

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee

2:00 p.m., Thursday, July 13, 2017

Meeting Location: 2223 W. Loop South, Room 532
Houston, Texas 77027

AGENDA

*=handout provided at meeting

I. Call to Order

- A. Welcome and Introductions
- B. Moment of Reflection
- C. Adoption of the Agenda
- D. Approval of the Minutes (May 11, 2017)

Isis Torrente and
Steven Vargas, Co-Chairs

II. Public Comment and Announcements

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV/AIDS status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV/AIDS status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person with HIV/AIDS", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing yourself, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.)

III. Update on Speakers Bureau

Amber Harbolt, Health Planner
Office of Support

IV. Recommendation on FY18 EIIHA Plan Process

V. Update on Special Study:
Social Determinants of Health Supplement

VI. Key Findings from Aging and Youth Profile*

VII. Announcements

- A. Tentative EIIHA Workgroup Meetings 7/17 (2p) and 8/17 (1p)
- B. Speakers Bureau Workgroup Meeting 8/15 (10a)

Isis Torrente and
Steven Vargas, Co-Chairs

VIII. Adjourn

Houston Area HIV Services Ryan White Planning Council

Comprehensive HIV Planning Committee

2:00 p.m., Thursday, May 11, 2017

Meeting Location: 2223 West Loop South, Room 532; Houston, Texas 77027

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Steven Vargas, Co-Chair	Herman Finley	Yitang Dang, HHD
Ted Artiaga	Shital Patel, excused	Melanie McNeese, HHD
Evelio Salinas Escamilla	Isis Torrente, excused	Zaida Lopez, HHD
Tracy Gorden	Larry Woods, excused	Nadia Barahmani, HHD
Osaro Mgbere	Taneisha Broaddus, excused	Cathy Wiley, HHD
Allen Murray	Kris Sveska	Scott Brooks, Janssen
Esther Ogunjimi	Amana Turner, excused	Erin Bruce, Janssen
Oluseyi Orija	David Watson	Sha'Terra Johnson-Fairley
	Maggie White	Amber Harbolt, Office of Support
		Diane Beck, Office of Support

Call to Order: Isis Torrente, co-chair, called the meeting to order at 2:02 p.m. and asked for a moment of reflection. She then asked everyone to introduce themselves.

Adoption of Agenda: Motion #1: *it was moved and seconded (Artiaga, Mgbere) to adopt the agenda. Motion carried.*

Approval of the Minutes: Motion #2: *it was moved and seconded (Escamilla, Artiaga) to approve the March 9, 2017 minutes. Motion carried.* Abstention: Ogunjimi.

Public Comment: None.

Presentation: NHBS/HMMP Data: Melanie McNeese presented on National HIV Behavioral Surveillance, see attached. Mgbere presented data from the Houston Medical Monitoring Project, see attached.

Determine Focus Areas Special Study – Social Determinants of Health: See attached. Harbolt reviewed questions that were removed from the 2016 needs assessment consumer survey. The committee would like data on social determinants of health that are barriers to achieving viral suppression; first CD4/viral load and where diagnosed, when and why; if consumers received substance abuse treatment; homeless and transportation information; compare self report to medical chart regarding mental health diagnoses; education level; employment/income; health insurance status; disability; general prevention information. Mgbere will send the entire questionnaire so the committee can see exactly what data is available.

EIIHA Workgroup Recommendations/Data Requests: See attached EIIHA Workgroup Meeting Minutes from March 23, 2017.

Speaker's Bureau Evaluation, March 2017: Harbolt presented the attached report.

QI 2017 Comprehensive Plan Implementation Progress Report: Harbolt presented the attached report.

Speaker's Bureau Workgroup: Harbolt said that both of the workgroup co-chairs were unavailable so the meeting will be rescheduled.

Ageing and Youth Profile: Harbolt said that these will be combined into one profile and be distributed next month.

Texas Health Equity Summit: See attached.

Adjournment: ***Motion #3:** it was moved and seconded (Artiaga/Mgbere) to adjourn the meeting at 3:58 p.m..* **Motion Carried.**

Submitted by:

Approved by:

Amber Harbolt, Office of Support Date

Chair of Committee Date

JA = Just arrived at meeting
LR = Left room temporarily
LM = Left the meeting
C = Chaired the meeting

2017 Voting Record for Meeting Date May 11, 2017

MEMBERS	Motion #1: Agenda Carried				Motion #2: Minutes Carried				Motion #3: Adjournment Carried			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Isis Torrente, Co-Chair	X											
Steven Vargas, Co-Chair				C				C				C
Ted Artiaga		X				X				X		
Evelio Salinas Escamilla		X				X				X		
Tracy Gorden		X				X				X		
Herman Finley	X				X				X			
Osaro Mgbere		X				X				X		
Allen Murray		X				X				X		
Shital Patel	X				X				X			
Larry Woods	X				X				X			
Taneisha Broaddus	X				X				X			
Esther Ogunjimi		X						X		X		
Oluyesi Orija		X				X				X		
Kris Sveska	X				X				X			
Amana Turner	X				X				X			
David Watson	X				X				X			
Maggie White	X				X				X			

SPEAKERS BUREAU

PROCEDURE FOR SECURING A SPEAKING ENGAGEMENT

(Updated: 06-06-17)

Establishing Contact & Scheduling the Event

1. Contact the Chamber of Commerce representatives to see if they are interested in securing one of our speakers with mailing (Office of Support) and follow-up calls (Workgroup Contact Appointee). If yes:
2. A Workgroup Contact Appointee works with the Chamber representative and speakers to select at least two appropriate speakers (one alternate) and a date for the presentation. The Workgroup Contact Appointee then sends this information to the Office of Support via email.

Anyone who has a contact with a local Chamber of Commerce/Business Group should obtain contact information for the Chamber/Group member responsible for coordinating speaker, sends this information to the Office of Support via email, and the Office of Support will confirm that the Chamber is within the Houston HSDA, and share the contact information with a Workgroup Contact Appointee.

If a Chamber of Commerce contacts the Office of Support, staff will email an information packet (speakers, topics, etc.) to the contact for review prior to follow-up from a Workgroup Contact Appointee.

Before the Event

3. The Office of Support contacts all Workgroup members to see if 1 – 2 event volunteers can assist at the event.
4. Event volunteers will contact the Office of Support to arrange a date when they can come to pick up:
 - a. Evaluation forms
 - b. Case(s) of Blue Books (when available) and Blue Book Flyers
5. The Office of Support sends follow up reminders to the Chamber representative, speaker and event volunteers assigned to the event.

The Day of the Event

6. Event volunteers will meet up with the speaker and:
 - a. Offer to help the speaker hand out any materials
 - b. Manage distribution of Blue Books (when available)
 - c. Distribute and collect evaluation forms near the end of the presentation

After the Event

7. Event volunteers will return to the Office of Support to drop off completed evaluations and any remaining Blue Books.
8. The Office of Support will create and send thank you notes to the Chamber representative and speaker, which the Workgroup co-chairs and the Council chair will sign
9. Staff will compile the evaluations for review at the next Workgroup meeting. Attendees who indicated they would like to be contacted regarding Ryan White news and events will be added to the email distribution list.

FY 2018 EIIHA Plan

For the past few years, the Council approved the following motion regarding the EIIHA Strategy. Staff suggests that the Comprehensive HIV Planning Committee recommend an updated version of this same motion in 2017 for the FY 2018 EIIHA Plan.

Item: FY 2018 EIIHA* Plan

Recommended Action: Motion: In order to meet HRSA grant application deadlines, request the Planning Council to allow the Comprehensive HIV Planning Committee to have final approval of the FY 2018 EIIHA Plan, provided that:

- The FY 2018 EIIHA Plan is developed through a collaborative process that includes stakeholders from prevention and care, community members, and consumers; and
- The recommended FY 2018 EIIHA Plan is distributed to Planning Council members for input prior to final approval from the Comprehensive HIV Planning Committee.

