific Islander MSM (aged 13–24) increased by 255.6%, which represented the largest proportionate increase by race/ethnicity for MSM. These current trends have been indicative of a consistent and substantial increase in the incidence and prevalence of HIV and AIDS among MSM of Color in the U.S.

Overall, the AIDS epidemic has had a significant impact on MSM of Color communities since its onset in the 1980s in the U.S.[16] Nonetheless, there has been a significant void in HIV prevention research on MSM of Color communities in relation to AIDS epidemic.[4,6,16–21] Within this context, the objective of this chapter is to better understand the factors that have led to the disproportionately high HIV incidence and prevalence rates in MSM of Color communities. Thus, this chapter will examine: (1) theoretical approaches to HIV prevention in MSM

of Color communities with specific focus on the role of stigma, marginalization, and structural inequalities in MSM of Color communities; (2) factors associated with disproportionate HIV infection rates and HIV sexual behavior in MSM of Color; (3) assessment of current HIV prevention strategies; (4) revised HIV testing, prevention, and risk-reduction strategies; and (5) psychosocial support and mental health needs of MSM of Color. In particular, this chapter will be nested within culturally relevant conceptualizations for MSM of Color that articulates the significance of a paradigm shift in the field of public health that integrates core theoretical premises of interdisciplinarity, intersectionality, and structural inequalities. Parallel to these fundamental ideas, this work will provide praxis – theoretical applications and strategies for engaging the intersection of race/ethnicity, gender, sexuality, and social class – that transcend traditional ways of thinking, and provide focus to culture-specific contexts associated with AIDS epidemic in MSM of Color communities.

Theoretical Approaches to HIV Prevention in MSM of Color Communities

The Role of Stigma, Marginalization, and Structural Inequalities

A key element in addressing HIV-related health disparities for MSM of Color relates to the development of theoretical frameworks that are grounded within culturally relevant conceptualizations.[6,12,19,21–25] Within this context, a critical analytic framework for HIV prevention research – including theory, methodologies, and praxis – incorporates a connection to the interface of racial, gender, sexual, and social class politics.[26] Thus, a major part of this work calls for a paradigm shift that links HIV prevention within intersectional and interdisciplinary discourses that correspond with sociocultural factors that are relevant to life experiences of MSM of Color.[21] In particular, the concepts of stigma, marginalization, and structural inequalities provide a theoretical framework to examine the complexities of the AIDS epidemic, as situated in the everyday, lived experiences of MSM of Color.

Building on the work of Cohen,[27] these fundamental ideas provide a conceptual framework for addressing asymmetrical power relationships (i.e., power inequalities) in communities of color, including those that incorporate sociohistorical and -political experiences of "exclusion and marginalization" based on race/ethnicity, gender, sexuality, and social class. Further, as articulated by Cohen,[27] a major component of these critical analyses relates to the duality of examining macro (e.g., external processes) and micro (e.g., internal processes) structures that have an impact on communities of color in relation to AIDS epidemic. For example, macrolevel processes involve marginalization associated with larger social structures (e.g., structural inequalities based on legal, political, economic, and educational social structures such as institutionalized racism) and microlevel processes relate to "secondary marginalization" within communities of color (e.g., based on

gender and sexuality).[27] Therefore, the integration of transformative discourses in the area of AIDS that provide intersectional and interdisciplinary analyses serves as significant interventions in the field of public health. As such, this scholarly work must be at the center of the discourse through incorporating critical, innovative, and transformative analyses that interrogate and challenge hegemonic, Eurocentric, patriarchal, and heteronormative discourses that pathologize communities of color.[21]

Within this context, one critical question to pose is: How does scholarly research or the production of knowledge contribute to the current state of AIDS epidemic in MSM of Color communities, particularly in relation to their substantial disproportionate rates of HIV and AIDS in the U.S.? In the field of public health, the building of knowledge in HIV prevention research has been based, in part, on epistemological/theoretical frameworks in biomedical and social science research that have not incorporated interdisciplinary and intersectional approaches in the study of HIV-related health disparities in a systematic or substantive way for MSM of Color communities.[6,18,21,28,29] In particular, the work of Mullings and Schulz[29] is relevant here and provides an account of the significance of incorporating intersectional approaches as a mechanism to better understand and to develop theoretical formulations that address health disparities within the sociocultural contexts of communities: "…. Intersectional theory views race, gender, class [and sexuality] not as fixed and discrete categories or as properties of individuals but as social constructs that both reflect and reinforce unequal relationships between classes, racial groups, genders, [and sexualities]" (p. 373).[29]

Core theoretical paradigms in areas of public health and social science research that relate to HIV prevention have been primarily based on Western/Eurocentric theoretical or conceptual frameworks that focus on individual behavior (e.g., social cognitive theoretical frameworks).[30] As a result, the production of knowledge in HIV prevention research has often been shaped within an insular disciplinary context, thus maintaining a disconnection from transformative scholarly inquiries as well as sociocultural realities of lived experiences of MSM of Color communities. Thus, building on the work of Collins,[31] as situated through an intersectional theoretical conceptualization, one of the major problematic implications of this logic is that multiple identities of MSM of Color (e.g., racial, gender, and sexual identities) have been negatively constructed and pathologized through theoretical frameworks that have not adequately integrated the sociohistorical, -political, -economic, and -cultural contexts that have been integral to the cultural specificities of their lived experiences.[28]

The Problematic of SES as a Singular Discourse

Within this context, in public health, socioeconomic status (SES) has served as a primary predictor of health outcomes and has been incorporated as a key logic to account for disparate incidence and prevalence in the morbidity and mortality of health.[32] This logic has been, in part, used in the area of HIV prevention to account

for the HIV-related health disparities in communities of color.[21] Based on the work of a number of scholars,[33,34] when controlling for social class in research on health outcomes (e.g., AIDS, cancer, diabetes), racial disparities often remain constant. Consequently, one of the key problematic limitations related to the utilization of social class as part of a core singular unit of analysis in health outcomes in communities of color links with the marginalization of the impact of the intersectional nature of race-, gender-, social class-, and sexuality-based structural inequalities.[35] For example, the logic of social class does not account for the racialization of social class as reflected in the incidence and prevalence of health disparities in communities of color.[34] Also, through incorporating the theoretical lens of Cohen's[27] work on marginalization, the intersectional nature of structural inequalities based on race/ethnicity, gender, social class, and sexuality relate to the disproportionate number of people of color that have been impacted by AIDS epidemic in the U.S.

Further, another major limitation of the SES discourse in public health involves the absence or peripheralization of the sociohistorical and -political impact of marginalization based on racial hierarchies in the U.S. (e.g., institutionalized racism).[36] Historically, several scholars have challenged the hegemonic, Eurocentric theoretical paradigms that have been utilized in research on communities of color.[33,37] For example, as articulated by Washington,[38] the historical legacy of cultural mistrust has been a central theme related to the health experiences (e.g., medical experimentation of black men and black women) of black communities in the U.S. Other researchers also have studied the historical trajectory and role of medical abuse in communities of color.[39] A recent significant illustration of medical abuse has been documented in black and Latino/ children living with HIV in foster care in the New York Metropolitan area; these youth of color were mandated by a child welfare agency to take highly toxic and experimental HIV drug medicines.[38] More specifically, over the years, several scholars[40] have documented the cumulative effects of the Tuskegee Syphilis study that was conducted on black men to study untreated tertiary syphilis in Macon County, Alabama from 1932 through 1972 by the U.S. Public Health Service. Researchers also have investigated cultural mistrust and cultural beliefs about AIDS-related genocide in communities of color.[41–43] In particular, as MSM of Color have experienced a significant impact of the AIDS epidemic, cultural mistrust and cultural beliefs about genocide have had an impact on HIV prevention as a result of the historical experiences with the medical establishment,[43,44] including the Tuskegee Syphilis Study.[45]

A Critique of Syndemic Theoretical Conceptualizations

Based on syndemic theory, the term "syndemic" has been conceptualized as the intersection of multiple areas of health or epidemics that have an impact on the health of communities.[46] In relation to MSM, Stall[47,48] posited that the interaction of several health factors, including substance abuse, depression, childhood sexual abuse, and intimate partner violence, related to increased HIV risk in urban MSM.

One of the major strengths of this scholarly work involves moving the field of public health beyond a unicentric level of analysis to a multifaceted structural level that engages the interrelationships of overlapping epidemics that have an impact on the current state of the AIDS epidemic in MSM. Nonetheless, a significant theoretical and empirical limitation of this area of scholarly inquiry relates to the void regarding the cultural specificities for MSM of Color at the core of this analysis, particularly in relation to the salient sociocultural health factors (e.g., racism and homophobia) that provide the basis for addressing HIV related disparities and developing culturally applicable HIV prevention interventions for this group of men. Within this context, based on the theoretical concept of marginalization, Cohen[27] articulated the salient role of intersectional influences on the AIDS epidemic in black communities: "AIDS touches on, or is related to, many other issues confronting, in particular, poor black communities: health care, poverty, drug use, homelessness" (p. 34). In this regard, the work of Cohen[27] serves as an intersectional and interdisciplinary theoretical framework to examine HIV prevention in MSM of Color communities. Further, the scholarly works of several researchers provide the basis for the incorporation of intersectional analyses related to overlapping epidemics in communities of color.[4,25,49–51]

Integrating Interdisciplinary and Intersectional Approaches in Health Disparities

Building on interdisciplinary and intersectional theoretical approaches, an integral component to the study of health disparities in MSM of Color communities is the incorporation and application of epistemological/theoretical frameworks and methodologies based on racial/ethnic/cultural studies (e.g., African Diaspora Studies, Latino/a Studies, Asian Diaspora Studies, Native American Studies), gender studies, queer/lesbian/gay/bisexual studies, and sexuality studies.[21] One of the objectives in utilizing the scholarly work of these areas in the study of health disparities relates to the development of epistemological/theoretical frameworks that provide the basis for incorporating the socio–historical, -political, -economic, and -cultural contexts that have been integral in communities of color. As such, theoretical and methodological approaches based on these scholarly areas work to juxtapose theory and practice that are grounded in culturally relevant conceptualizations, which are fundamental to the lived experiences of MSM of Color. According to Schulz et al.,[35] "Central to this intersectional theory is the tenet that racism and sexism, as well as other forms of oppression,... operate as mutually reinforcing systems of inequality" (p. 371). These areas provide a critical approach to the work on health disparities that engage a critique of service at macro and micro levels with respect to the sociopolitical processes that influence structural inequalities in MSM of Color communities. This paradigm shift has the promise of providing opportunities to engage intellectually rigorous dialogues regarding the centrality of social justice

perspectives as well as the interrogation of knowledge to incorporate intersectional and interdisciplinary approaches within the domain of health disparities.

One current illustration of the innovative and groundbreaking scholarly research on MSM of Color communities that incorporates culturally grounded theoretical, methodological, and community-centered approaches has related to research on house-ball communities.[52] This work provides originality within the context of integrating intersectional and interdisciplinary perspectives that are integrated into the core of the analysis within the context of HIV prevention. According to researchers, house-ball communities have been conceptualized as a network or group of individuals that are connected through houses, which serve as familial, cultural, and supportive systems (e.g., fictive kin) for MSM of Color (with a particular focus on black, Latino, and transgender individuals). In this ethnographic investigation, the researchers examined the critical role that house-ball communities have served in building home and kinship networks, including a core value of articulating the importance of gender and sexuality expression as an integral part of an individual's racial, gender, and sexual identities. As such, this work is particularly relevant for groups that have experienced multiple forms of marginalization based on the intersection of racial, gender, social class, and heteronormative hierarchies as well as those that manifest in customary HIV prevention interventions developed for MSM of Color. According to Arnold and Bailey,[52] the findings of this study demonstrated that house-ball communities have assumed a salient leadership role in providing HIV prevention "intraventions" (e.g., prevention work that occurs organically within the context of communities) for groups that often have experienced stigma and discrimination.

