Black MSM and the National Strategy for HIV/AIDS: A Strengths Based Policy Analysis

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Abstract: The National Strategy on HIV/AIDS (NHAS) is the latest in a long line of policy measures that attempt to address the needs of domestic populations who are vulnerable to HIV/AIDS. This article utilizes a strengths framework to guide policy formulation, implementation, and analysis. It explores whether the NHAS is strengths based and how effectively it addresses the unique vulnerability of Black Men Who Have Sex with Men (BMSM) to HIV/AIDS. Recommendations for policy practitioners include embracing the diversity and strengths of BMSM and enhancing the involvement of social workers in the implementation and evaluation of NHAS programs.

Keywords: HIV/AIDS, Strengths, Black MSM, Social Work, Social Policy.

INTRODUCTION

Social policy development can be viewed as "societal responses to social problems" [1]. Social workers have long advocated for a practice emphasis on client strengths rather than pathologies [2-4]. Social work researchers have further developed this framework and have made recommendations for applying a strengths perspective to social policy development [2-4]. This paper builds on existing concepts and research on the application of the strengths perspective to social policy development. Specifically, it examines the National HIV/AIDS Strategy (NHAS) and its applications for black men who have sex with men (BMSM), a group that has been identified as particularly high risk of HIV/AIDS [5-7].

There is limited but important research on the role of social work practice with Men who have Sex with Men (MSM) [8-9] and little emphasis on social work's role in addressing the needs of BMSM in practice and policy arenas. In this paper, we present information on the impact of the NHAS on BMSM who are a marginalized population and more vulnerable to contracting the HIV/AIDS virus than any other group identified in prevention policy. We utilize the strengths approach to social policy development to frame our discussion on the NHAS and its impact on BMSM.

NATIONALS HIV/AIDS STRATEGY

The Obama Administration identified HIV/AIDS as a policy priority during his campaign and early in his term [10] The National HIV/AIDS strategy aims to address stigma and discrimination associated with HIV/AIDS and to provide "high quality, life extending care across race, gender, age, race/ethnicity, and sexual orientation" [10, p4]. The policy writers, who authored the NHAS aimed to build on existing research and best practices in the field, identify areas that need immediate attention, target resources to meet the needs of the most vulnerable groups, and evaluate the success of measures in meeting the above-mentioned goals. The NHAS is not intended as a budget document, per se, but as a policy statement that informs the federal budget development process and encourages commitment to collaboration, efficiency and innovation on HIV/AIDS programs at all levels of government [10].

The policy document identifies three major goals to be achieved by the year 2015. These include: 1) reducing the number of the people who become infected with HIV/AIDS; 2) increasing access to care and optimizing health outcomes for people living with HIV/AIDS; and 3) reducing HIV-related health disparities. To accomplish these goals, the NHAS "identified a set of priorities and strategic action steps tied to measurable outcomes" [10 p3] Organizations that support the implementation of the strategic goals and the vision of the NHAS include the Federal Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC) and the Health Resources Services Administration.

The NHAS has acknowledged the need to train social workers in HIV/AIDS prevention and has

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provided funding to the National Association of Social Workers (NASW) through SAMHSA. The NASW HIV/AIDS Partnership Initiative aims to train to social workers in “mental health and psychosocial needs” of individuals living with HIV/AIDS in twelve jurisdictions identified by the NHAS (“New York City Chapter (New York City); California Chapter (Los Angeles and San Francisco); Metro-DC Chapter (Washington, DC); Georgia Chapter (Atlanta); Texas Chapter (Houston and Dallas); Maryland Chapter (Baltimore); Illinois Chapter (Chicago); Florida Chapter (Miami); Pennsylvania Chapter (Philadelphia); and Puerto Rico Chapter (San Juan”) (National Association of Social Workers, para 4. n.d.). This paper can augment information presented to social workers in these trainings as well as to those who may not be able to access these opportunities in specific locations.