**EIIHA = Early Identification of Individuals with HIV/AIDS*

UPDATED:
06/26/17

All meetings subject to
change. Please call in
advance to confirm:
713 572-3724.

*Unless otherwise noted,
meetings are held at:*

2223 W. Loop South,
Suite 240
Houston, TX 77027

July

2017

<i>Sun</i>	<i>Mon</i>	<i>Tue</i>	<i>Wed</i>	<i>Thu</i>	<i>Fri</i>	<i>Sat</i>
2	3	4 Independence Day OFFICE CLOSED	5	6 12 noon Steering Committee	7	1
						8
9	10 11:00 a.m. Project LEAP Advisory Committee	11	12	13 12 noon Planning Council Room 532 2:00 p.m. Comp HIV Planning Room 532	14	15
16	17 TENTATIVE 2:00 p.m. EIIHA Workgroup Room 416	18 2:00 p.m. Operations	19	20 CANCELLED Quality Improvement	21	22
23	24 12 noon Affected Community Room 532	25	26	27 11:00 a.m. Priority & Allocations Room 532	28	29
30	31					

<p>UPDATED: 07/03/17</p> <p>All meetings subject to change. Please call in advance to confirm: 713 572-3724.</p> <p><i>Unless otherwise noted, meetings are held at:</i></p> <p>2223 W. Loop South, Suite 240 Houston, TX 77027</p>	<i>Sun</i>	<i>Mon</i>	<i>Tue</i>	<i>Wed</i>	<i>Thu</i>	<i>Fri</i>	<i>Sat</i>
			1	2	3 10:00 a.m. Quality Improvement Room 416 12 noon Steering Committee Room 240	4	5
	6	7	8	9	10 12 noon Planning Council Room 532 2:00 p.m. Comp HIV Planning Room 532	11	12
	13	14	15 10:00 a.m. Speaker's Bureau Wg Room 240 2:00 p.m. Operations	16	17 CANCELLED Quality Improvement TENTATIVE 1:00 p.m. EIIHA Workgroup Room 532	18	19
	20	21 12 noon Affected Community Room 416	22	23 SIRR	24 11:00 a.m. Priority & Allocations Room 532	25	26
	27	28 6:00 p.m. Road 2 Success Leonel Castillo Community Center 2101 South St. 77009	29	30	31		

August
2017

Logic Model for CDC-RFA-PS17-1711
Use of molecular HIV surveillance to identify active HIV transmission networks and implement HIV interventions for Hispanic/Latino men who have sex with men (MSM)

Strategies and Activities	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
<ol style="list-style-type: none"> 1. Create new or expand existing partnerships within the health department and between health departments and local (e.g., community-based) organizations to support project activities 2. Use molecular HIV surveillance data and CDC tools to identify molecular clusters that include Hispanic/Latino MSM; use partner services and other data to assess underlying transmission clusters and HIV risk networks 3. Deliver high impact prevention services to identified Hispanic/Latino MSM and other persons in their networks, including <ul style="list-style-type: none"> • <u>HIV testing</u> • <u>Linkage to or re-engagement in care</u> • <u>Pre-exposure prophylaxis (PrEP)</u> 4. Identify and prioritize social-structural factors that negatively affect participation by Hispanic/Latino MSM in HIV prevention and care services and implement activities to mitigate the effects of identified factors 5. Develop and implement performance measurement and evaluation strategies 6. Identify and disseminate promising practices relative to strategies and activities 	<ul style="list-style-type: none"> • Increased internal and external partnerships to support HIV prevention activities • Increased ability to identify and respond to ongoing molecular clusters and underlying transmission clusters and HIV risk networks that include Hispanic/Latino MSM • Increased knowledge of HIV status among Hispanic/Latino MSM • Increased linkage to and re-engagement in HIV care among HIV-positive Hispanic/Latino MSM • Increased linkage to PrEP-related services by high risk HIV-negative Hispanic/Latino MSM • Increased knowledge and clinical management skills by providers about PrEP for HIV prevention with Hispanic/Latino MSM • Increased knowledge about PrEP for HIV prevention among HIV-negative Hispanic/Latino MSM at high risk for HIV infection 	<ul style="list-style-type: none"> • Decreased time between HIV diagnosis among Hispanic/Latino MSM and engagement in HIV care • Increased retention of HIV-positive Hispanic/Latino MSM in HIV care • Increased prescription of PrEP by providers to HIV-negative Hispanic/Latino MSM • Increased PrEP uptake among high risk HIV-negative Hispanic/Latino MSM • Increased uptake by Hispanic/Latino MSM of HIV prevention services in addition to PrEP (e.g., HIV testing, condom use) and in HIV care 	<ul style="list-style-type: none"> • Increased adherence to antiretroviral therapy among HIV-positive Hispanic/Latino MSM in HIV care • Increased viral suppression among Hispanic/Latino MSM living with HIV • Reduced new HIV infections among high risk HIV-negative Hispanic/Latino MSM

CDC Call to Action

Let's Work Together to Stem the Tide of Rising Syphilis in the United States



April 2017

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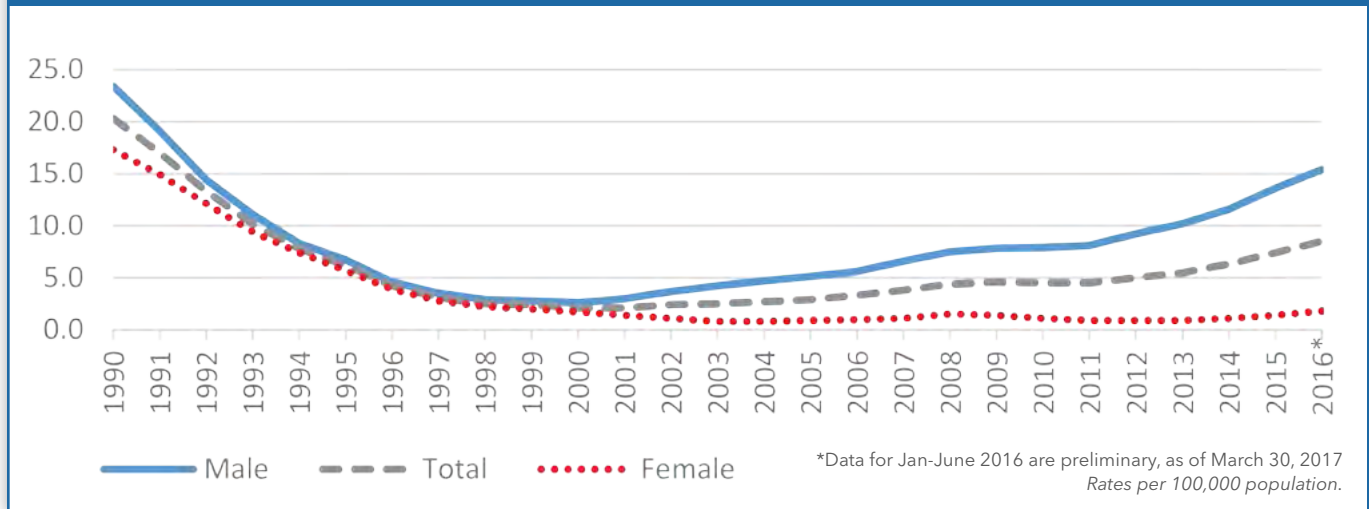
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CALL TO ACTION: Syphilis rates are increasing among women and their babies, and men throughout the United States. Untreated syphilis can cause severe medical issues. Efforts are needed to create new tools to detect and treat syphilis, increase testing, control the further spread of syphilis, and improve electronic medical records in order to improve patient outcomes.