In this regard, in a community study involving MSM of Color associated with the house ball community in the New York Metropolitan Area $(n = 504)$, findings demonstrated that: (1) slightly more than half of the sample had not tested for HIV within the last year prior to assessment; (2) the majority of the respondents that tested HIV positive (17%) were unaware of their HIV positive status (73%); and (3) based on a subsample of respondents $(n = 371)$ who reported having a male sexual partner within the last year prior to evaluation, an HIV positive status was associated with being black, 29 years of age or older, and a lack of HIV testing.[53] Further, house-ball communities have served as large scale, social networks in the U.S. for individuals often disenfranchised from accessing HIV prevention programs.[53] The implications of this work for providing culturally applicable HIV prevention "intraventions" for MSM of Color communities represent transformative approaches in the field of public health.

Sociocultural Factors as Innovative Theoretical Frameworks

Connected to stigma, marginalization, and structural inequalities, recent research has examined the effect of sociocultural factors on HIV sexual risk behavior in MSM of Color.[4,54] In one study, Diaz et al.[4] have incorporated the concept of social oppression as a core domain to account, in part, for the disproportionate

health-related disparities in HIV, based on their work with a probability sample of 912 Latino gay men surveyed from three U.S. cities. Diaz et al.[4] provided an intersectional, tripartite model that found empirical support for the impact of sociocultural factors (e.g., racism, homophobia, and poverty) on HIV sexual risk behavior in Latino gay men. Findings demonstrated that social oppression based on racism, poverty, and homophobia related to sexual experiences that provided the context for HIV sexual risk behavior. Specifically, higher levels of social oppression (e.g., racism, poverty, and homophobia) and psychological distress were predictive of Latino gay men engaging in risky sexual situations.

Further, based on this work, social oppression influenced HIV sexual risk behavior in that Latino gay men were more likely to engage in sexual experiences that were challenging to negotiate safer sexual practices. For example, according to Diaz et al.,[4] "Men who were more discriminated and psychologically distressed were more likely to participate in sexual situations under the influence of drugs or alcohol, to engage in sex as a way to alleviate anxiety and stress, and to be with partners who resisted condom use, among others" (p. 265). Taken together, the experience of challenging "sexual situations" mediated the influence of social oppression (e.g., racism, poverty, and homophobia) on HIV sexual risk behavior.[4] Further, in a community based sample of Asian/Pacific Islander gay men, findings showed that the lack of social support in modulating the effects of racism, homophobia, and anti-immigrant discrimination related to increased HIV sexual risk behavior (e.g., UAI) in the men.[9] These research investigations provide theoretical and empirical support in examining the impact of racism, homophobia, poverty, and immigration status as these intersectional domains manifest in the lives of MSM of Color.

Factors Related to HIV Sexual Risk Behavior in MSM of Color

Overview of HIV Related Risk Factors in MSM of Color

According to the CDC,[1] current surveillance data have demonstrated that approximately 60,000 new HIV infections occur each year in the U.S., and MSM account for a significant proportionate rate of new HIV infections. In this context, HIV behavioral research on MSM has shown that unprotected anal intercourse (UAI) with ejaculation with an HIV/STI-infected sexual partner has served as a key risk factor for HIV/STI transmission and/or coinfection.[16] For HIV-positive MSM, the practice of UAI with ejaculation has been associated with the risk of acquiring or transmitting another strain of HIV virus (e.g., HIV superinfection) as well as STI-infection.[55] Research has differentiated four levels of HIV sexual risk behavior in MSM: (1) unprotected receptive anal intercourse (URAI), (2) unprotected insertive anal intercourse (UIAI), (3) unprotected receptive oral intercourse (UROI), and (4) unprotected insertive oral intercourse (UIOI).[56]

Sexually transmitted infections (STIs), including Chlamydia, gonorrhea, syphilis, herpes, and Hepatitis B, have increased significantly among MSM of Color, partic-

ularly in urban cities in the U.S.[57] Importantly, the presence of an STI increases the biological vulnerability for the acquisition and transmission of HIV.[58] For HIV positive men, STIs (e.g., gonorrhea, nongonococcal urethritis, Herpes simplex virus type 2) may have deleterious effects on their current health status (e.g., immune system functioning) and contribute to an increase in viral load.[59] Biomedical research also has shown that acute HIV infection (e.g., significant levels of HIV virus in the blood or other bodily fluids) occurs during the initial phase of HIV infection.[60] Clearly, early diagnosis and treatment of HIV have predicted increased quality of life for persons living with HIV and AIDS.[2]

Building Formative Research on MSM of Color

Since the beginning of AIDS epidemic, there has been a substantial void in scientific research on MSM of Color, which has, to a considerable extent, contributed to inadequate theoretical/epistemological frameworks as well as formative research in most areas of their lives.[18] More specifically, as HIV epidemiological data have demonstrated that MSM of Color experience persistent HIV-related health disparities in the U.S., there has been a dearth of scholarly research that has systematically investigated factors associated with HIV sexual risk (and protective) behaviors in this group of men. However, recent trends in research on HIV-related health disparities have indicated that: (1) MSM of Color (e.g., Asian, black, and Latino MSM) are more likely to have unrecognized HIV infection and advanced disease (i.e., AIDS) at the time of their HIV diagnosis; (2) MSM of Color have been less likely to have HIV testing on a consistent basis; and (3) MSM of Color have had inadequate access to HIV care including HIV antiviral therapies.[2,7,61,62]

The development of a systematic base of scientific research in the area of HIV-related health disparities that focus on MSM of Color has been germane to addressing the considerable limitations in the field of public health. In this regard, the current state of HIV prevention research poses substantial challenges for conducting research on Asian/Pacific Islander (API) MSM as a result of the perception that the AIDS epidemic has not had a significant impact on API communities based on their reported prevalence rates of HIV and AIDS in the U.S.[12,19] However, researchers have challenged this premise and articulated the importance of providing a more sophisticated level of analysis to this issue through assessing HIV incidence rates, HIV testing patterns, and HIV sexual risk behaviors for API MSM.[64] For example, API MSM accounted for 67% of adolescent and adult male cases of HIV and AIDS among Asian Pacific Islanders, which represented the largest proportion in HIV transmission categories for this group (e.g., high-risk heterosexual contact, 16%; injection drug use, 11%; MSM/IDU, 4%).[3] Moreover, there have been significant increases in HIV incidence rates for API MSM, as evidenced by recent epidemiological data that reported a 255.6% increase for younger API MSM (aged 13–24) during the 2001–2006 period.[15] These data are indicative of the need to develop cross-sectional and longitudinal studies to have a better understanding of

the structural pathways that relate to the incidence of HIV transmission risk among API MSM.

Community studies on API MSM have demonstrated increasing incidence and prevalence rates of HIV and AIDS, as well as other STIs (e.g., gonorrhea and syphilis), in the U.S. based on work related to HIV testing patterns, HIV sexual risk behavior, and access to culturally competent health care.[19] In a study of young, API MSM ($n = 908$) recruited from community venues in two cities (e.g., San Diego and Seattle) in the U.S., Do et al.[64] investigated recent HIV testing patterns in relation to prevalence, trends, and factors associated with HIV testing in the sample. Findings indicated that the role of ethnicity, familiarity and perceived connection to HIV testing locations, racial and sexual identities, having a primary partner, increased levels of social support, and the report of recent UAI were factors that were related to recent HIV testing. In another study, Do et al.[61] assessed HIV testing patterns and unrecognized HIV infection among 495 young API MSM in San Francisco. Results demonstrated that previous HIV testing was associated with being older, identifying with a gay sexual identity, having had an STI, higher frequency of lifetime sexual partners, and a higher level of acculturation. Also, approximately one quarter of the sample reported not having had prior HIV testing (e.g., based on perceived low risk and anxiety regarding HIV testing results); findings also indicated that of the 2.6% of the sample that tested HIV positive, the majority of the respondents were unaware of their HIV positive status. On the basis of available research in this area, considerable implications for the provision of culturally and linguistically competent HIV testing and prevention services are needed.[65] For example, for API MSM, cultural worldviews (e.g., cultural beliefs and values) regarding sexuality influence the contexts and processes associated with sexual behavior[19] and HIV testing practices.[64] As such, these factors are fundamental in transcending barriers to HIV prevention and care, particularly those that are representative of culturally appropriate strategies for API MSM.

In relation to black MSM, in a formative meta-analytic investigation, researchers examined 12 hypotheses as a method to identify factors related to their increased HIV infection rates.[66] The hypotheses that were examined were as follows: (1) sexual risk; (2) sexual identity/disclosure; (3) substance use; (4) STI history; (5) HIV testing patterns; (6) biological vulnerability to HIV; (7) penis circumcision; (8) HAART use; (9) sex with HIV-positive partners; (10) sexual networks; (11) incarceration history; and (12) anorectal douching. Notably, findings showed that black MSM engaged in comparable rates of HIV sexual risk behavior (e.g., UAI and number of sexual partners) and substance use as compared to men from other racial/ethnic backgrounds. Findings also demonstrated that black MSM had higher rates of STIs, lower frequencies of HIV testing patterns, and were less likely to be aware of their HIV positive serostatus.

Similarly, another current study[7] that examined HIV-related health disparities reported that black MSM, as compared to white MSM, showed lower substance use, fewer sexual partners, and were less likely to disclose same gender sexual behavior. Also, in this study, racial differences were not found in UAI, commercial sex work, HIV testing history, or sex with an HIV-positive sexual partner. Taken together,

these formative research investigations pose considerable implications regarding the state of knowledge in HIV prevention research for black MSM in that the focus has shifted from an emphasis on individual behavior to include an examination of the social and structural factors that have an impact on HIV-related health disparities. In this regard, the next steps in the development of scholarly research on HIV-related health disparities among black MSM involves incorporating intersectional and interdisciplinary approaches that are culturally relevant for black MSM.

More specifically, as a strategy to develop scholarly research on black MSM that serves to curtail their substantial HIV prevalence rates, researchers from the Black Gay Men's Research Group[18] have posited that a vision for research on black MSM incorporates several guiding principles in the development and implementation of this work: (1) research must be conducted in an efficient manner; (2) research needs to be developed, implemented, and applied principally by black MSM researchers; (3) research needs to examine the cultural complexities and specificities of the intersectional identities of black MSM; (4) research should be funded through a multiplicity of resources that will have a meaningful impact on the state of the AIDS epidemic for black MSM; and (5) research must be conducted in combination with organizations and individuals reflective of black MSM.