FOCAL POPULATION: BLACK MEN WHO HAVE SEX WITH MEN

Among populations who have been identified as high risk in the NHAS policy document, black men who have sex with men (BMSM) are at the greatest risk of HIV/AIDS. Specifically, the policy document aims to increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20 % and to increase the proportion of HIV diagnosed African Americans with undetectable viral load by 20 % by 2015 [10 p31]. The NHAS requires that 85% of all blacks diagnosed be linked to care and 80% be retained in care in order to meet policy goals of reducing the spread of HIV among African American populations [10 p31).

Current research indicates that the goals set for the NHAS for 2015 are not likely to be achieved because of a lack of sufficient investment in existing programs and that there needs to significant planning on how stated policy goals may be achieved by 2020 [11]. In 2010, black MSM had the “lowest level of linkage to care (71.6%)” and the “lowest level of retention in care (46.3%)” [11, p831]. Both these levels were lower than African Americans in all other transmission categories and significantly lower than the NHAS goal of retaining 80% of at risk African American populations in care [11].

Black MSM occupy an intersection of two vulnerable populations. While they experience the risks associated with being both black and gay, they have a unique group identity, which in turn exposes them to specific challenges that may not be experienced by African Americans who do not identify as gay or gay populations who do not identify as African American. In 2010, among persons newly infected with the HIV/AIDS virus, 10,600 were Black MSM. Among gay and bisexual people in the United States in 2012, African American men represented 39% of cases with a diagnoses with HIV infection, (whites accounted for 33% and Hispanics for 23% of cases) and 40 percent of cases categorized as stage 3 or AIDS (Whites accounted for 32% and Hispanics for 22%) [12]. Young BMSM are particularly high risk and account for a majority of new documented infections [13].

Although studies have consistently found higher HIV/AIDS prevalence among BMSM relative to MSM of other races/ethnicities, comparable or lower rates of sexual risk behavior (i.e., unprotected anal sex [UAS]) have been observed among BMSM compared to White and/or Latino MSM, suggesting that behavioral risk factors for HIV/AIDS infection alone do not sufficiently explain elevated rates of HIV/AIDS among BMSM (Millet *et al*., 2012). Some causes of the spread of the epidemic among BMSM include a lack of awareness of HIV status [5-7] rapid spread of infection in a close knit community, prevalence of deadly strains that are communicated quicker, lower levels of testing and lack of access to care that makes it less likely that BMSM get to hospitals when their disease is at an advanced stage, making it more likely that they will die [14].

Reasons cited for low levels of testing and treatment adherence are internalized homonegativity that accompanies low socioeconomic status, stigma that may accompany being a drug user or being incarcerated, community stigma towards BMSM, individual difficulties reconciling gay and black identities, and difficulties reconciling religious beliefs and BMSM identities [14]. Other causes include health insurance disparities [6, 14, 15] and mistrust of providers [6, 15].

BMSM are diverse. The phrase “Black men who have sex with men” has often been used in the literature to categorize sexual behavior and not include individuals’ sexual orientation or their personal definition of sexuality. An example of this diversity is the use of the term men on the *down low* which refers to men who are in heterosexual relationships but have a diverse range of sexual experiences and partnerships with other men. These men are primarily in heterosexual relationships, also have sex with men and are presumed to transmit infections across both groups [16].

Research on the challenges faced by BMSM at risk of HIV/AIDS and barriers to their access to care has been extensive. Yet this group continues to remain at high risk. Rates of infections continue to grow and BMSM continue to be stigmatized and marginalized. The range of sexual behaviors, sexual orientations, and community identities espoused by BMSM make them a challenging population to address in practice and policy implementation. Service providers need to take these realities into account as they design prevention and care interventions and services.

Social work literature has addressed general interventions by service providers who work with MSM [17, 18] explored sociocultural, interpersonal, and structural issues that affect MSM, including BMSM (Natale & Moxley, 2009), and made recommendations for interventions with Latino MSM [8] and Asian/Pacific Islander MSM [19]. There is little research on the impact that the NHAS has for the lives of BMSM. This paper will add to existing knowledge base in the field by presenting a discussion on strengths based policy analysis of the National HIV/AIDS Strategy.