The U.S. Centers for Disease Control and Prevention's Division of STD Prevention provides national leadership; funds and works with state, territorial and local STD programs; conducts program research and evaluation; and disseminates scientific information to prevent STDs and their complications.

OVERVIEW

Primary and Secondary Syphilis—Rate of Reported Cases by Sex, United States, 1990–June 2016*



Syphilis Is Preventable and Treatable

Syphilis is a sexually transmitted disease that can have very serious complications when left untreated, but it is simple to prevent and can be cured with the right treatment. Penicillin has been used to treat syphilis since 1943 and remains the best drug for treating the infection. When not adequately treated, syphilis can lead to visual impairment, hearing loss, stroke, and other neurological problems. Syphilis infection can also increase a person's risk for getting HIV or giving it to others. All 50 states require that syphilis cases be reported to the state or local public health agency so that it can take action to find and treat exposed persons. This prevents others from becoming infected and also prevents the adverse health outcomes of untreated syphilis.

Syphilis Rates Are Increasing in Men, Women, and some Newborns

Recent data show that syphilis rates are on the rise. Rates of primary and secondary (P&S) syphilis—the most infectious stages of the disease—increased a troubling 19% between 2014 and 2015. Preliminary data show a similar rate of increase in the first 6 months of 2016.

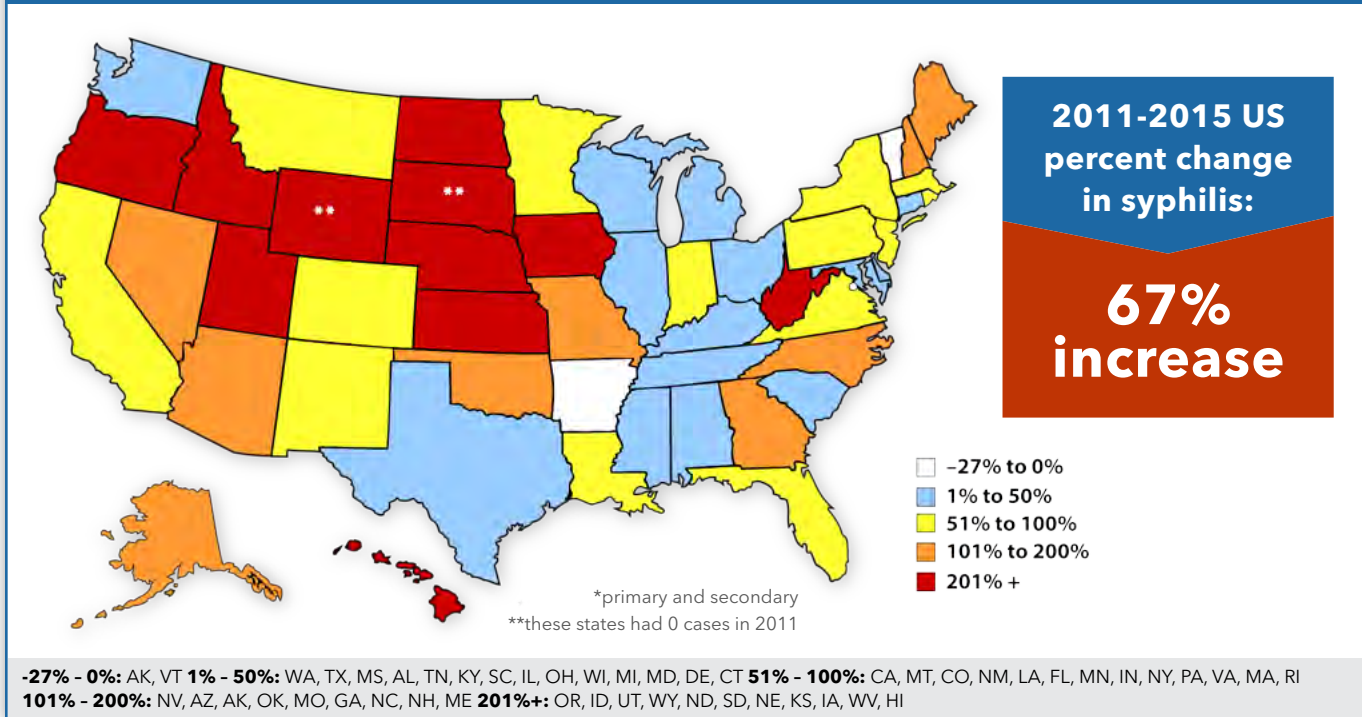
While rates have increased among both men and women, men account for more than 90% of all P&S cases. Gay, bisexual, and other men who have sex with men (MSM) account for 82% of male cases where the sex or gender of the partner is known.

Likewise, increases in congenital syphilis (CS) have paralleled the national increase in P&S syphilis among women of reproductive age. CS, which can cause miscarriage, stillbirth, early infant death, or severe illness in those infants who survive, increased each year from 2012 through 2015. Preliminary data show further increases in 2016. A pregnant woman with untreated syphilis can infect her fetus through the bloodstream during any stage of syphilis.

CDC is working with other federal agencies and national partners to reverse increasing trends of both congenital syphilis and syphilis among MSM. To achieve these goals, CDC needs the support of various sectors of society, including health care providers, public health departments, decision-makers, academic institutions, researchers, industry, and, most importantly, those members of society who are at higher risk.



Percent change in syphilis* rate from 2011 to 2015



The United States Needs New Tools for Syphilis Prevention and Control to Supplement Those in Use Since the 1940s

Fortunately, penicillin still works to treat syphilis. However, it is the only known antibiotic to treat syphilis during pregnancy. So for pregnant women with a severe allergy to penicillin, or when there is a drug shortage, there are no alternative treatment regimens to turn to. The rest of our treatment and prevention tools are outdated.

The most commonly used tests require at least two sequential antibody tests in blood and do not confirm active syphilis infection. These blood tests are cumbersome, hard to interpret, unable to diagnose early infections and may lead to treatment delays. Tests to directly detect the presence of syphilis-causing bacteria in lesions by complex microscopy or nucleic acid amplification tests (NAATs) are not widely available. There is a critical need for commercially available direct detection tests and modernized blood test development looking at specific proteins or genetics-based technologies to detect active infection.

Treatment options need to be expanded, especially for pregnant women, CS, ocular syphilis, and neurosyphilis. Research is also needed to better identify the stage of disease and determine appropriate management of syphilis, factors associated with the development of neurosyphilis and ocular syphilis, and treatment for syphilis disease in individuals living with HIV.

There is no syphilis vaccine, despite early work demonstrating that vaccination could potentially protect from syphilis disease. Additionally, very few biomedical scientists have entered the field, and in the 21st century many clinicians are not familiar with the appropriate diagnosis and management of syphilis.

Screening and Treating Women with Syphilis Can Prevent Congenital Syphilis

There has been a sharp increase in the number of babies born with CS in the U.S., despite CDC recommendations that all pregnant women get tested for syphilis at their first prenatal visit. After a steady decline from 2008 to 2012, cases of CS increased by 46% between 2012 and 2015, and preliminary data suggest that CS increased again in 2016. This increase parallels a national increase in P&S syphilis among women of reproductive age during the same time period.



Congenital Syphilis (CS) Rate and Rate of Primary and Secondary (P&S) Syphilis Among Females Age 15-44 Years, 2008 - June 2016*



*Data for Jan-June 2016 are preliminary, as of March 30, 2017
CS rate per 100,000 live births; female P&S rate per 100,000 women

A pregnant woman with untreated syphilis can infect her fetus through the bloodstream at any stage of syphilis. Up to 40% of babies born to women with untreated syphilis may be stillborn or die from the infection as a newborn. Infants born with CS might have health problems, including skin rashes, yellowing of the skin or whites of the eyes (jaundice), enlarged liver and spleen, or severe anemia. Untreated babies that survive the newborn period can develop problems later on, such as developmental delays and bone and joint abnormalities.