From a theoretical perspective, much of the research on Latino MSM has focused on the significant role that cultural worldviews (e.g., cultural beliefs, values, and norms) have had on HIV risk and protective behaviors.[4] This scholarly research has served a critical role in providing intersectional and interdisciplinary theoretical and empirical contributions to the discourse on HIV-related health disparities for Latino MSM.[67] Building on the research in this area, the concepts of familismo (e.g., family-centeredness) and machismo (e.g., conceptions of masculinity) as well as the influence of religiosity and spirituality have been fundamental concepts that have had an impact on the social constructions of gender and sexuality (e.g., gender role socialization) for Latino MSM.[22] In this regard, cultural conceptualizations of gender (e.g., machismo) have had an impact on power differentials in relationships (e.g., the sexual role during anal intercourse), which may have an influence on HIV risk or protective behaviors.[68] Moreover, the intersectional role of marginalization (e.g., racism, poverty, homophobia, immigration status) has had an impact on the physical health and psychological well-being of Latino MSM.[69] As will be discussed later in the section on immigration status, the process of immigration and acculturation have provided complexities to the discourse on HIV-related health disparities for Latino MSM.[70]

Studies on Latino MSM have focused on several factors in relation to HIV sexual risk behavior including but not limited to HIV disclosure,[71,72] acculturation,[73] role of the Internet,[74,75] ethnic identity,[76] substance use,[77] and the impact of social inequalities.[4] In a community based sample of Latino HIV positive gay and bisexual men, findings demonstrated that: (1) UAI (e.g., UIAI and URAI) was related to alcohol and illicit drug use during sex; (2) older age, higher levels of acculturation, and depression were associated with a greater frequency of sexual partners during URAI; and (3) seroconcordance in a relationship was predictive of UAI with a "most recent" sexual partner.[73] In another study, Ramirez-Valles et al.[78] reported

that younger age, higher education, and substance use (e.g., club drugs or other illicit drugs) were predictive of respondents engaging in UAI based on a sample of 643 Latino MSM from Chicago and San Francisco. Further, Jarama et al.[68] found that communication patterns regarding HIV, sexual attraction, machismo, and experiences of discrimination (e.g., homophobia) were predictive of Latino MSM ($n = 250$) engaging in HIV risk behaviors; additionally, 62% of respondents reported having had one or more sexual partners, while less than half of the sample engaged in UAI with a casual sex partner, within the last 3 months prior to assessment.

Contextualizing Sex in MSM of Color Communities: The Role of Sexual Contexts and Networks

Recent research has shown that a number of sexual contexts have contributed to HIV sexual behavior in MSM of Color over the last few years.[79,80] Some of these contexts are related to the characteristics of sexual partners,[81–83] emergence of bareback sex (e.g., the intention to engage in condomless anal intercourse),[84] the use of the Internet in interfacing with sexual partners (e.g., sexual partners in cyberspace),[85] the use of substances (e.g., alcohol and illicit drugs before or during sex),[26,86] and perceived safer sex strategies (e.g., serosorting, seropositioning, withdrawal before ejaculation).[87,88] One of the strengths in conducting formative research on emerging trends and contextual factors associated with HIV sexual risk behavior in MSM of Color is that findings can be used to contribute to current scientific knowledge and the development of efficacious HIV prevention strategies. However, one of the research challenges in this area relates to the need to incorporate culturally appropriate methodologies based on strong collaborations with practitioners affiliated with community based organizations. This represents a major component of culturally competent HIV prevention work as communities provide perspectives that are relevant to the experiences of MSM of Color.

HIV prevention research has posited that sexual networks have had a significant impact on the disproportionate rate of HIV prevalence in MSM of Color communities.[89] Sexual networks have been conceptualized as a network of individuals that have been "linked directly or through sexual contact."[90] One factor that has been shown to influence sexual networks relates to the influence of partner characteristics on the incidence and prevalence of HIV in MSM of Color communities.[83] For example, some studies[81] have shown that MSM of Color tend to have romantic/sexual partners reflective of their racial/ethnic backgrounds. The primary issue here is that HIV transmission risk for MSM of Color increases exponentially because research has demonstrated that MSM of Color (e.g., Asian, black, and Latino) have higher frequencies of STIs, lower frequencies of consistent HIV testing, disproportionate rates of HIV infection, and higher levels of unrecognized HIV infection.[5,7,64] In terms of black MSM, acute HIV infection has been shown to result in higher viral load and lower CD4 counts, which serve as critical factors for HIV seroconversion.[7]

Therefore, MSM of Color, especially black MSM, have experienced a substantially higher risk of acquiring and transmitting HIV due to the high HIV prevalence in their sexual networks.

Experiences of Violence in the Context of HIV Prevention for MSM of Color Communities

Studies have provided empirical support for examining the relationship between multiplicative forms of violence, including childhood sexual abuse (CSA), intimate partner violence (IPV), and other kinds of victimization in relation to HIV sexual risk behavior[91,92] including MSM of Color.[93–95] These areas of scholarly inquiry have been significantly understudied in MSM of Color, although some research has emerged in this area.[96] For example, in a qualitative study of childhood sexual abuse (CSA) in black MSM, findings indicated a 32% prevalence rate in CSA, based on a sample from three geographic regions in the U.S.[97] Also, according to Fields et al.,[97] the contexts of CSA involved: (1) the experience of CSA from a familial individual (e.g., older male relative); (2) the attribution of "same sex desire" as a result of the experience of CSA; and (3) psychological distress (e.g., depression, suicidality) and substance use due to CSA. In another study, black and Latino gay- and nongay identifying MSM who reported histories of CSA, which often were connected to a history of trauma, related to HIV sexual risk behavior.[95] Moreover, Toro-Alfonso and Rodriguez-Madera[94] showed that IPV within relationships was related to HIV sexual risk behavior in Latino MSM. These research investigations provide empirical data for the significance of developing research studies to further examine the social contexts of how experiences of violence relate to HIV sexual risk behavior. Moreover, the implications of these studies for both medical and mental health providers relate to the development and implementation of mechanisms to assess violence-related experiences, particularly within the context of how these foci relate to HIV prevention.

Substance Use in Relation to HIV Sexual Risk Behavior in MSM of Color

Much of the HIV prevention research has demonstrated that the influence of substance use (e.g., alcohol and illicit drugs) has had an impact on HIV sexual risk behavior in MSM.[77,98,99] However, a limited number of intra- or within-group studies have specifically examined the relationship between substance use and HIV sexual risk behavior (e.g., UAI) in community-based samples of MSM of Color.[26] For example, Choi et al.,[86] in a study of 496 Asian/Pacific Islander MSM in the San Francisco Bay area, reported that UAI was related to "being high and buzzed" on ecstasy and poppers with sex; no relationship was found between "being high

or buzzed" on alcohol, marijuana, gamma hydroxybutyrate (GHB), and crystal methamphetamine with sex. On the basis of qualitative narratives in a sample of Latino gay men in the San Francisco Bay Area, Diaz[100] reported that crystal methamphetamine use was related to HIV sexual risk behavior. Further, Wilton,[26] in a community-based sample of 481 black gay and bisexual men in the New York Metropolitan Area, found that the use of alcohol before or during sex was related to relationship status (e.g., having a primary and casual sexual partner), higher income, STI testing history, and higher number of male sex partners, and that recreational drug use before or during sex was associated with being younger, having a casual sex partner, HIV positive status, and reporting UAI with a male sex partner.

The Influence of Immigration Status on MSM of Color and Its Connection to HIV Prevention

The role of immigration status on the sexual health of MSM of Color has been an understudied domain in HIV prevention research.[22,23,67,101] Much of the scholarly work in this area has focused on the experiences of Latino MSM and Asian MSM[65,102] with a void in studies on Caribbean (e.g., English-speaking) MSM and African MSM.[103] Significantly, the process of immigration has been a critical factor in understanding how cultural worldviews (e.g., cultural values and beliefs) influence sexual attitudes and behavior[65] as well as impact access to healthcare, including HIV prevention and care, for immigrant groups.[104,105]

More specifically, in a large-scale epidemiological study of Asian/Pacific Islanders, findings showed that while the largest proportion of those with AIDS resided in California (42.9%), New York (15.7%), and Hawaii (11%), a significant proportion (two-thirds) of Asian/Pacific Islanders reported their place of birth as outside of the U.S.[106] Ramirez et al.[78] found that HIV prevalence rates were significantly higher in a sample of Latino gay and bisexual men and transgender individuals in San Francisco that were born within the U.S. as compared to those respondents who were born outside of the U.S.; however, findings also demonstrated that HIV prevalence rates were higher for those respondents in Chicago whose place of birth was outside the U.S. as compared to individuals whose place of birth was in the U.S. In a study of Latino MSM from Miami who were born outside of the U.S., findings showed that higher levels of psychological distress and substance use (e.g., club drugs), greater number of sexual partners, having an HIV positive status (e.g., at the onset of immigration), and a higher level of acculturation to U.S. culture related to HIV sexual risk behavior (e.g., UAI).[102]

This emerging area of research provides considerable implications for increasing the scholarly focus on the experiences and processes associated with immigration for MSM of Color that explore the complexities of the social contexts of sexuality and how these factors relate to sexual health.[54,67,107] In terms of immigration, contextual factors involving identity (e.g., racial, gender, and sexual identities) as well as stigma and discrimination (e.g., based on immigration status) need to be

addressed in HIV prevention research and services for MSM of Color.[22] Indeed, a sustained emphasis on addressing how social structures have an impact on health care inequities for MSM of Color are critically significant, especially those that examine the role of discrimination based on legal status (e.g., undocumented individuals) in the U.S.[106] Also, the development, implementation, and assessment of culturally congruent HIV prevention and testing services (e.g., pre/post-test counseling), including the provision of linguistically competent services, needs to be integrated into HIV prevention and care.[108]

Transgender Women of Color and their HIV Prevention Needs

Much of the HIV prevention research that has been conducted on transgender (Male-to-Female) women, particularly transgender women of color, has demonstrated that this group experiences a considerable disproportionate incidence and prevalence rate of HIV and AIDS in the U.S.[109–112] In a recent systematic review of HIV prevalence and risk behaviors for transgender individuals in the U.S,[113] major findings showed that: (1) calculated rates of HIV infection for transgender women indicated a high prevalence (e.g., 27.7% of MTFs tested HIV positive and 11.8% of MTFs self-reported an HIV positive status); (2) transgender women reported significant rates of HIV sexual risk behavior (e.g., UAI, higher frequency of casual partners, and commercial sex work); (3) URAI, a primary risk for HIV transmission, was calculated at 44.1% for transgender women; and (4) black transgender women demonstrated increased HIV infection rates (e.g., 56.3% tested HIV positive and 30.8% self-reported an HIV positive status). Studies also have reported that transgender women have experienced health-related risks, including HIV risk behavior, through the administration of nonprescribed hormones (e.g., liquid subcutaneous silicon injections) by nonmedical providers as a method to feminize their physical appearance (e.g., face, breasts, thighs, buttocks).[114]

There has been an emergence of community based research that has focused on transgender women of color in relation to examining correlates of HIV sexual risk behavior.[115] Nemoto et al.[109] conducted a study of 312 transgender women of color (e.g., Asian, black, and Latina) in San Francisco and examined URAI by partner status. The results of the study showed that respondents who engaged in URAI with both primary partners and casual sex partners reported drug use before sex; however, respondents who had URAI with casual partners also were more likely to have an HIV positive status. Additionally, black transgender women from lower socioeconomic backgrounds were more likely to have engaged in URAI during commercial sex work.[109] In another study, Operario and Nemoto[116] found that Asian/Pacific Islander transgender women who engaged in URAI were more likely to report commercial sex work and have a history of attempted suicide; commercial sex work also was related to substance use before or during sex and a college level education, while illicit drug use related to commercial sex work. Further, in a qualitative study of transgender women of color that focused on contextual factors associated

with HIV risk behavior (substance use and sexual behaviors), findings indicated that respondents engaged in HIV risk behavior with sexual partners as a way to affirm their gender identity and to provide "emotional connection" with their sexual partners. However, at the same time, respondents also discussed how the need for economic stability often had an impact on whether they would engage in HIV risk behavior during commercial sex work.[109]

On the basis of current HIV prevention research, large-scale epidemiological studies need to be conducted to assess HIV seroprevalence rates among transgender women of color in the U.S, particularly those that differentiate regional characteristics. As such, HIV behavioral research investigations are needed to describe patterns and characteristics of HIV risk and protective behaviors as well as to examine the interrelationships among a number of variables including but not limited to sexual and substance use behaviors, psychological factors (e.g., suicidality, depression, coping), and access to services. Further, qualitative investigations utilizing ethnographic fieldwork, focus groups, and individual interviews, need to be conducted to better understand how contextual factors work in the lives of transgender women of color. For example, qualitative studies need to explore how social constructions of gender and sexuality within culturally relevant frameworks relate to barriers in accessing culturally competent transgender health care (including HIV prevention and care). An integral part of this work calls for an examination of how stigma and discrimination (e.g., the intersection of racialized and genderized forms of stigma) relate to lived experiences of transgender women of color within inter- and intragroup domains. These multimethod methodological approaches will provide critical formative data as a basis for the development of culturally grounded HIV prevention interventions for transgender women of color that will address HIV-related health disparities.