THE STRENGTHS APPROACH TO SOCIAL POLICY DEVELOPMENT

Strengths based social work requires a paradigm shift [4] that moves the focus from “problems and deficits to strengths identified in egalitarian, collaborative relationships” [4, p38]. Key tenets of the strengths perspective include placing the client in the center of the decision making process, utilizing individual and community strengths to increase access to resources, recognizing the role that culture may play in decision making, and empowering individual clients, groups and organizations to take charge of their own destinies. A focus on strengths “drives growth” while a focus on deficits can stop progress [21 p107].

According to Chapin [2] the strengths approach to policy analysis provides a roadmap for an analyst to examine existing policy with a focus on client strengths and rights. Using this framework, the social work practitioner/policy analyst is able to assess if the policy effectively identifies barriers to client needs and goals. Recommendations for improvement in implementation are based on an in-depth exploration of various alternatives and best practices in the field.

The social work analyst must explore whether policy planning and implementation goals include spaces for clients to engage in collaborative decision making processes, claims making endeavors based on principles of self determination and social justice, and negotiated consensus building activities [2]. Finally, the social work policy analyst examines if plans for policy evaluation go beyond examining overall policy and program successes and incorporate measures that include client outcomes and feedback from many different individuals, groups, organizations, and communities.

Hill [20] synthesized key work by Chapin (1995) Rapp *et al*. (2006), and Saleebey (2006) - among other authors [1-4] - who inform work on strengths based policy analysis and presented several key points that she suggests be applied to all strengths based policy analysis. She utilized strengths criteria in her analysis of the John H. Chafee Foster Care Independence Act [20]. Hill [20] also collated key criteria identified by different analysts as being key to any strength based policy. These include the use of strengths based language; involvement of target populations in policy planning and implementation process; positive use of community environments and resources and evidence of collaborative endeavors; recognition of unique barriers and challenges for target populations; use of non coercive implementation strategies; and recognizing the need for a diversity of responses to social issues rather than a one stop approach to addressing a social concern.

These core ideas presented by social work theorists and researchers represent a commitment to the most important values of the social work profession, namely client empowerment and belief in the worth and dignity of all human beings regardless of their race, gender, income, sexual orientation, or behaviors/decisions. It is imperative that social workers influence every system that impacts clients including the political and structural systems that impact the lives of vulnerable and hard to reach populations. With this in mind, this paper applies the strengths-based policy analysis approach to the NHAS with an emphasis on the policy’s impact on BMSM.

STRENGTHS ANALYSIS OF THE NHAS AND ITS IMPACT ON BMSM

The NHAS meets some of the criteria identified by social policy analysts as hallmarks for strengths based policy. The policy was inclusive of target populations in the planning process, and makes provisions for the positive perception and utilization of community resources. Program implementation measures address some of the unique challenges of BMSM and encourage non-coercive action strategies. We

recognize areas of strength and suggest areas for further reflection and growth.

Inclusion of Target Populations in Policy Planning

During the policy-planning phase the White Office of National AIDS Policy (ONAP) conducted over 14 community discussions in which over 4200 people voiced their solidarity and concerns about at risk populations. These included those who had the interests of BMSM in mind. Specifically, community discussions focused on:

- acknowledging that some MSM may identify as bisexual or heterosexual and would not respond to social messages targeting gay populations;
- targeting venues that were used by BMSM, addressing the needs of BMSM ages 13-29 who had higher rates of infection than white BMSM;
- recognizing the diversity in injection drug use among MSM (based on geography, social class and race); and
- utilizing online forums and other media for social messaging and campaigns among BMSM [21]

ONAP then convened a panel of federal officials who reviewed community recommendations and chose those which appeared commensurate with the evidence available in the scientific evidence based literature on HIV/AIDS prevention. Strengths based policy requires that key stakeholders and clients be involved in collaborative decision making processes where client voice is recognized and valued in the policy formulation and goal setting process [2, 20]. ONAP integrated both community feedback and evidence based science in its policy planning and goal setting stage. The policy document would be enhanced if it included provisions for periodic community forums that reflect on successes and failures. The inclusion of BMSM and their advocates in such forums would allow for further discussion on the efficacy of evidence based interventions and areas where fresh ideas may be incorporated.