The resurgence of CS points to missed opportunities for prevention. One quarter of CS cases are due to a lack of prenatal care. But even among those receiving some prenatal care, the detection and treatment of maternal syphilis often occur too late to prevent CS. Of women who gave birth to an infant with CS, 42% were not tested in time to be treated to prevent CS.

Syphilis Screening Needs to Increase among Men Who Have Sex with Men

MSM account for only 4% of the U.S. male population, but they account for about two thirds of reported P&S syphilis cases. Although CDC recommends that sexually active MSM be tested at least yearly for syphilis, many MSM are not screened annually. The current situation is stark—reported syphilis among MSM increased 56% from 2011 to 2015. In 2015, the rate of syphilis in MSM was 106 times higher than the syphilis rate among men who have sex with only women, and half of MSM diagnosed with syphilis also have HIV.

Addressing syphilis among men is challenging. Syphilis epidemics vary by geography, race/ethnicity, age, and HIV serostatus. Syphilis prevention has historically relied on partner notification to interrupt disease transmission, which has been difficult to scale up to levels that would reduce new infections at an MSM population level. Dramatic improvements in access to and effectiveness of HIV treatment have resulted in changes in sexual behavior and social norms that may reduce the risk of HIV but have little impact on syphilis risk reduction, such as treatment as prevention, pre-exposure prophylaxis (PrEP), seroadaptive behaviors, and reduced reliance on condoms.



ACTIONS FOR SPECIFIC POPULATIONS



Pregnant Women

Increases in CS have paralleled the national increase in P&S syphilis. After a steady decline from 2008 to 2012, cases of CS increased by 46% between 2012 and 2015.

What Pregnant Women Can Do

- **Go to Your Doctor.** If you think you may be pregnant, see a health care provider as soon as possible to be sure that you and your baby are healthy during your pregnancy. Prenatal care is important for every pregnancy. Even if you've been pregnant before, it's important to ensure that THIS pregnancy is healthy. All pregnant women should be tested for syphilis, ideally at their first doctor visit. Make sure to ask your doctor about getting tested at your first visit.
- **Ask for the Results of Your Syphilis Test.** If you test positive for syphilis during pregnancy, be sure to get treatment right away. Doctors can treat pregnant women who have syphilis with an injectable form of penicillin G.
- **Complete Follow-Up Visits with Your Doctor.** Continue to visit your doctor regularly during your pregnancy to be sure that you and your baby stay healthy. If you learn that one of your sexual partners has or may have syphilis, tell your doctor right away so you and your partner can be treated, and your baby can be protected. If you live in an area where syphilis cases are occurring among women of reproductive age, retesting at the beginning of the third trimester and at delivery are recommended. Ask your doctor if you should be retested during your pregnancy and at delivery.



To learn more about CS, visit [CDC's Fact Sheet on Congenital Syphilis](#)



Gay, Bisexual, and Other Men Who Have Sex with Men

Syphilis rates are increasing among gay, bisexual, and other MSM. They comprise 82% of all syphilis cases among men (who comprise 90% of all cases of P&S syphilis).

What Gay, Bisexual, and Other Men Who Have Sex with Men Can Do

- **Talk to Your Doctor.** Have an honest and open talk with your health care provider about your sexual history and ask to be tested for syphilis and other STDs at anatomic sites for exposure. Testing is the only way to be sure that you do not have syphilis, because many men do not have symptoms. If you are HIV negative and have syphilis, ask your health care provider about PrEP.
- **Protect Yourself and Your Partner.** If you are sexually active, doing the following can lower your chances of getting syphilis: (1) being in a long-term, mutually monogamous relationship with a partner who has been tested and has negative STD test results and (2) using latex condoms the right way every time you have sex. If you have sex with more than one partner, don't use condoms, or engage in risky sex behaviors, then you should get tested more frequently (e.g. every 3 to 6 months).



To learn more about syphilis among gay, bisexual, and other MSM, visit [CDC's Fact Sheet on Syphilis & MSM](#)





Health Care Providers

Health care providers can play important roles in reducing CS and in reducing syphilis in MSM.

Health Care Providers: Take Action to Reduce Congenital Syphilis

- › **Complete a Sexual History for Your Patients.** Have an honest and open talk with your patients about their sexual history. STD counseling should be provided to those at risk for STDs, and contraceptive counseling should be provided to those at risk of unintended pregnancy.
- › **Test All Pregnant Women for Syphilis.** This should occur at the first prenatal visit or at the time pregnancy is confirmed. Repeat screening for pregnant women at high risk and in areas of high prevalence at the beginning of the third trimester and at delivery.
- › **Treat Women Infected with Syphilis Immediately.** If a woman has syphilis or suspected syphilis, treat her immediately with long-acting penicillin G, especially if she is pregnant, according to CDC's STD Treatment Guidelines. Test and treat the infected woman's sex partner(s) to avoid reinfection. If you have challenges obtaining penicillin G, contact your state or local health department.
- › **Confirm Syphilis Testing at Delivery.** Before discharging the mother or infant from the hospital, make sure the mother has been tested for syphilis at least once during pregnancy or at delivery. If she tests positive, manage the infant appropriately. All women who deliver a stillborn infant should be tested for syphilis.
- › **Quickly Report All Cases of Syphilis and CS.** Report cases of syphilis by stage to the local or state health department right away; CS cases should be reported within 24 hours.

Health Care Providers: Take Action to Reduce Syphilis in Men Who Have Sex with Men

- › **Complete a Sexual History for Your Patients.** Have an honest and open talk with your patients about their sexual history. Order CDC-recommended tests based on age, gender, sex or gender of sex partners, anatomic sites of exposure, and risk.
- › **Test.** Perform a syphilis test for sexually active MSM, including those with HIV infection, at least annually, and as frequently as every 3 to 6 months if there are multiple sex partners or substance use.
- › **Immediately Treat and Report Syphilis Cases.** Stage and treat syphilis cases according to CDC's STD Treatment Guidelines. Presumptively treat all MSM with signs or symptoms suggestive of primary or secondary syphilis and all MSM who are sexual contacts to a case of syphilis at the initial visit. If you have challenges obtaining penicillin G, contact your state or local health department. Report all syphilis cases by stage to your state or local health department.



To find clinician resources related to syphilis, visit [CDC's Syphilis Treatment and Care Guidelines](#)



EXERCISE



STOP SMOKING



MEDICAL CENTER



MEDICATION PILLS



FIRST AID KIT



HEARTBEAT RATE



MEDICAL RECORD



MEDICAL CARE

TEST AND TREAT



Public Health Departments

Public health partners work across the spectrum of public health, from surveillance, to partner outreach, to working with health care providers in order to reduce CS and syphilis in MSM.

Public Health Departments: Take Action to Reduce Congenital Syphilis

- › **Partner with Health Care Providers.** Offer resources for providers on how to properly screen, interpret results, and diagnose and treat syphilis. Work with the National Network of STD Clinical Prevention Training Centers (NNPTC) to train and educate providers. Address policy and other barriers to obtaining early and adequate prenatal care for the most vulnerable pregnant women in the community. Work together to conduct targeted screening in various settings.
- › **Work Together with State and Local STD and Maternal and Child Health Programs.** CS should be addressed through collaboration between these two programs to make the most impact. Infant morbidity review boards could include CS cases to identify missed opportunities in the health care and public health systems.
- › **Conduct Partner Services and Increase Screening.** Prioritize partner services for syphilis cases among pregnant women and women of reproductive age, their sex partners, and men who have sex with women.
- › **Partner with Patient Advocacy Groups.** Work together to engage communities and develop and promote programs directed towards their residents.
- › **Improve CS Surveillance.** Work to eliminate data gaps. This could include working with providers and labs to obtain pregnancy status along with epidemiologic and clinical data on female syphilis cases.