Moving Beyond Current HIV Prevention Strategies

Assessment of Current HIV Prevention Strategies for MSM of Color

As the significant increase in HIV infection rates in MSM of Color communities in the U.S. has been well substantiated,[15] empirical research has demonstrated that HIV behavioral prevention interventions (e.g., individual-, group-, and community-level interventions) have had a positive impact on decreasing HIV sexual risk behavior (e.g., UAI and number of sexual partners) and increasing protective behaviors (e.g., condom use) in MSM.[117] Yet, the field of public health has been at crossroads in the development of culturally specific HIV prevention strategies for MSM of Color.[6,118] In this context, there has been a void in culturally applicable, evidence-based, HIV prevention interventions that have been developed and implemented for MSM of Color.[24,119,120] According to the CDC,[121] development

and implementation of DEBIs (Diffusion of Evidence-Based Effective Behavioral Interventions) have served to distribute high quality HIV prevention interventions (e.g., best evidence and promising evidence interventions) in the U.S., particularly for those individuals at a significant risk for the transmission of the HIV virus. However, there has been an absence of HIV behavioral interventions that have demonstrated effectiveness as a DEBI in the category of best-evidence or promising-evidence for MSM of Color with the exception of an HIV prevention intervention for API MSM.[122] It should be noted that, at the time of the publication of this chapter, the *Many Men, Many Voices* (*3MV*) HIV/STI behavioral intervention for black MSM was in the evaluation phase to determine the efficacy of the intervention. Nonetheless, *3MV* intervention represents one HIV behavioral intervention for black MSM, although the state of the AIDS epidemic calls for multiple prevention interventions for black MSM.

As an innovative, culturally grounded intervention, the *3MV* intervention has been conceptualized as an integrated HIV/STI group-level behavioral intervention for black MSM who identify as HIV negative and serostatus unknown. The primary objectives of *3MV* intervention are as follows: (1) to prevent the transmission of HIV/STIs through reducing HIV sexual risk behavior (e.g., UAI); (2) to increase protective sexual behaviors (e.g., condom use); (3) to promote influencing factors that relate to HIV sexual risk behavior (e.g., HIV/STI knowledge, perceived HIV/STI risk, identity, self-efficacy/behavioral intentions for condom use); (4) to increase health care seeking behaviors (e.g., HIV/STI testing); and (5) to increase mutual monogamy with a sexual partner who is not HIV positive. The core innovative elements of *3MV* intervention relate to the focus on dual-identity processes (e.g., racial and sexual identities), the integration of HIV/STIs as a mechanism for HIV seroconversion, and the influence of gender role socialization on HIV protective and risk behavior as manifested in power dynamics in relationships [e.g., sexual roles during anal intercourse including insertive ("top") and receptive ("bottom") anal intercourse]. Another critical dimension of the *3MV* intervention relates to the emphasis on safer sex strategies (e.g., outer course, mutual masturbation, etc). These contextual factors provide the basis for the cultural applicability of the intervention for Black MSM.

There have been other HIV prevention interventions for MSM of Color that have been published in HIV prevention research;[119,120,123–125] however, these interventions are not a part of the DEBI initiative. Two of these interventions (group- and community-level interventions) were developed for Black MSM,[119,124] while other interventions (group-level) were designed for Latino MSM[123,125] as well as Black and Latino MSM and MSMW (men who have sex with men and women) with histories of childhood sexual abuse.[120] On the basis of available HIV prevention research, there have been no published HIV prevention interventions for Native American MSM. It is beyond the scope of this chapter to provide a description of the aforementioned interventions. However, the issue of what constitutes an effective intervention needs to be raised for critical discussion, particularly since there may be effective interventions for MSM of Color that are not congruent with criteria established by the CDC as a DEBI.

As the field of public health has moved toward the development of evidence-based interventions as a method to strengthen prevention interventions,[126] one of the outcomes of this work that needs to be addressed relates to "structural impediments" that communities experience in the development, implementation, and assessment of their programs, including the emphasis on what constitutes scientific evidence (e.g., randomized controlled trials, quasi-experimental research designs, prospective cohort studies, etc.).[127] Also, there is a dire need to challenge the positivist paradigm of quantitative methodological approaches as the primary source of what constitutes scientific evidence, including the incorporation of qualitative methodological approaches as a core element in the assessment of HIV prevention interventions.[18,28] As such, the issue of scientific evidence raises critical questions, as articulated by Buchanan and Allegrante,[127] that have been germane to communities regarding the role of ethics and "… the rights of community members to be involved in the decisions about the goals and methods of community research, since such intervention research holds the potential to affect their lives in ways both intended and unintended" (p. 82). Therefore, a hierarchy of evidence-based standards[127] for HIV prevention interventions poses a critical tension experienced by communities, particularly those of MSM of Color, that have been disenfranchised based on racial, gender, social class, and sexuality based hierarchies. As such, these hierarchies have been embedded as a part of core processes associated with evidence-based interventions, including posing critical implications for acquiring and maintaining funding of HIV prevention interventions for MSM of Color.[108]

Another persistent challenge in HIV prevention research has related to the development and implementation of HIV prevention strategies, including individual, group, community, and structural level interventions, for MSM of Color that incorporate culturally grounded theoretical conceptualizations based on cultural beliefs, values, and norms of their respective MSM of Color communities.[6,21,22,24] A significant part of this work involves researchers that are representative of MSM of Color communities and maintain values that are congruent with those communities.[18] Parallel to this process, the development of HIV prevention strategies need to be based on culturally congruent formative research in MSM of Color communities with respect to theoretical formulations, methodological approaches, and application of knowledge in the respective communities. This represents a major area of concern because formative studies on MSM of Color communities have been in the process of emerging in scholarly research. However, there have been several structural challenges that relate to the development of scholarly research on MSM of Color communities by MSM of Color researchers (e.g., racism and homophobia associated with acquiring adequate levels of funding for research investigations).[18] Further, based on the work of social movements in the U.S. (e.g., Civil Rights, Gay Liberation, Feminist), there has been a developing network of MSM of Color researchers. In this regard, one significant strategy for moving HIV prevention research forward is to develop scholarly research experiences for MSM of Color researchers that incorporate theoretical frameworks and methodologies nested in culturally relevant approaches reflective of MSM of Color communities. This initiative would provide research opportunities for MSM of Color in the development

of theoretically conceptualized and methodologically rigorous studies, which would be grounded in their communities.

At the present time, there has been an emphasis on the adaptation of existing interventions for MSM of Color that have served as a strategy to address their current HIV-related health disparities.[128] However, the adaptation of existing interventions provides an interim strategy to address the issue of the inadequate number of HIV prevention interventions for MSM of Color. Within this context, the development of innovative, well conceptualized, and efficacious HIV prevention interventions nested within cultural conceptual frameworks will be paramount to addressing the increasing HIV rates among MSM of Color.[6] However, the issue of time serves as a key factor in the development and implementation of HIV prevention interventions for MSM of Color. For example, the process of high quality intervention research occurs within a longer-term period. As such, formative research (e.g., focus groups, individual interviews, ethnographic fieldwork, and quantitative surveys) needs to be conducted on MSM of Color, which will be followed by the development, assessment, and implementation of the HIV prevention interventions. Therefore, at the current moment, one of the dilemmas in the field relates to the need to address the increasing HIV incidence and prevalence rates in MSM of Color communities. Yet, the question remains regarding the reason(s) for the void in culturally relevant HIV prevention interventions for MSM of Color post 25 years into the AIDS epidemic – perhaps, a focus on structural barriers that relate to these processes may move the field in the right direction.

What Does the Future Hold for HIV Prevention Interventions for MSM of Color?

In relation to the concept of adaptation in HIV prevention interventions, there has been an adapted, peer-based, community-level HIV prevention intervention that was developed, implemented, and assessed for young black MSM between ages of 18 and 30 in three North Carolina metropolitan areas (Raleigh, Greensboro, and Charlotte) from 2004 to 2005.[119] On the basis of the Popular Opinion Leader (POL) model as a part of the Diffusion of Innovation Theory, approximately 15% of black MSM from these communities were recruited and trained in HIV prevention risk and served as popular opinion leaders with their peers as a strategy to promote safer sex norms in their respective communities. The results of this community level HIV prevention intervention demonstrated significant decreases in URAI. For example, while the baseline data showed that 32.4% ($n = 284$) of young black MSM engaged in URAI, this number decreased to 23.6% at the 4-month measurement point, 24.4% at the 8-month measurement point, 18.0% at the 12-month measurement point. This initiative provides the basis for the development of community level HIV prevention interventions for MSM of Color communities.

A Community Level HIV Prevention Intervention for Young black MSM was developed based on the adaptation of the Mpowerment project (e.g., Mpowerment for Black MSM).[129] The Mpowerment Intervention was developed based on formative qualitative research methodologies. Currently, the Mpowerment Intervention for black MSM has been in the field to determine the efficacy of the intervention; the anticipated completion date for this outcome evaluation is 2010. The aim of the project is to assess the effectiveness of a community level HIV prevention intervention through a reduction in HIV sexual risk behavior (e.g., UAI and number of sexual partners) and an increase in HIV healthcare seeking behaviors (e.g., HIV testing) in young black MSM in the southwest region of the U.S. (e.g., Dallas and Houston, Texas). Other areas that will be assessed for intervention effectiveness include knowledge of HIV status as well as psychosocial and mental health factors. Since the Mpowerment Intervention will be conducted in Dallas and the comparison group will be Houston, the objective is to compare cross-sectional data in both areas for the pre- and post-intervention of Mpowerment.