Positive Use of Community Resources and Environments

Scholars who provide guidelines for strengths based policy analysis emphasize a positive perception of the environment of clients as well as recognition of long-term responses developed by local communities [2-4, 20]. The NHAS guides program efforts that encourage collaboration among a wide variety of stakeholders, an important component of a strengths based policy [2-3]. In 2011, the CDC granted $55 million that would be disbursed over 5 years to 34 community-based organizations (CBOs) to develop HIV prevention services for young gay and bisexual men of color, transgender youth of color, and their partners. The award added an additional ten million dollars to a previous program that supported CBO's working with BMSM [22].

The CDC, a key figure in the planning and implementation of the NHAS goals and strategies also supports efforts such as the Act Against AIDS Leadership Initiative (AAALI), which was launched by the CDC in 2009 in collaboration with many African American leadership organizations across the country. In 2010, CDC expanded AAALI to include organizations that focus specifically on men who have sex with men (MSM). Funding empowers these organizations to hire an HIV coordinator who then can integrate materials and information for BMSM into already existing programing efforts. Organizations such as Black Men's Xchange National and the Center for Black Equity have a significant focus on the needs of BMSM in their planning of outreach, testing and prevention programs [22].

The CDC has also invested in the evaluation of local homegrown programs such as Many Men Many Voices, a group intervention that acknowledges the role of religious, social and cultural systems in the lives of BMSM. Research indicates that program participants were less likely to engage in risk behaviors such as unprotected anal intercourse with casual partners [23]. Other programs supported by the CDC include the Critical Thinking and Cultural Affirmation intervention, developed by Black Men's Exchange Program in New York City, which focuses on positive and negative impacts of black culture, community, education and the impact of societal stigma on risk behaviors [24] and My Life. My Style, a program that supports healthy lifestyles for young BMSM developed by In the Meantime Men's Group, Inc., in Los Angeles (my life my style, n.d.)

NHAS supports allies of the BMSM community; it promotes funding programs that protect confidentiality while providing for opportunities for BMSM to safely access testing, information and treatment. The policy encourages the efforts of local communities and recognizes the role of unique cultural and organizational contexts in which BMSM can access services.

Addressing Unique Barriers and Use of Non-Coercive Strategies

The NHAS recognizes the need to implement systems that help identify unique challenges faced by BMSM and funds research projects that identify specific challenges of BMSM. The National HIV/AIDS behavioral surveillance system, using recurring interviews, has been used in 21 cities with BMSM populations who are at particularly high risk, with identified lower levels of partners status, and lower antiretroviral use among BMSM that may affect their risk behavior and vulnerability [22].

The NHAS also supports programs that build on existing research in the field. *The Know Where You Stand* campaign a sub campaign of the larger *Act Against AIDS* campaign builds on research that cites low testing rates for BMSM. This programming effort seeks to increase testing for BMSM. The campaign recognizes barriers that BMSM face in accessing testing sites and resources. The banner campaign allows BMSM to enter their zip codes and find testing locations nearest them that are safe, private and free. The MSM Testing Initiative, another program supported by the CDC, uses non-coercive measures such as at home based internet testing and voluntary couples testing and episodic testing in cities with high prevalence of HIV/AIDS in order to increase testing and detection of the virus [22].

The policy recognizes that populations at risk of HIV/AIDS have “co-occurring” medical and social barriers that further burden vulnerable communities [22, p21]. In the particular case of BMSM, the policy highlights disparities affecting African Americans, gay and bisexual men, and even black gay and bisexual men. Analysts should focus in greater depth on intersections between these subpopulations and the need to design prevention and interventions based on evidence on what works with, for instance, BMSM who are also IVDUs and living in poverty. Or perhaps consider where mixed race men who have sex with men fit into overall policy implementation goals. While these intersections are implicitly acknowledged, a revision of the policy could make those clearer.

Incorporating Strengths Based Language

The NHAS policy document acknowledges the importance of individual and community strengths of people living with HIV/AIDS. However certain areas of the policy document still utilize terms such as “high-risk communities” [22, p18, p34], and “high-risk populations” (p.15). This language has potential to blame the people who have the infection or people who don’t have the infection and may put others at risk through their behavior. It is best to continue with the language that focuses on behaviors and on structural issues of stigma and discrimination, so readers are not led to believe it is something inherent in the BMSM population that puts them at risk.