Public Health Departments: Take Action to Reduce Syphilis in Men Who Have Sex with Men

- › **Improve Syphilis Surveillance.** Syphilis surveillance should capture HIV serostatus, gender of sex partners, use of HIV PrEP, ocular and neurological manifestations, and sexual and social network characteristics. Syphilis and HIV surveillance systems and registries should be aligned and coordinated. Barriers to data sharing between STD and HIV programs should be addressed.
- › **Implement Standing Orders in STD and other Clinics Serving MSM.** Implement standing orders for a sexual health panel of laboratory tests for all MSM seeking clinical services.
- › **Partner with Health Care Providers.** Offer resources for providers on how to properly screen, interpret results, and diagnose and treat syphilis among MSM, including those living with HIV. Work with the NNPTCs to train and educate providers. Address barriers to obtaining care and work together to conduct targeted screening in various settings.
- › **Work Together with State and Local STD and HIV Prevention Programs.** Syphilis among MSM should be addressed through collaboration between these two programs to make the most impact.
- › **Partner with Patient Advocacy Groups.** Work together to engage communities and develop and promote programs directed towards their residents.



Decision-makers and Community Leaders

Reducing CS and syphilis requires strong public health policy and leadership.

Decision-makers and Community Leaders: Take Action to Reduce Congenital Syphilis

- **Talk to the STD Program Professionals in Your Jurisdiction.** Find out what the local syphilis trends are and what public health programs are doing to address them.
- **Address Any Policy Barriers.** Support the availability of appropriate resources for CS prevention programs. Ensure that policies are supportive of pregnant women seeking or obtaining prenatal services and recommended screening and treatment for syphilis.

Decision-makers and Community Leaders: Take Action to Reduce Syphilis in Men Who Have Sex with Men

- **Talk to the STD Program Professionals in Your Jurisdiction.** Find out about local syphilis trends and what public health programs are doing to address them.
- **Address Any Policy Barriers.** Support the availability of appropriate resources for comprehensive screening and treatment services for MSM. Ensure that policies do not prevent MSM from seeking or obtaining recommended screening and treatment for syphilis.



Biomedical Scientists

Current tools have been used since the 1940s. We need new ones to prevent, detect, diagnose, and treat syphilis.

- Develop new tools for syphilis prevention, detection, diagnosis, and treatment.
- Generate interest in the field.



Universities and Industry

Research and support are needed to develop new tools and to improve existing biomedical tools to reduce all forms of syphilis.

- Develop and bring to market novel syphilis tests to rapidly diagnose active infection (i.e., CS in infants and all disease stages in adults).
- Conduct clinical research to improve clinical management of all disease stages, including research on complications from treatment non-response, repeat infection, ocular and neurosyphilis, and HIV co-infection.
- Research effective vaccine design, acceptability, cost, and potential impact.
- Stimulate training of biomedical and clinical researchers and address basic biological research questions (e.g., genetics, immune response, pathogenesis) in order to galvanize future technological advances in diagnostics, therapeutics, and vaccines.



Electronic Medical Record (EMR) Developers

Current EMRs may not support syphilis screening and treatment in patients.

- Ensure that EMRs support syphilis screening and treatment in patients.



EMR Vendors

Patient outcomes could be improved by enhancing EMRs.

- Support clinical data systems that capture a patient's sexual history, including sexual orientation, gender identity, gender of sex partners, and sites of exposure.
- Incorporate accurate, updated STD screening and treatment recommendations into EMRs and clinical decision support systems.
- Develop data systems that easily interface with STD program data and laboratory data to enhance surveillance and support a better understanding of syphilis transmission and adverse health outcomes.

New Tools Are Needed for Syphilis Prevention and Control

There is an urgent need for new tools to prevent, diagnose, treat, and manage syphilis. This will allow people to protect themselves from getting syphilis or learn quickly and easily if they have it; and help health care professionals monitor, and assure effective treatments for years to come.

0

NUMBER OF VACCINES AVAILABLE TO PREVENT SYPHILIS

0

NUMBER OF BLOOD TESTS TO DIAGNOSE ACTIVE SYPHILIS INFECTION

75

NUMBER OF YEARS CURRENT SYPHILIS TREATMENTS HAVE BEEN IN USE

74,702

NUMBER OF CASES OF SYPHILIS DIAGNOSED IN 2015

GOAL

Create New Tools to Detect and Treat Syphilis

Syphilis is treatable, but the medicine used to treat the disease has been in use for 75 years. Tools to directly detect active syphilis infection in lesions such as commercially available nucleic acid tests or complex microscopy are not available for most clinicians. The currently available syphilis blood tests cannot detect active infection. Clinicians must use the blood test results along with other clinical findings to diagnose syphilis.

WHAT CAN BE DONE?

CDC Will

- › Develop and disseminate laboratory guidelines.
- › Create and make the syphilis specimen repository available for technological developments in diagnostics, therapeutics and vaccines.
- › Evaluate existing and new technologies and incorporate findings into diagnostic guidelines.
- › Develop novel diagnostic tools and better molecular surveillance tools, including strain surveillance.



Biomedical Scientists Can

- › Develop new tools for syphilis prevention, detection, diagnosis, and treatment.
- › Generate interest in the field.



Universities and Industry Can

- › Develop and bring to market novel syphilis tests to rapidly diagnose active infection in all disease stages.
- › Conduct clinical research to improve clinical management of all disease stages, including complications from treatment non-response, repeat infection, neuro- and ocular syphilis, and HIV co-infection.
- › Research effective vaccine design, acceptability, cost, and potential impact.
- › Stimulate training of biomedical and clinical researchers and address basic biological research questions (e.g., genetics, immune response, pathogenesis) in order to galvanize future technological advances.

GOAL

Improve Electronic Medical Records (EMRs)

Syphilis is a reportable disease that is increasing across the country. Keeping records of screenings, diagnoses, and treatment are vital to managing it and to enhancing surveillance efforts. Current EMRs may not include syphilis screening and treatment or have treatment guidelines available for easy access.

WHAT CAN BE DONE?

CDC Will

- › Implement a cloud-based application to make STD Treatment Guidelines available to all EMR systems.



Electronic Medical Record (EMR) Developers Can

- › Ensure that EMRs support syphilis screening and treatment in patients.



EMR Vendors Can

- › Support clinical data systems that include a patient's sexual history, including sexual orientation, gender identity, and gender of sex partners.
- › Incorporate accurate, updated STD screening and treatment recommendations into EMRs and clinical decision support systems.
- › Develop data systems that easily interface with STD program and laboratory data to enhance surveillance and support a better understanding of syphilis transmission.

WHAT CDC WILL DO

To reduce the numbers of women and their babies who are infected with syphilis, CDC will

- › Work to improve CS data through an enhanced CS surveillance system to capture stillbirths, infant morbidity, and cases prevented.
- › Investigate all CS cases in states to identify missed opportunities and improve services.
- › Develop tools and evaluate high-impact prevention services, such as syphilis screening; timely treatment; partner services; and linkage to contraceptive counseling, behavioral health, and pregnancy case management programs.
- › Develop CS prevention guidelines for health care providers and health departments.
- › Identify and share best practices, such as infant morbidity review boards, assessment approaches to identify missed opportunities, and implementation of system level changes.
- › Support health care providers to implement recommended syphilis screening and treatment of pregnant women and women of reproductive age through training, guidelines, tools, and resources.

To reverse this increasing trend of syphilis among MSM, CDC will

- › Work to harmonize STD/HIV screening recommendations and prevention messages related to sexual health services for MSM.
- › Support health care providers to implement recommended STD screening, treatment, and vaccination services through training, guidelines, tools, and resources.
- › Improve syphilis surveillance among gay, bisexual, and other MSM.
- › Conduct epidemiologic studies to better understand factors associated with syphilis adverse outcomes, such as neurosyphilis and ocular syphilis, and transmission networks.
- › Identify and share best practices.