With respect to HIV prevention strategies, there has been a trend toward the development of "intraventions"[52] in MSM of Color communities as a strategy to address their health-related HIV disparities. Currently, several community based organizations across the country have developed "intraventions in their respective communities," which refer to HIV prevention strategies that have been organically designed and implemented within their communities. Therefore, a major emphasis has been placed on the development of innovative, culturally relevant "ground level" or "home grown" HIV prevention "intraventions" for MSM of Color communities. An illustration of three community level "intraventions" that have been developed by community based organizations in this area involve: (1) Pride in the City (PITC), (2) The Love Ball, and (3) CRIBB. The PITC and Love Ball were conceptualized by People of Color in Crisis (POCC) in Brooklyn, New York and CRIBB (Creating Responsible Intelligent Black Brothers) was developed by the National AIDS Education and Services for Minorities, Inc. (NAESM) in Atlanta, Georgia.

Pride in the City (PITC)

Pride in the City (PITC) has been conceptualized as a community level HIV prevention intravention for the black lesbian, gay, bisexual, and transgender (LGBT) community in the New York Metropolitan Area. A major component of this intravention involves a large-scale sexual health-focused program that occurs within the context of a weekend including park and beach events. The primary aim of PITC is to cultivate a community oriented collective space that is culturally grounded within the context of black LGBT communities. As such, one of the key strategies is to provide access to HIV/STI counseling, testing, and prevention in combination with a focus on community norms that relate to the importance of sexual health. Through this community level HIV prevention intravention, several community based organizations (e.g., AIDS Service Organizations) engage in a collaborative process to

provide HIV counseling, testing, and prevention to community members. This intravention poses considerable implications for the significance of providing access to HIV prevention and services for individuals who may experience marginalization within conventional healthcare settings.

The Love Ball

The Love Ball involves the engagement of members of the House Ball community in an innovative, culturally specific, community-level HIV prevention intravention. Research has shown that house-ball community members have experienced multiple forms of marginalization based on their racial/ethnic, gender, and sexual identities (Arnold & Bailey, in press). For example, members of house-ball communities may be disenfranchised from conventional HIV prevention and care (Murrill et al., 2008).[53] To address HIV-related health disparities within House Ball communities, *The Love Ball* works to affirm the racial/ethnic, gender, and sexual identities of the members involved with the house-ball community based on the theme of love. A major component of the intravention is to sponsor a ball where members compete in a competition. Moreover, HIV counseling and testing along with prevention messages are integrated within the context of the Ball. This initiative provided a context to offer HIV prevention services that are not routinely provided at community events.

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The CRIBB initiative was conceptualized in 2007 to focus on the development of leadership on the national level for young black MSM between the ages of 18 and 25. In this pursuit, the focus of this program has been on the development of a new generation of researchers and community practitioners that undertake the work of transformative leadership with respect to having an impact on the AIDS epidemic in black MSM communities. This year-long initiative introduces a group of approximately 10–12 young black MSM representative of different regions of the country to concepts of leadership and community as a strategy to address HIV-related health disparities for younger black MSM. During the course of a year, CRIBB members participate in culturally grounded institutes and seminars that focus on aspects of the current state of the AIDS epidemic for black MSM, leadership, and community work. One of the major objectives of CRIBB has been for each member to participate in the development and implementation of a selected community project that focuses on HIV prevention intraventions in black MSM communities.

Raising the Bar of Competence: An Assessment of HIV Testing Strategies

Need for Revised HIV Testing, Prevention, and Risk Reduction Agenda

The core principles of the recently revised recommendations for HIV testing and prevention have worked to incorporate HIV testing as a component of routine medical care with health care providers and to reduce barriers to HIV testing.[130] The objectives of these principles are as follows: (1) incorporate HIV testing as a component of routine medical care with health care providers; (2) develop models for the diagnosis of HIV beyond health care settings; (3) promote secondary HIV prevention with individuals living with HIV and AIDS as a strategy to prevent new HIV infections, and (4) decrease perinatal HIV transmission. Specifically, according to the CDC,[121] the aim for HIV prevention has been to "reduce the number of new HIV infections and to eliminate racial and ethnic disparities by promotion of HIV counseling, testing, and referral and by encouraging HIV prevention among both persons living with HIV and those at high risk for contracting the virus" (p. 585). Clearly, the increasing rates of unrecognized HIV infections among MSM of Color needs to be addressed – particularly since research has indicated that approximately 50–70% of HIV positive individuals have transmitted new sexually transmitted HIV infections.[130]

One primary strategy for addressing HIV-related health disparities in the U.S. has been the development of the Partner Counseling and Referral Services (PCRS) initiative. According to Hogben et al.,[131] the aim of PCRS strategy is to reduce HIV transmission in the U.S. by a focus on engaging sexual partners of HIV positive individuals through HIV counseling and testing. The underlying objective of the PCRS strategy is to identify HIV positive individuals and to promote protective behaviors (e.g., condom use) that have an impact on HIV transmission. On the basis of the work of Hogben et al.,[131] current studies have reported preliminary evidence that indicates the effectiveness of the PCRS strategy in serving as a strategy in achieving their objectives. However, there has been incongruity between these recent preliminary findings and the increasing disproportionate HIV infection rates among MSM of Color.

Further, one of the major limitations of the PCRS initiative relates to the complexities of the critical role that stigma, marginalization, and structural inequalities have on HIV testing and counseling for MSM of Color communities, thus significantly undermining the effectiveness of this strategy. For example, having access to high quality, culturally competent HIV prevention and care (including HIV counseling and testing) has been a significant barrier for MSM of Color.[132–134] For example, Malebranche et al.[135] found that healthcare experiences of black MSM involving racial and sexual discrimination served as barriers to the utilization of healthcare and HIV testing; additionally, these experiences involving healthcare had an impact on provider-patient communication patterns and protective behaviors. The implications

of the findings, as posed by Malebranche et al.,[135] relate to the importance of developing a cadre of healthcare providers reflective of communities of color based on race, gender, and sexuality, thus establishing core domains for cultural competencies in working with MSM of Color.

On the basis of the substantial recent HIV incidence rates among MSM of Color in the U.S., there is a dire need for the development and implementation of innovative, culturally relevant HIV testing and prevention strategies for MSM of Color. To address this problem, significant funding resources on the local, state, and federal levels need to be allocated to community based organizations in the development, implementation, and assessment of culturally relevant HIV testing procedures. In particular, there has been promising evidence[3] that indicates that gay pride of color programs and events sponsored by community based organizations have become an effective strategy for providing contexts for the development and implementation of culturally applicable models of HIV testing and prevention. Also, based on the work of Mayer et al.,[136] through community based organizations, a major part of this work can focus on accessing marginalized groups of individuals within MSM of Color communities (e.g., House Ball communities, commercial sex workers, incarcerated youth, homeless youth, etc.) who may be at significant risk for HIV transmission. In this pursuit, researchers that are reflective of MSM of Color communities need to provide the leadership in the development and implementation of HIV testing and prevention programmatic efforts.[135]

Psychosocial Support and Mental Health Needs for MSM of Color

As the AIDS epidemic enters a third decade, the current state of scholarly research regarding psychosocial and mental health issues for MSM of Color remains understudied.[95] According to the U.S. Surgeon General's Report, people of color have experienced barriers in accessing quality mental health services and care and have not been adequately represented in research in the area of mental health.[137] Similarly, MSM of Color have reported dissatisfaction with mental health services as a result of structural barriers including but not limited to heterosexism and homophobia.[138] Further, much of the extant research on the influence of racial/ethnic discrimination on mental health for people of color utilizing population based studies has found that the experience of racial/ethnic discrimination relates to increased psychological distress for people of color, including diagnosis of major depression, generalized anxiety disorder, and onset of substance use.[139] Similarly, population based studies of LGBT communities have shown that perceived discrimination (e.g., lifetime and daily discrimination) had a negative impact on their quality of life in addition to increases in current psychological distress and mental health disorders.[140] Other population based studies have reported a higher prevalence of mental health disorders, suicidal ideation, and substance use among lesbian, gay, and bisexual individuals as compared to heterosexual individuals.[141,142] In this

regard, population based studies of LGBT communities of color are needed to ascertain characteristics of mental health utilization as well as the prevalence of mental health and substance use morbidity.[143] Yet, there has been a significant void in population based studies that have focused on MSM of Color.

Sociocultural Factors in Relation to Mental Health for MSM of Color

Building on the work of several scholars,[144] stigma has been a core critical issue for MSM of Color. Specifically, the negotiation of racial, gender, and sexual identities juxtaposed with experiences of individual and institutionalized racism and homophobia have served as relevant culturally specific psychosocial issues for MSM of Color.[138] For example, according to Wheeler,[24] Black MSM have to work through the stressors associated with being a black male (e.g., racism, unemployment, incarceration, health issues) and that of being emotionally and/or sexually attracted to men (e.g., gender role expectations). A significant part of this work relates to the negotiation of relationships with significant others including family, friends, and sexual partners. Similarly, with respect to gender expression and socialization, Sandfort et al.[145] found that Latino gay and bisexual men who identified as effeminate reported greater psychological distress in addition to instances of homophobia as compared to those who did not identify as effeminate. Further, in a qualitative study of Black and Latino HIV-positive MSM who reported a history of childhood sexual abuse, findings showed that the sociocultural context of the men's lives was central to their lived experiences. For example, predominant themes related to sexual identity, role of family and cultural expectations regarding children, gender role socialization, influence of substance use, religiosity and spirituality, and HIV-related stigma, marginalization, and barriers to HIV care.[95]

On the basis of the work of Meyer,[146] the sociocultural model of minority stress in lesbian, gay, and bisexual (LGB) communities has provided a theoretical framework to examine the relationship between chronic stress and stigmatization, particularly as related to psychosocial distress. In particular, through the use of a distal-proximal domain, Meyer posited that the experiences of "minority" stressors for LGB individuals (e.g., expectations of stigma, internalized homophobia, and experiences of prejudice and discrimination) relate to mental health outcomes. As a part of minority stress processes, distal refers to experiences of prejudice, discrimination and violence based on sexual identity and proximal relates to experiences associated with "expectations of rejection, concealment, and internalized homophobia" (p. 248).[146] Additionally, with a specific focus on MSM of Color (e.g., Latino gay and bisexual men), researchers have developed theoretical models to examine the effects of social discrimination (e.g., racism, homophobia, poverty) in relation to psychological distress and resiliency.[144]

Further, the experiences of HIV-related stigma and discrimination both within and external to MSM of Color communities have served as relevant psychosocial issues for MSM of Color. For example, in a study of 301 Latino gay and

bisexual men, Zea et al.[147] found that HIV disclosure was predictive of respondents reporting higher levels of social support which had an impact on their lower depression and self-esteem. Similarly, Peterson et al.[148] reported that greater psychosocial resources mediated the relationship between stress and depressed mood in a community sample of Black gay, bisexual, and heterosexual men. Within this context, MSM of Color living with HIV and AIDS have to negotiate their HIV positive status involving issues of disclosure to romantic and sexual partners, families, friends, health care providers, as well as other significant others.[132] HIV positive MSM of Color also have to manage the stressors of stigma within MSM Communities of Color (e.g., issues of rejection and discrimination). Therefore, HIV prevention interventions need to address the stigmatization of HIV positive MSM of Color by HIV negative MSM of Color. For example, Diaz[149] found high levels of HIV-related stigma among Latino HIV negative MSM and high levels of psychological distress associated with the experiences of HIV related stigma for Latino HIV positive MSM.