The policy also calls for the enhancement of client assessment tools and measurement of health outcomes. It must be noted that the primary policy documents of the NHAS do not overtly emphasize strengths based language in their assessment of the needs and challenges of BMSM. However, the policy provides support for funding of programs that have utilized strengths based language in their mission statements and strategic plans. An example of such a campaign is “Testing Makes Us Stronger” which focuses on increasing testing for BMSM ages 18-44. The campaign stresses that getting tested for HIV is an act of strength and not a weakness [25].

BMSM continue to experience a severe burden of the HIV/AIDS epidemic compared to individuals of other races and sexual orientations. Effective policy planning and implementation must take into consideration the unique structural, socio-economic, religious and cultural challenges that increase the vulnerability of BMSM. A continued emphasis on community and individual strengths as well as a broader focus on societal issues of stigma and prejudice is required to meet the needs of vulnerable BMSM.

DISCUSSION

In our analysis of the policy implementation efforts this far, we see several places where social workers can focus strengths-based efforts in work with BMSM. To truly address the strengths and challenges of BMSM, social workers need to be involved in practice and advocacy at all levels of the HIV care continuum from the time that BMSM individuals know that they are HIV positive, engage in HIV care, and receive and adhere to antiretroviral treatment. The first step is to address biases and stigma toward this population, with deep awareness of how homophobia, racism, fear of sexuality and sexual behaviors, and ignorance about drug use can render workers ineffective with this population. The challenge of “starting where the client is”, when the client is part of a fairly hidden and deeply stigmatized population, is one social workers must address.

The NHAS focuses its efforts on reaching communities where the HIV/AIDS epidemic seems concentrated and growing. While social workers must value every client in every community, it is critical that we identify and advocate for communities that are particularly vulnerable and use our skills and resources to meet the needs of BMSM where they are located. Educators would benefit from increasing awareness about locations where services are most required and where graduating students with an interest in the field could be encouraged to engage with BMSM populations.

The NASW Code of Ethics sets out six values central to our work. Overlaid on the NHAS, we see that many social work values are evident. *Service* is implicit in the whole document. *Social justice*, while not mentioned overtly, underlies the concern about access to prevention and treatment and the barriers caused by poverty, stigma, and discrimination. The *dignity and worth* of BMSM is implied, and little judgmental language is applied to them in the policy. The policy emphasizes the *competence* and *integrity* of providers and stresses cultural appropriateness of interventions (15). In a particular strength of the policy, the *importance of human relationships* is stressed in the enormous effort put into collaborations with community-based organizations located in the black and gay communities. While social work is mentioned only briefly in the policy itself, many social workers practice in the HIV arena, and can be pleased that the NHAS fits well with our ethical code. If it is the case the NHAS fits with social work values, then we must encourage social worker to claim a more central role as important professionals in working with BMSM on HIV prevention, treatment, and care.

Social work researchers and practitioners must work within community based organizations to explore biopsychosocial factors that increase the vulnerability for BMSM and best practices that can mitigate risk at individual, familial and community levels of practice. Social workers need to learn more deeply about the relationship of BMSM to their communities, their spiritual resources, and local cultures in which they interact. Such awareness of these multiple, inter-related, unique strengths and challenges of BMSM can aid the work of social workers with this important population of focus. Social work can make valuable contributions to the implementation of NHAS with BMSM by collaborating with researchers from other disciplines, contributing to the social work literature, and completing evaluations of smaller community-based interventions.

CONCLUSION

Policy discourse on the concerns of BMSM at risk of HIV/AIDS must acknowledge the systemic barriers and concerns that make BMSM particularly vulnerable in the AIDS epidemic. A strengths based framework for policy analysis shifts the focus from perceiving BMSM and their needs as problems that should be addressed in policy planning and implementation processes to acknowledging the larger structural and systemic barriers of race, class, gender and sexual orientation that may prevent BMSM from accessing prevention programs. It also can move the focus toward the individual strengths of BMSM, the friend and peer networks that support them and the families and communities in which they are embedded. It provides a powerful tool for social workers that seek improvements in the larger policy and who work tirelessly to recognize the strengths of, and advocate for the needs of, marginalized at risk BMSM populations.

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