CDC encourages health care providers; public health departments; decision makers; community leaders; scientists; universities; EMR developers and vendors; pregnant women; and gay, bisexual, and other MSM to take action.

SOURCES

- › Centers for Disease Control and Prevention. [Sexually Transmitted Diseases Treatment Guidelines, 2015](#). MMWR Recomm Rep 2015; 64(No. RR-3): 1-137.
- › Centers for Disease Control and Prevention. [Sexually Transmitted Disease Surveillance 2015](#). Atlanta: U.S. Department of Health and Human Services; 2016.
- › [CDC Syphilis & MSM Fact Sheet](#)
- › [CDC Congenital Syphilis Fact Sheet](#)
- › [CDC November 12, 2015 Dear Colleague Letter from Gail Bolan, Director, Division of STD Prevention](#)
- › [National STD Curriculum](#)
- › [CDC AtlasPlus](#): Use this interactive, surveillance-based tool to view maps, charts, and tables of syphilis rates by age and sex.

America's Hidden H.I.V. Epidemic

Why do America's black gay and bisexual men have a higher H.I.V. rate than any country in the world?

By LINDA VILLAROSA JUNE 6, 2017

Early on a balmy morning last October, Cedric Sturdevant began his rounds along the bumpy streets and back roads of Jackson, Miss. Sturdevant, 52, has racked up nearly 300,000 miles driving in loops and widening circles around Jackson in his improvised role of visiting nurse, motivational coach and father figure to a growing number of young gay men and transgender women suffering from H.I.V. and AIDS. Sturdevant is a project coordinator at My Brother's Keeper, a local social-services nonprofit. If he doesn't make these rounds, he has learned, many of these patients will not get to the doctor's appointments, pharmacies, food banks and counseling sessions that can make the difference between life and death.

Negotiating a maze of unpaved roads in Jackson in the company car, a 13-year-old Ford Expedition with cracked seats and chipped paint, he stopped to drop off H.I.V. medication at a couple's home. One of the men was H.I.V.-positive, the other negative; they lived in the neighborhood locals call the Bottom, where every fifth or sixth home is abandoned, with broken windows, doors hanging off hinges, downed limbs and dry leaves blanketing front yards. Sturdevant banged on the door of a small house, its yard overgrown with weeds; he knew not to leave the package on the doorstep, where it could be stolen. After a while a young man emerged, shirtless, shrugging off sleep. He had just gotten out of jail. Sturdevant handed him the package, shook his hand and told him to "stay out of trouble."

Sturdevant drove on another 15 minutes to pick up Marq (a shortened version of his name to protect his privacy), a teenager who was still reeling from the H.I.V.

diagnosis he received the previous spring. As they headed to and from a doctor's appointment and a meeting with a counselor, Sturdevant, slow-talking and patient, with eyes that disappear into his cheekbones when he smiles and a snowy beard, gently grilled him, reminding him to stay on his meds. The teenager slumped in the back seat, half listening, half checking his texts. He looked up briefly when Sturdevant told him, "You've come a long way. I'm proud of you." But Marq barely said goodbye as he jumped out of the car in front of a convenience store on an avenue scattered with a pawnshop, a liquor store and several Baptist churches, and he all but admitted he was planning to spend the afternoon smoking weed and looking at Instagram. "Knucklehead," Sturdevant whispered, as the teenager slammed the door. Pulling off his favorite Dallas Cowboys baseball cap and running a hand over his bald head, Sturdevant added softly, "Breaks my heart."

These patients of Sturdevant's are the faces of one of America's most troubling public-health crises. Thanks to the success of lifesaving antiretroviral medication pioneered 20 years ago and years of research and education, most H.I.V.-positive people today can lead long, healthy lives. In cities like New York and San Francisco, once ground zero for the AIDS epidemic, the virus is no longer a death sentence, and rates of infection have plummeted. In fact, over the past several years, public-health officials have championed the idea that an AIDS-free generation could be within reach — even without a vaccine. But in certain pockets of the country, unknown to most Americans, H.I.V. is still ravaging communities at staggering rates.

Last year, the Centers for Disease Control and Prevention, using the first comprehensive national estimates of lifetime risk of H.I.V. for several key populations, predicted that if current rates continue, one in two African-American gay and bisexual men will be infected with the virus. That compares with a lifetime risk of one in 99 for all Americans and one in 11 for white gay and bisexual men. To offer more perspective: Swaziland, a tiny African nation, has the world's highest rate of H.I.V., at 28.8 percent of the population. If gay and bisexual African-American men made up a country, its rate would surpass that of this impoverished African nation — and all other nations.

The crisis is most acute in Southern states, which hold 37 percent of the country's population and as of 2014 accounted for 54 percent of all new H.I.V.

diagnoses. The South is also home to 21 of the 25 metropolitan areas with the highest H.I.V. prevalence among gay and bisexual men. Jackson, the capital of Mississippi, the country's poorest state, is best known for blues, barbecue and "The Help." It also has the nation's highest rate — 40 percent — of gay and bisexual men living with H.I.V., followed by Columbia, S.C.; El Paso; Augusta, Ga.; and Baton Rouge, La. In Jackson, a small city of just over 170,000, half a dozen black gay or bisexual men receive the shock of a diagnosis every month, and more than 3,600 people, the majority of them black men, live with the virus.

The South also has the highest numbers of people living with H.I.V. who don't know they have been infected, which means they are not engaged in lifesaving treatment and care — and are at risk of infecting others. An unconscionable number of them are dying: In 2014, according to a new analysis from Duke University, 2,952 people in the Deep South (Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Texas) died with H.I.V. as an underlying cause, with the highest death rates in Mississippi and Louisiana. Among black men in this region, the H.I.V.-related death rate was seven times as high as that of the United States population at large.

Sturdevant, born and raised in Metcalfe, a tiny Mississippi Delta town of about 1,000, understands all too well the fear, stigma and isolation that can come with being a black gay man in the South. "Growing up, I was taught that God was not fixing to forgive a person who was homosexual," Sturdevant said. "The Bible supposedly said you're going straight to hell, automatically, there's no forgiveness. There were several times I thought about suicide. There were several times I wanted to get sick and die. Finally, my thought was, I just want to get out of here." He moved to Dallas, and then to Memphis.

When he learned he had H.I.V. in 2005, Sturdevant knew little about the virus and was too depressed and ashamed to tell anyone at first. When his partner died the following year, he let the disease consume him. "I was weak, had a fever of 103, couldn't even keep down water," he recalled. Sturdevant has shared his story too many times to count, to let young men know that he has been there, too, and to help them understand that they can survive this plague. He also knows that many black gay and bisexual men have been rejected and discarded, and has wrapped his arms

around as many as he can grab hold of, treating them like family. Sturdevant has two daughters from an early marriage and three grandchildren, but he says he feels just as strongly about his 16 or so unrelated “children,” most of them living with H.I.V. He feeds them, sometimes houses them, but mostly listens to them. “Young black men feel abandoned and need someone they can believe in and who believes in them,” Sturdevant said as he drove past fields of fluffy cotton, his hands resting lightly on the steering wheel. “I told God I want to be able to help guys like me, that didn’t grow up with their father, and they started coming to me, wanting to talk. After a while, they would bring other people to me and say, ‘Dad, can you help him, too?’ ”

Sturdevant moved his seat back, preparing for a long drive, and adjusted the radio to 107.5, the local R.&B. oldies station. Toni Braxton’s wail — “I wish you’d hold me in your arms like that Spanish guitar” — filled the car. He was headed to a small town 90 miles east of the city to visit Jordon, an H.I.V.-positive 24-year-old. When Sturdevant himself was at his lowest point, he said, “I looked something like this boy we’re going to see.”