Summary

Since the onset of AIDS epidemic, MSM of Color communities have experienced considerable HIV-related health disparities in the U.S. There has been a substantial void in scholarly research on MSM of Color within the context of the AIDS epidemic. There have been significant limitations in the conceptual frameworks utilized in research on HIV-related health disparities for MSM of Color. Traditional models used in research on HIV-related health disparities have not integrated to a substantial degree culturally relevant conceptualizations at the core of the work. Thus, the objective of this chapter was to examine the factors that contribute to the significant incidence and prevalence rates of HIV and AIDS in MSM of Color communities. In particular, the concepts of stigma, marginalization, and structural inequalities were posed as a theoretical framework to examine HIV-related health disparities in MSM of Color communities. A basic premise of this work involves a paradigm shift that integrates intersectional and interdisciplinary theoretical and methodological approaches in the study of HIV related health disparities in MSM of Color communities. One of the core ideas put forth in the development of this work relates to a focus on the intersection of race, gender, social class, and sexual politics within the context of HIV prevention in MSM of Color communities.

References

1. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 2006, 18*, 1–46. U.S. Department of Health and Human Services: Atlanta, GA; 2008
2. Hall HI, Byers RH, Ling Q, Espinoza L. Racial/ethnic and age disparities in HIV prevalence and disease progression among men who have sex with men in the United States. *American Journal of Public Health*. 2007; 97: 1060–1066

3. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 2005, 17*, 1–55. U.S. Department of Health and Human Services: Atlanta, GA; 2007
4. Diaz RM, Ayala G, Bein E. Sexual risk as an outcome of social oppression: data from a probability sample of Latino gay men in three U.S. cities. *Cultural Diversity and Ethnic Minority Psychology*. 2004; 10: 255–267
5. Koblin BA, Torian LV, Guilin V, Ren L, MacKellar DA, Valleroy LA. High prevalence of HIV infection among young men who have sex with men in New York City. *AIDS*. 2000; 14: 1793–1780
6. Mays VM, Cochran SD, Zamudio A. HIV prevention research: are we meeting the needs of African American men who have sex with men? *Journal of Black Psychology*. 2004; 30: 8–105
7. Millet GA, Flores SA, Peterson JL, Bakeman R. Explaining disparities in HIV infection among Black and White men who have sex with men: a meta-analysis of HIV risk behaviors. *AIDS*. 2007; 21: 2083–2091
8. Vernon I. *Prevention of HIV Infection in Native American Communities*. Paper presented at the National Institutes of Health, Office of AIDS Research Advisory Council: Bethesda, MA; 2007
9. Yoshikawa H, Wilson PAD, Chae DH, Cheng J. Do family and friendship networks protect against the influence of discrimination on mental health and HIV risk among Asian and Pacific Islander gay men? *AIDS Education and Prevention.* 2004; 16: 68–83
10. Valleroy LA, MacKellar DA, Karon JM, Rosen DH, McFarland W, Shehan DA, et al. HIV prevalence and associated risks in young men who have sex with men. *Journal of the American Medical Association.* 2000; 284: 198–204
11. Fieland KC, Walters KL, Simoni JM. Determinants of health among two-spirit American Indians and Alaska Natives. In: Meyer IH, Northridge ME, eds. *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual, and Transgender Populations.* New York: Springer, 2007, pp. 268–300
12. Nemoto T, Wong FY, Ching A, Chung CL, Bouey P, Herncikson M, et al. HIV seroprevalence, risk behaviors, and cognitive factors among Asian and Pacific Islander American men who have sex with men: a summary and critique of empirical studies and methodological issues. *AIDS Education and Prevention.* 1998; 10: 31–47
13. Centers for Disease Control and Prevention. HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men – five U.S. cities, June 2004–April 2005. *Morbidity and Mortality Weekly Report*. 2005; 54: 597–601
14. Centers for Disease Control and Prevention. HIV incidence among young men who have sex with men – seven U.S. cities, 1994–2000. *Morbidity and Mortality Weekly Report*. 2001; 50: 440–444
15. Centers for Disease Control and Prevention. Trends in HIV/AIDS diagnoses among men who have sex with men – 33 states, 2001–2006. *Morbidity and Mortality Weekly Report*. 2008; 57: 681–686
16. Wilton L. Perceived health risks and psychological factors as predictors of sexual risk-taking within HIV positive gay male seroconcordant couples. *Dissertation Abstracts International.* 2001; 61(7-B): 3867
17. Bing EG, Bingham T, Millett GA. Research needed to more effectively combat HIV among African American men who have sex with men. *Journal of the National Medical Association.* 2008; 100: 52–56
18. Black Gay Research Group. *Black Gay Research Agenda.* Black Gay Men's Research Group and National Black Gay Men's Advocacy Coalition: New York; 2007
19. Choi KH, Yep GA, Kumekawa E. HIV prevention among Asian and Pacific Islander American men who have sex with men: a critical review of theoretical models and directions for future research. *AIDS Education and Prevention.* 1998; 10: 19–30
20. Peterson JL, Coates TJ, Catania JA, Middleton L, Hilliard B, Hearst N. High-risk sexual behavior and condom use among gay and bisexual African American men. *American Journal of Public Health*. 1992; 82: 1490–1494

21. Wilton L. *The Absence of Color in Black Gay Men's Experiences – It's a Paradox: Thinking About HIV and AIDS*. Paper presented to the New York State Department of Health, AIDS Institute: Albany, NY; 2006
22. Diaz RM. *Latino Gay Men and HIV: Culture, Sexuality, and Risk Behavior*. Routledge Press: New York; 1997
23. Padilla M, Castellanos D, Guilamo-Ramos V, Reyes AM, Sanchez ML, Soriano MA. Stigma, social inequality, and HIV risk disclosure among Dominican male sex workers. *Social Science & Medicine*. 2008; 67: 380–388
24. Wheeler DP. Exploring HIV prevention needs for nongay-identified Black and African American men who have sex with men: a qualitative exploration. *Sexually Transmitted Diseases*. 2006; 33: S11–S16
25. Zea MC, Reisen CA, Diaz RM. Methodological issues in research on sexual behavior with Latino gay and bisexual men. *American Journal of Community Psychology*. 2003; 31: 281–291
26. Wilton L. Correlates of substance use in relation to sexual behavior in Black gay and bisexual men: implications for HIV prevention. *Journal of Black Psychology*. 2008; 34: 70–93
27. Cohen C. *The Boundaries of Blackness: AIDS and the Breakdown of Black politics*. University of Chicago Press: Chicago; 1999
28. Wyatt GE, Williams JK, Myers HF. African American sexuality and HIV/AIDS: recommendations for future research. *Journal of the National Medical Association*. 2008; 100: 44–51
29. Mullings L, Schulz AJ. Intersectionality and health: an introduction. In: Schulz AJ, Mullings L, eds. *Gender, Race, Class, and Health: Intersectional Approaches*. New York: John Wiley & Sons, Inc, 2005, pp. 3–20
30. Airhihenbuwa CO, Okonor TA. Toward evidence-based and culturally appropriate models for reducing global health disparities: an Africanist perspective. In: Wallace BC, ed. *Toward Equity in Health: A New Global Approach to Health Disparities*. New York: Springer, LLC, 2008, pp. 47–60
31. Collins PH. *Black Sexual Politics: African Americans, Gender, and the New Racism*. Routledge Press: New York; 2005
32. Smedley BD, Stith AY, Nelson AR. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press: Washington, D.C.; 2002
33. Williams RA. Historical perspectives on health care disparities: is the past prologue? In: Williams RA, ed. *Eliminating Healthcare Disparities in America: Beyond the IOM Report*. Totowa, NJ: Humana Press, 2007, pp. 3–19
34. LaVeist T. *Minority Populations and Health: An Introduction to Health Disparities in the U.S.*. Jossey-Bass: San Francisco; 2005
35. Schulz AJ, Freudenberg N, Daniels J. Intersections of race, class, and gender in public health interventions. In: Schulz AJ, Mullings L, eds. *Gender, Race, Class, and Health: Intersectional Approaches*. New York: John Wiley & Sons, Inc, 2005, pp. 371–393
36. Smedley A. *Race in North America: The Origin and Evolution of a Worldview*, 3rd edition. Westview Press: Boulder, CO; 2007
37. Krieger N. Studies of difference: theoretical underpinnings of the medical controversy of black-white differences in the United States, 1830–1870. In: LaVest TA, ed. *Race, Ethnicity, and Health: A Public Health Reader*. San Francisco, CA: John Wiley & Sons, 2002, pp. 11–33
38. Washington HA. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. New York: Harlem Moon Press; 2008
39. Briggs L. *Reproducing Empire: Race, Sex, and U.S. Imperialism in Puerto Rico*. University of California Press: Berkeley; 2002
40. Brandt AM. Racism and research: the case of the Tuskegee Syphilis experiment. In: Reverby SM, ed. *Tuskegee's Truths: Rethinking the Tuskegee Syphilis Study*. Chapel Hill, NC: University of North Carolina Press, 2000, pp. 15–33

41. Bird ST, Bogart L. Conspiracy beliefs about HIV/AIDS and birth control among African Americans: Implications for the prevention of HIV, other STIs, and unintended pregnancy. *Journal of Social Issues*. 2005; 61: 109–126
42. Klonoff EA, Landrine H. Do blacks believe HIV/AIDS is a governmental conspiracy against them? *Preventive Medicine*. 1999; 28: 451–457
43. Ross MW, Essien EJ, Torres I. Conspiracy beliefs about the origin of HIV/AIDS in four racial/ethnic groups. *Journal of Acquired Immune Deficiency Syndromes*. 2006; 41: 342–344
44. Silvestre AJ, Hylton JB, Johnson LM, Houston C, Witt M, Jacobson L, et al. Recruiting minority men who have sex with men for HIV research: results from a 4-city campaign. *American Journal of Public Health*. 2006; 96: 1020–1027
45. Thomas SB, Quinn SC. The Tuskegee Syphilis Study, 1932–1972: implications for HIV education and AIDS risk education programs in the Black community. *American Journal of Public Health*. 1991; 81: 1498–1505
46. Singer M. AIDS and the health crisis of the U.S. urban poor: the perspective of critical medical anthropology. *Social Science and Medicine*. 1994; 39: 931–948
47. Stall R, Mills TC, Williamson J, Hart T, Greenwood G, Paul J, et al. Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men. *American Journal of Public Health*. 2003; 93: 939–942
48. Stall R. *An Update on Syndemic Theory Among Urban Gay Men.* Paper presented at the American Public Health Association: Washington, DC; 2007
49. Fullilove R. *African Americans, Health Disparities and HIV/AIDS: Recommendations for Confronting the Epidemic in Black America*. National Minority AIDS Council: Washington, DC; 2006
50. Harawa N, Adimora A. Incarceration, African Americans and HIV: advancing a research agenda. *Journal of the National Medical Association.* 2008; 100: 57–62
51. Jones KT, Johnson WD, Wheeler DP, Gray P, Foust E, Gaiter J. The North Carolina Men's Health Initiative Study Team. Nonsupportive peer norms and incarceration as HIV risk correlates for young Black men who have sex with men. *AIDS & Behavior*. 2008; 12: 41–50
52. Arnold EA, Bailey MM. Constructing home and family: how the ballroom community supports African American GLBTQ youth in the face of HIV/AIDS. *Journal of Gay and Lesbian Social Services*. 2009, in press
53. Murrill CS, Liu K, Guilin V, Colon ER, Dean L, Buckley LA, et al. HIV prevalence and associated risk behaviors in New York's house ball community. *American Journal of Public Health*. 2008; 98: 1074–1080
54. Choi KH, Hudes ES, Steward WT. Social discrimination, concurrent sexual partnerships, and HIV risk among men who have sex with men in Shanghai, China. *AIDS & Behavior*. 2008; 12(1): 71–77
55. Ghosn J, Thibault V, Delaugerre C, Fontaine H, Lortholary O, Rouzioux C. Sexually transmitted hepatitis c virus superinfection in HIV/hepatitis c virus co-infected men who have sex with men. *AIDS*. 2008; 22: 658–661
56. Vittinghoff E, Douglas J, Judon F, McKirnan D, MacQueen K, Buchbinder SP. Per-contact risk for human immunodeficiency virus transmission between male sexual partners. *American Journal of Epidemiology*. 1999; 150: 306–311
57. Buchacz K, Klausner JD, Kerndt PR, Shouse RL, Onorato I, McElroy PD, et al. HIV incidence among men diagnosed with early syphilis in Atlanta, San Francisco, and Los Angeles, 2005 to 2005. *Journal of Acquired Immune Deficiency Syndromes*. 2008; 47: 234–240
58. Corey L, Wald A, Celum CL, Quinn TC. The effects of herpes simples virus-2 on HIV-1 acquisition and transmission: a review of two overlapping epidemics. *Journal of Acquired Immune Deficiency Syndromes.* 2004; 35: 435–445
59. Kaul R, Pettengell C, Seth PM, Sunderji S, Biringer A, MacDonald K, et al. The genital tract immune milieu: an important determinant of HIV susceptibility and secondary transmission. *Journal of Reproductive Immunology*, 2008; 77: 32–40
60. Keele BF, Giorgi EE, Salazar-Gonzalez JF, Decker JM, Pham KT, Salazar MG, et al. Identification and characterization of transmitted and early founder virus envelopes in primary

HIV-1 infection. *Proceedings of the National Academy of Sciences of the United States of America*. 2008; 105: 7552–7557
61. Do TD, Chen S, McFarland W, Secura GM, Behel SK, MacKellar DA, et al. HIV testing patterns and unrecognized HIV infection among young Asian and Pacific Islander men who have sex with men in San Francisco. *AIDS Education and Prevention*. 2005; 17: 540–544
62. Manning SE, Thorpe LE, Ramaswamy C, Hajat A, Marx MA, Karpati AM, et al. Estimation of HIV prevalence, risk factors, and testing frequency among sexually active men who have sex with men, aged 18–64 years – New York City, 2002. *Journal of Urban Health*. 2007; 84: 212–225
63. Raymond HF, Chen S, Truong HM, Knapper KB, Klausner JD, Choi KH, et al. Trends in sexually transmitted diseases, sexual risk behavior, and HIV infection among Asian/Pacific Islander men who have sex with men, San Francisco, 1999–2005. *Sexually Transmitted Diseases*. 2007; 34: 262–264
64. Do TD, Hudes ES, Proctor K, Han CS, Choi KH. HIV testing trends and correlates among young Asian and Pacific Islander men who have sex with men in two U.S. cities. *Sexually Transmitted Diseases*. 2006; 45: 77–84
65. Chng CL, Wong FY, Park RJ, Edberg MC, Lai DS. A model for understanding sexual health among Asian American/Pacific Islander men who have sex with men (MSM) in the United States. *AIDS Education and Prevention*. 2003; 15: 21–38
66. Millett GA, Peterson JL, Wolitski R, Stall R. Greater risk for HIV infection of Black men who have sex with men: a critical literature review. *American Journal of Public Health*. 2006; 96: 1007–1019
67. Carrillo H. *The Night is Young: Sexuality in Mexico in the Time of AIDS*. University of Chicago Press: Chicago; 2001
68. Jarama SL, Kennamer JD, Poppen PJ, Hendricks M, Bradford J. Psychosocial, behavioral, and cultural predictors of sexual risk for HIV infection among Latino men who have sex with men. *AIDS & Behavior*. 2005; 9: 513–523
69. Marin BV. HIV prevention in the Hispanic community: sex, culture, and empowerment. *Journal of Transcultural Nursing*. 2003; 14: 186–192
70. Bianchi FT, Reisen CA, Zea MC, Poppen RJ, Shedlin MG, Penha NM. The sexual experiences of Latino men who have sex with men who migrated to a gay epicenter in the U.S. *Culture, Health, & Sexuality*. 2007; 9: 505–518
71. Poppen PJ, Reisen CA, Zea MC, Bianchi FT, Echeverry JJ. Serostatus disclosure, seroconcordance, partner relationship, and unprotected anal intercourse among HIV-positive Latino men who have sex with men. *AIDS Education and Prevention*. 2005; 17: 227–237
72. Zea MC, Reisen CA, Poppen RJ, Bianchi FT, Echeverry RJ. Predictors of disclosure of human immunovirus-positive serostatus among Latino gay men. *Cultural Diversity and Ethnic Minority Psychology*. 2007; 13: 304–312
73. Poppen PJ, Reisen CA, Zea MC, Bianchi FT, Echeverry JJ. Predictors of unprotected anal intercourse among HIV-positive Latino gay and bisexual men. *AIDS & Behavior*, 2004; 8: 379–389
74. Carballo-Dieguez A, Miner M, Dolezal C, Rosser BR, Jacoby S. Sexual negotiation, HIV-status disclosure, and sexual risk behavior among Latino men who use the internet to seek sex with other men. *Archives of Sexual Behavior*. 2006; 35: 463–481
75. Fernandez MI, Warren JC, Varga LM, Pardo G, Hernandez N, Bowen GS. Cruising in cyber space: Comparing internet chatroom versus community venues for recruiting Hispanic men who have sex with men to participate in prevention studies. *J Ethn Subst Abuse*. 2007; 6: 143–162
76. Warren JC, Fernandez MI, Harper GW, Hidalgo MA, Jamil OB, Torres RS. Predictors of unprotected sex among young sexually active African American, Hispanic, and White MSM: the importance of ethnicity and culture. *AIDS & Behavior*. 2008; 12: 459–468
77. Dolezal C, Carballo-Dieguez A, Nieves-Rosa L, Diaz F. Substance use and sexual risk behavior: Understanding their association among four ethnic groups of Latino men who have sex with men. *Journal of Substance Abuse*. 2000; 11: 323–336

78. Ramirez-Valles J, Garcia D, Campbell RT, Diaz RM, Heckathorn DD. HIV infection, sexual risk behavior, and substance use among Latino gay and bisexual men and transgender persons. *American Journal of Public Health*. 2000; 98: 1036–1042
79. Eaton LA, Kalichman SC, Cain DN, Cherry C, Stearns HL, Amaral CM, et al. Serosorting sexual partners and risk for HIV among men who have sex with men. *American Journal of Preventive Medicine*. 2007; 33: 479–485
80. Horvath KJ, Rosser BR, Remafedi G. Sexual risk taking among young Internet-using men who have sex with men. *American Journal of Public Health*. 2008; 98: 1059–1067
81. Berry M, Raymond HF, McFarland W. Same race and older partner selection may explain higher HIV prevalence among Black men who have sex with men. *AIDS*. 2007; 21: 249–350
82. Bingham TA, Harawa NT, Johnson DF, Secura GM, Valleroy LA. The effect of partner characteristics of HIV infection among African American men who have sex with men in the Young Men's Survey, Los Angles, 1999–2000. *AIDS Education and Prevention*. 2003; 15: 39–52
83. Choi KH, Operaio D, Gregorich SE, McFarland W, MacKellar D, Valleroy L. Age and race mixing patterns of sexual partnerships among Asian men who have sex with men: implications for HIV transmission and prevention. *AIDS Education and Prevention*. 2003; 15: 53–65
84. Mansergh G, Marks G, Colfax GN, Guzman R, Rader M, Buchbinder S. "Barebacking" in a diverse sample of men who have sex with men. *AIDS*. 2002; 16: 653–659
85. Rosser BR, Miner MH, Bockting WO, Ross MW, Konstan J, Gurak L, et al. HIV risk and the internet: results of Men's Internet sex (MINTS) study. *AIDS & Behavior*. 2008
86. Choi KH, Operaio D, Gregorich SE, McFarland W, MacKellar D, Valleroy L. Substance use, substance choice, and unprotected anal intercourse among young Asian American and Pacific Islander men who have sex with men. *AIDS Education and Prevention*. 2002; 17: 418–429
87. Berry M, Raymond HF, Kellogg T, McFarland W. The internet, HIV serosorting and transmission risk among men who have sex with men, San Francisco. *AIDS*. 2008; 30: 787–789
88. Parsons JT, Schrinshaw EW, Wolitski RJ, Halkitis PN, Purcell DW, Hoff CC, et al. Sexual harm reduction practices of HIV-seropositive gay and bisexual men: serosorting, strategic positioning, and withdrawal before ejaculation. *AIDS*. 2005; 19: S13–S25
89. Centers for Disease Control and Prevention. Use of social networks to identify persons with undiagnosed HIV infection – seven U.S. cities, October 2003–September 2004. *Morbidity and Mortality Weekly Report*. 2004; 54: 601–605
90. Adimora AA, Schoenbach VJ. Social context, sexual networks, and racial disparities in rates of sexually transmitted infections. *Journal of Infectious Diseases*. 2005; 191: 1007–1019
91. Wyatt GE, Myers HF, Williams JK, Kitchen CR, Loeb T, Carmona JV, et al. Does a history of trauma contribute to HIV risk for women of color? implications for prevention and policy. *American Journal of Public Health*. 2005; 92: 660–665
92. Wyatt GE, Myers HF, Loeb TB. Women, trauma, and HIV: an overview. *AIDS & Behavior*. 2004; 8: 401–403
93. Simoni JM, Walters KL, Balsam KF, Meyers SB. Victimization, substance use, and HIV risk behaviors among gay/bisexual/two-spirit and heterosexual American Indian men in New York City. *American Journal of Public Health*. 2006; 96: 2240–2245
94. Toro-Alfonso J, Rodriguez-Madera S. Domestic violence in Puerto Rican gay male couples: perceived prevalence, intergenerational violence, addictive behaviors, and conflict resolution skills. *Journal of Interpersonal Violence*. 2004; 19: 639–654
95. Williams JK, Wyatt E, Resell J, Peterson J, Asuan-O'Brien A. Psychosocial issues among gay- and non-gay-identifying HIV-seropositive African American and Latino MSM. *Cultural Diversity and Ethnic Minority Psychology*. 2004; 10: 268–286
96. Arreola S, Neilands TB, Pollack LM, Paul JP, Catania JA. Higher prevalence of childhood sexual abuse among Latino men who have sex with men than non-Latino men who have sex with men: data from the Urban Men's Health Study. *Child Abuse & Neglect*. 2005; 29: 285–290