He took a call from De’Bronski, one of the “sons” he has cared for and bonded with. Sturdevant met the young man in 2009 and took him in; he later helped him deal with his H.I.V. diagnosis. “I love you, too,” Sturdevant told him. Then he turned down a dead-end street and pulled up in front of the one-story brick home where Jordon lived. “I’m real worried about him,” Sturdevant said, lowering his voice as he walked up the driveway’s cracked pavement toward the front door. Jordon had recently posted a photo of his skeletal frame on Facebook, asking friends to “pray for me.”

As he stepped into Jordon’s stuffy bedroom, Sturdevant’s eyes scanned from a wheelchair leaning against the wall to a can of Ensure on the bedside table before settling on the young man. He was rubbing his feet, wincing from H.I.V.-related neuropathy that caused what he described as “ungodly pain.” Jordon’s round, hooded eyes were sunk deep into his face. Gray sweatpants pooled around his stick-thin legs, so fragile they looked as if you could snap them in two. His arms were marked with scars from hospital visits and IVs. Over six feet tall, he weighed barely

100 pounds. He smiled slightly when he saw Sturdevant, dimples folding into his hollow cheeks. “Hey, Mr. Ced,” he said, his voice raspy.

In February 2016, Jordon suddenly found himself too weak and tired to attend the community-college classes he had enrolled in; he could hardly lift his head from his mother’s couch. He wasn’t accustomed to being sick and had tested negative for H.I.V. just five months before, so thinking he had a bad cold, he waited weeks before his family forced him to go to the emergency room at a hospital in his small town, where he was tested again. “The doctor said to me, ‘Your H.I.V. is so bad — how could you not know?’ ” Jordon recounted through tears. He ended up in intensive care for three weeks. “I honestly didn’t believe it.” He paused and then added quietly, “It was the worst day of my life.”

With effort, Jordon sat up slightly, untangling himself from a jumble of sheets. Sturdevant asked how he was doing, and he cataloged a laundry list of what he called his “old man” ailments. “I’ve had everything — diarrhea, hemorrhoids, now this neuropathy,” he said. “My body hates me.” Once a month, his mother or grandmother drove him to medical appointments in Jackson, to receive care from providers experienced in treating people living with H.I.V. and to avoid the small-town gaze at the local facilities; there is no Gay Men’s Health Crisis for him to visit in his small town, as there would be if he lived in New York. “Everybody knows everybody here,” Jordon said. “At the hospital, they know my mom and my brother and my grandmother. I would rather be around people who don’t know me.” Too ashamed to admit that he had the virus, Jordon had told few friends about his diagnosis.

“Are you taking your medicine?” Sturdevant asked. For many young men, the H.I.V. diagnosis and the illness are so overwhelming that maintaining a new and unfamiliar regimen of medication can be difficult. Jordon looked down. “Not as often as I should.” When he saw Sturdevant’s glare, he continued, sounding like a little boy. “I hate taking medicine; I hate it. I have to take six pills, now seven, eight, plus a shot —”

Sturdevant cut him off. “We all have to do this, Jordon. Don’t you want to get better?”

Jordon let his head fall back on the pillow. “I know I can get better, Mr. Ced,” he said, massaging his feet. “I just don’t know how everything got so bad.”

Given the advances in research, information and treatment, it seems inconceivable that someone living with the virus today, like Jordon, could look as if he had stepped out of the early years of the epidemic. And yet a series of fateful decisions and omissions, dating back to the discovery of the disease, have led to a present that looks like the past — but only for some.

History marks the beginning of the American AIDS epidemic as June 5, 1981, when an issue of the C.D.C.’s Morbidity and Mortality Weekly Report — the authoritative voice of the agency — highlighted five cases of pneumocystis pneumonia (PCP) in previously healthy men in Los Angeles. Healthy people do not contract a disease like PCP, which had been largely confined until then to patients on medication to suppress their immune systems for an organ transplant or cancer patients on chemotherapy. Though not stated explicitly, the language of the report, by omitting race, implied that its “five young men, all active homosexuals,” were white, which they were. But there were two more documented cases, not mentioned in the notice, and these sixth and seventh cases were black — one of them a gay African-American, the other a heterosexual Haitian.

Dr. Michael Gottlieb, the lead author of the report and a renowned physician specializing in H.I.V./AIDS, treated Rock Hudson before he died of AIDS complications in 1985 and still practices in Los Angeles. Gottlieb said he is often asked why he didn’t include in that first report the documented case of the gay African-American man, who had both PCP and cytomegalovirus, a virus that attacks the organs of patients with compromised immune systems. He explains that he discovered the case after the report was finalized. “Until recently, I wouldn’t have thought it mattered,” said Gottlieb, who said that he and others on the front line were grappling with an unprecedented and frightening medical mystery and largely working in the dark. “But in retrospect, I think it might’ve made a difference among gay black men.”

Including gay black men in the literature and understanding of the origins of the disease and its treatment could have meant earlier outreach, more of a voice and a

standing in H.I.V./AIDS advocacy organizations, and access to the cultural and financial power of the L.G.B.T. community that would rise up to demand government action. But 35 years of neglect, compounded by poverty and inadequate local health care infrastructure, have left too many black gay and bisexual men falling through a series of safety nets.

This has been true of even the most recent advances. In 2010, the Obama administration unveiled the first National H.I.V./AIDS Strategy, an ambitious plan that prioritized government research and resources to so-called key populations, including black men and women, gay and bisexual men, transgender women and people living in the South. With a mandate to “follow the epidemic,” several pharmaceutical companies and philanthropic organizations also started projects to help gay black men, particularly in the Southern states. That same year, the Affordable Care Act and later the expansion of Medicaid in more than half of the country’s states linked significantly more H.I.V.-positive Americans to lifesaving treatment and care.

In 2011, HPTN 052, a study of 1,763 couples in 13 cities on four continents funded by the National Institute of Allergy and Infectious Diseases, found that people infected with H.I.V. are far less likely to infect their sexual partners when put on treatment immediately instead of waiting until their immune systems begin to fall apart. This “test and treat” strategy also significantly reduces the risk of illness and death. The data was so persuasive that the federal government began pushing new H.I.V./AIDS treatment guidelines to health care providers the following year. And in 2012, the Food and Drug Administration approved the preventive use of Truvada, in the form of a daily pill to be taken as pre-exposure prophylaxis (commonly called PrEP). It has been found to be up to 99 percent effective in preventing people who have not been infected with H.I.V. from contracting the virus, based on the results of two large clinical trials; an estimated 80,000 patients have filled prescriptions over the past four years.

But these measures have not extended to most black gay and bisexual men. A C.D.C. report in February noted that only 48 percent of black gay and bisexual men effectively suppress the virus with consistent medication, and the numbers are even lower for these men in their late teens and 20s. In 2014, nearly one in five black gay

men who had received a diagnosis of H.I.V. had progressed to AIDS by the time they learned of their infection — which meant that they were generally very ill by the time they began treatment. Only a small percentage of black people use PrEP to prevent contracting the virus, accounting for only 10 percent of prescriptions; the vast majority of users are white. Many black gay and bisexual men either can't afford PrEP or don't know about it — they may not see a doctor regularly at all, and many medical providers haven't even heard of PrEP.

Turning things around would mean expanding testing and providing affordable treatment for those who are positive — to stop sickness and dying and also to block transmission of the virus. It would also require getting information and medication, including PrEP, to those most at risk. Even more challenging would be reducing the stigma, discrimination and shame that drive gay and bisexual men to hide their sexuality and avoid the health care system — and making sure providers have adequate resources and understand how to care for H.I.V. patients.