97. Fields S, Malebranche D, Feist-Price S. Childhood sexual abuse in Black men who have sex with men: results from three qualitative studies. *Cultural Diversity and Ethnic Minority Psychology*. 2008; 14: 385–390
98. Fernandez MI, Bowen GS, Varga LM, Collazo JB, Hernandez N, Perrino T, et al. High rates of club drug use and risky sexual practices among Hispanic men who have sex with men in Miami, Florida. *Substance Use & Misuse*. 2005; 40: 1347–1362
99. Operario D, Choi KH, Chu PL, McFarland W, Secura GM, Behel S, et al. Prevalence and correlates of substance use among young Asian Pacific Islander men who have sex with men. *Prevention Science*. 2006; 7: 19–29
100. Diaz RM. Methamphetamine use and its relation to HIV risk: data from Latino gay men in San Francisco. In: Meyer IH, ed. *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual, and Transgender Populations*. New York: Springer, 2007, pp. 584–603
101. Huang ZJ, Wong FY, De Leon JM, Park RJ. Self-reported HIV testing behaviors among a sample of Southeast Asians in an urban setting in the United States. *AIDS Education and Prevention*, 20, 65–77
102. Akin M, Fernandez MI, Bowen GS, Warren JC. HIV risk behaviors of Latin American and Caribbean men who have sex with men in Miami, Florida, U.S. *Pan American Journal of Public Health*. 2008; 23: 341–348
103. Hutchinson C. *Comparing Stigma Management Among Men who have Sex with Men in Barbados, West Indies and the San Francisco Bay Area.* University of California at Berkeley: Berkeley, CA; 2005
104. Morin SF, Carrillo H, Steward WT, Maiorana A, Trautwein M, Gomez CA. Policy perspectives on public health for Mexican migrants in California. *Journal of Acquired Immune Deficiency Syndromes*. 2004; 37: S252–S259
105. Organista KC, Carrillo H, Ayala G. HIV prevention with Mexican migrants: review, critique, and recommendations. *Journal of Acquired Immune Deficiency Syndromes*. 2004; 37: S227–S239
106. Zaidi IF, Crepaz N, Song R, Wan CK, Lin LS, Hu DJ, et al. Epidemiology of HIV/AIDS among Asians and Pacific Islanders in the United States. *AIDS Education and Prevention.* 2005; 17: 405–417
107. Choi KH, Ning Z, Gregorich SE, Pan QC. The influence of social and sexual networks in the spread of HIV and syphilis among men who have sex with men in Shanghai, China. *Journal of Acquired Immune Deficiency Syndromes.* 2007; 45: 77–84
108. Ayala G, Chion M, Diaz RM, Heckert AL, Nuno M, del Pino HE, et al. Accion mutua (shared action): a multipronged approach to delivering capacity-building assistance to agencies serving Latino communities in the United States. *Journal of Public Health Management Practice*. 2007; 13: S33–S39
109. Nemoto T, Operario D, Keatley J, Han L, Soma T. HIV risk behaviors among male-to-female transgender persons of color in San Francisco. *American Journal of Public Health*. 2004; 94: 1193–1199
110. Operario D, Soma T, Underhill K. Sex work and HIV status among transgender women: Systematic review and meta-analysis. *Journal of Acquired Immune Deficiency Syndromes*. 2008; 48: 97–103
111. Sausa LA, Keatley J, Operario D. Perceived risks and benefits of sex work among transgender women of color in San Francisco. *Archives of Sexual Behavior*. 2008; 36: 768–777
112. Sugano E, Nemoto T, Operario D. The impact of exposure to transphobia on HIV risk behavior in a sample of transgendered women of color in San Francisco. *AIDS & Behavior*. 2006; 10: 217–225
113. Herbst JH, Jacobs ED, Finlayson TJ, McKleroy VS, Neumann MS, Crepaz N, et al. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS & Behavior*. 2008; 12: 1–17
114. Lawrence AA. Transgender health concerns. In: Meyer IH, Northridge ME, eds. *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual, and Transgender Populations*. New York: Springer, 2008, pp. 473–585

115. Garofalo R, Deleon J, Osmer E, Doll M, Harper GW. Overlooked, misunderstood and at-risk: exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health*. 2006; 38: 230–236
116. Operario D, Nemoto T. Sexual risk behavior and substance use among a sample of Asian Pacific Islander transgendered women. *AIDS Education and Prevention*. 2005; 17: 430–433
117. Herbst JH, Beeker C, Matthew A, McNally T, Passin WF, Kay LS, et al. The effectiveness of individual-, group-, and community-level HIV behavioral risk-reduction interventions for adult men who have sex with men: a systematic review. *American Journal of Preventive Medicine*. 2007; 32: S38–S67
118. Wheeler DP, Lauby JL, Liu K, Van Sluytman LG, Murrill C. A comparative analysis of sexual risk characteristics of Black men who have sex with men or with men and women. *Archives of Sexual Behavior*. 2008; 37(5): 697–707
119. Jones KT, Gray P, Whiteside O, Wang T, Bost D, Dunbar E, Foust E, et al. Evaluation of an HIV prevention intervention adapted for Black men who have sex with men. *American Journal of Public Health*. 2008; 98: 1043–1050
120. Williams JK, Wyatt GE, Rivkin I, Ramamurthi HC, Li X, Liu H. Risk reduction for HIV-positive African American and Latino men with histories of childhood sexual abuse. *Archives of Sexual Behavior*. 2008; 37(5): 763–772
121. Centers for Disease Control and Prevention. Twenty-five years of HIV/AIDS – United States, 1981–2006. *Morbidity and Mortality Weekly Report*. 2006; 55: 585–589
122. Choi KH, Lew S, Vittinghoff E, Catania JA, Barrett DC, Coates TJ. The efficacy of brief group counseling in HIV risk reduction among homosexual Asian and Pacific Islander men. *AIDS*. 1996; 10: 81–87
123. Carballo-Dieguez A, Dolezal C, Leu CS, Nieves L, Diaz F, Decena C, et al. A randomized controlled trial to test an HIV-prevention intervention for Latino gay and bisexual men: Lessons learned. *AIDS Care*. 2005; 17: 314–328
124. Peterson JL, Coates TJ, Catania J, Hauck WW, Acree M, Daigle D, et al. Evaluation of an HIV risk reduction intervention among African American homosexual and bisexual men. *AIDS*. 1996: 3: 319–325
125. Toro-Alfonso J, Varas-Diaz N, Andujar-Bello I. Evaluation of an HIV/AIDS prevention intervention targeting Latino gay men and men who have sex with men in Puerto Rico. *AIDS Education and Prevention*. 2002; 14: 445–456
126. Wallace BC. The forces driving and embodied within a new field of equity in health. In: Wallace BC, ed. *Toward Equity in Health: A New Global Approach to Health Disparities*. New York: Springer, LLC, 2008, pp. 1–40
127. Buchanan DR, Allegranate JP. What types of public health proposals should agencies be funding and what types of evidence should matter? Scientific and ethical considerations. In: Wallace BC, ed. *Toward Equity in Health: A New Global Approach to Health Disparities*. New York: Springer, LLC, 2008, pp. 81–96
128. Jones KT, Wilton L, Millett G, Johnson WD. Theoretical considerations for culturally relevant HIV prevention interventions for Black men who have sex with men (MSM): formulating the Black MSM stress severity and resiliency model. In: McCree D, Jones KT, O'Leary A, eds. *AIDS Among African Americans: A Community in Crisis*. New York: Springer, in press
129. Kegeles S. *A Community Level HIV Prevention Intervention for Young Black MSM*. Center for AIDS Prevention Studies: San Francisco; 2007
130. Branson BM, Handsfield HH, Lampe MA, Janssen RS, Taylor AW, Lyss SB, et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health care settings. *Morbidity and Mortality Weekly Report*. 2006; 55: 1–17
131. Hogben M, McNally T, McPheeters M, Hutchinson AB, & Task Force on Community Preventive Services. The effectiveness of HIV partner counseling and referral services in increasing identification of HIV-positive individuals: a systematic review. *American Journal of Preventive Medicine*. 2007; 33: S89–S100
132. Wheeler DP. Working with positive men: HIV prevention with black men who have sex with men. *AIDS Education and Prevention*. 2005; 17: 102–115

133. Wilson PA, Yoshikawa H. Improving access to health care among African American, Asian and Pacific Islander, and Latino lesbian, gay, and bisexual populations. In: Meyer IH, Northridge ME, eds. *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual, and Transgender Populations.* New York: Springer, 2007, pp. 607–637
134. Wilton L. *Experiences of Racism, Homophobia, and Discrimination in a Community Based Sample of Black Gay and Bisexual Men: Implications for HIV Prevention.* Paper presented at The Second Annual Health Disparities Conference, Teachers College, Columbia University: New York, NY; 2007, March
135. Malebranche DJ, Peterson JL, Fullilove RE, Stackhouse RW. Race and sexual identity: perceptions about medical culture and healthcare among Black men who have sex with men. *Journal of the National Medical Association.* 2004; 96: 97–107
136. Mayer KH, Mimiaga MJ, VanDerwarker R, Goldhammer H, Bradford JB. Fenway community health's model of integrated, community-based LGBT care, education, and research. In: Meyer IH, Northridge ME, eds. *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual, and Transgender Populations.* New York: Springer, 2008, pp. 693–715
137. United States Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General.* U.S. Department of Health and Human Services: Rockville, MD; 2001
138. Greene B. Ethnic-minority lesbians and gay men: Mental health and treatment issues. *Journal of Consulting and Clinical Psychology*. 1994; 62: 243–251
139. Williams DR, Neighbors HW, Jackson JS. Racial/ethnic discrimination and health: findings from community studies. *American Journal of Public Health*. 2003; 93: 200–208
140. Mays VM, Cochran SD. Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health*. 2001; 91: 1869–1876
141. Gilman SE, Cochran SD, Mays VM, Hughes M, Ostrow D, Kessler RC. Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the national comorbidity survey. *American Journal of Public Health*. 2001; 91: 933–939
142. Cochran SD, Ackerman D, Mays VM, Ross MW. Prevalence of non-medical drug use and dependence among homosexually active men and women in the U.S. population. *Addiction*. 2004; 99: 989–998
143. Cochran SD, Mays VM, Alegria M, Ortega A, Takeuchi D. Mental health and substance use disorders among Latino and Asian American lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology*. 2007; 75: 785–794
144. Diaz RM, Ayala G, Bein E, Henne J. The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: findings from 3 U.S. cities. *American Journal of Public Health*. 2001; 91: 927–931
145. Sandfort TG, Melendez RM, Diaz RM. Gender nonconformity, homophobia, and mental distress in Latino gay and bisexual men. *Journal of Sex Research.* 2007; 44: 181–189
146. Meyer I. Prejudice and discrimination as social stressors. In: Meyer IH, Northridge ME, eds. *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual, and Transgender Populations*. New York: Springer, 2007, pp. 242–267
147. Zea MC, Reisen CA, Poppen RJ, Bianchi FT, Echeverry RJ. Disclosure of HIV status and psychological well-being among Latino gay and bisexual men. *AIDS & Behavior*. 2005; 9: 15–26
148. Peterson JL, Folkman S, Bakeman R. Stress, coping, HIV status, psychosocial resources, and depressive mood in African American gay, bisexual, and heterosexual men. *American Journal of Community Psychology*. 1996; 24: 461–487
149. Diaz R. In our own backyard: HIV/AIDS stigmatization in the Latino gay community. In: Teunis N, Herdt G, eds. *Sexual Inequalities and Social Justice*. Berkeley, CA: University of California Press, 2007, pp. 50–65