“It's deeply troubling when 50 percent of African-American gay men are expected to get H.I.V. during their lifetime, but it's also been a clarion call for all of us to improve on what we're doing,” said Dr. Jonathan Mermin, the director of the C.D.C.'s National Center for H.I.V./AIDS, Viral Hepatitis, S.T.D. and TB Prevention. “What we have been trying to do is ensure that we're having the greatest effect with the resources we're provided.”

Few believe there is the kind of energy, leadership, money and political will in the current political climate to fix the situation in the community that has fallen through the cracks for so long. And experts in the field have grown increasingly worried about the new administration's commitment to fighting the disease. Soon after President Trump's inauguration, the web page of the Office of National AIDS Policy, the architect of the National H.I.V./AIDS Strategy, was disabled on the White House website. The president's proposed budget includes a \$186 million cut in the C.D.C.'s funding for H.I.V./AIDS prevention, testing and support services. The congressional fight over the repeal of the Affordable Care Act, and the president's declarations that “Obamacare is dead,” have conjured a disastrous return to even more alarming conditions, like waiting lists for medication. As recently as 2011, the AIDS Drug Assistance Program state-by-state list of people waiting for H.I.V.

medication ballooned to over 9,000 people, mostly poor black and brown men in Southern states.

“The key to ending the AIDS epidemic requires people to have either therapeutic or preventive treatments, so repealing the A.C.A. means that any momentum we have is dead on arrival,” said Phill Wilson, chief executive and president of the **Black AIDS Institute**, a Los Angeles-based nonprofit. “For the most vulnerable, do we end up back in a time when people had only emergency care or no care and were literally dying on the streets? We don’t know yet, but we have to think about it.”

June Gipson, president and chief executive of My Brother’s Keeper, the Jackson nonprofit Cedric Sturdevant works for, believes that the repeal of the Affordable Care Act wouldn’t have an immediate catastrophic effect in her state — but only because things are already so dire. Like most of the South, Mississippi refused Medicaid expansion, and nearly half of its citizens who are living with H.I.V. rely on the Ryan White H.I.V./AIDS Program to stay alive. Named for an Indiana teenager who contracted H.I.V. through a blood transfusion in the ’80s, this federal program provides funding for H.I.V. treatment and care for those who have no other way to finance their medication. If the A.C.A. is repealed, Gipson said, “it just means that the entire country becomes Mississippi.”

For nearly two decades, the United States has focused money and attention on the H.I.V./AIDS epidemic elsewhere. Barbara Lee, the longtime United States representative from Northern California, has signed her name as a sponsor to every piece of major federal H.I.V./AIDS legislation since she was first elected in 1998. In 2003, she was a co-author of legislation that led to the President’s Emergency Plan for AIDS Relief (Pepfar). The five-year, \$15 billion global strategy provided prevention, treatment and care services to the countries most affected by the disease, almost exclusively in Africa. The largest international health initiative in history to fight a single disease, Pepfar is considered a success story by any measure and a crowning achievement of George W. Bush’s presidency.

Black America, however, never got a Pepfar. Though the raw numbers were much lower than in Africa, parts of our country looked like the continent the program was created to save. Yet while buckets of money went overseas, domestic

funding for H.I.V./AIDS remained flat, and efforts to fight the disease here were reduced to a poorly coordinated patchwork affair. “When we saw that the epidemic was out of proportion in the black community, we started calling for a domestic PEPFAR that would bring new resources to the effort, create clear and ambitious objectives and rebuild health care infrastructure around the country,” Lee said. “But we just couldn’t get the administration to focus on a domestic plan.”

Greg Millett, a senior scientist for the C.D.C. for 14 years and a senior policy adviser for the Obama administration’s White House Office of National AIDS Policy, put it more candidly. “During the Bush years, the administration dropped all pretense that they cared about AIDS in this country,” said Millett, who is now the vice president and director of public policy at amfAR, the Foundation for AIDS Research. “The White House said H.I.V. is only a problem in sub-Saharan Africa, and that message filtered down to the public. Though the Bush administration did wonderful work in combating H.I.V. globally, the havoc that it wreaked on the domestic epidemic has been long-lasting.”

Beginning in the late ’90s, the United States government funneled billions of federal dollars into abstinence-until-marriage programs here and abroad. In place of effective sex education, these programs often discouraged condom use while teaching abstinence as the only way to prevent the spread of AIDS — even as well-regarded research established that this kind of sex education does not lower the risk of contracting H.I.V. and other sexually transmitted diseases.

During this time, many scientists, researchers and government administrators were afraid to speak openly about condoms, needle exchange and L.G.B.T. issues for fear of reprisal and loss of funding. Community organizations became targets of anti-gay crusades, subjected to intense scrutiny, including exhaustive audits, by federal agencies. “It is no coincidence that new rates of H.I.V. infection among gay men, especially gay black men, began to spike sharply from 2000 on, because of an anti-science campaign that allowed for little or nothing to be done for a maligned community simply due to ideology and bigotry,” Millett said. “The hostile environment made funding effective H.I.V.-prevention programs, messages or research impossible for U.S. communities most impacted by H.I.V.”

The election of Barack Obama brought renewed attention to the domestic epidemic and loosened the conservative grip on the federal government's prevention and research agenda. At the first post-Bush national H.I.V.-prevention conference in 2009, Christopher Bates, then the director of H.I.V./AIDS policy for Health and Human Services and interim executive director of the Presidential Advisory Council on H.I.V./AIDS, kicked off the event in Atlanta by jumping onstage with duct tape on his mouth, ripping it off and shouting, "Finally, I can speak!" On World AIDS Day in 2011, Obama directly addressed the H.I.V. crisis among gay black men in a speech at George Washington University: "When new infections among young black gay men increase by nearly 50 percent in three years, we need to do more to show them that their lives matter."

But good intentions have not translated into enough funding and resources — from either the government or philanthropic organizations. Good intentions also have not counteracted the crippled medical infrastructure in states like Mississippi, which the Commonwealth Fund, an independent health-policy research foundation, ranks dead last in more than 40 measures of health-system performance. A 2014 study conducted by Dr. David Holtgrave of the Johns Hopkins Bloomberg School of Public Health found that to make any real progress in the H.I.V./AIDS crisis among black gay and bisexual men in the United States, the government would need to invest an additional \$2.5 billion to address unmet testing, care, treatment and prevention needs. Despite the higher H.I.V. diagnosis and death rates in the Deep South, the region received \$100 less in federal funding per person living with H.I.V. than the United States over all in 2015.

As the center of the epidemic has moved from New York and San Francisco to the smaller cities in the South, and from gay white men of means to poorer people of color, L.G.B.T. advocacy and fund-raising has shifted to marriage equality. In 2013, H.I.V. activists persuaded 35 L.G.B.T. leaders to sign a statement and create a video imploring the greater gay community to recommit to the AIDS struggle. The message: "We need you to come back." But of \$168 million in H.I.V./AIDS philanthropic dollars spent in the United States in 2015, \$31 million was disbursed to the South, just 19 percent of total H.I.V. philanthropy in the United States; only \$26 million directly targeted African-Americans, and just \$16 million went directly

to gay and bisexual men, according to the organization Funders Concerned About AIDS.

During Millett's decades in government and nonprofit organizations, he has combed through mounds of data about H.I.V./AIDS and black gay and bisexual men. Two years ago, he and his amfAR colleagues published a comprehensive report titled "H.I.V. and the Black Community: Do #Black(Gay)Lives Matter?" When the calm, usually sunny Millett, known for his bookish blue glasses and ready smile, talks about what he calls this "perfect storm," his voice takes on a harder edge. "We are going to eventually end AIDS in the United States, but I fear it's not going to happen for black M.S.M.," he said, referring to men who have sex with men. "We have waited too long. With so many black gay men already infected, the horse is already out of the barn."

On Saturday nights, men of color in and around Jackson make their way to the gay club Metro. The windowless building with royal blue paint peeling off aluminum siding stands on Highway 80 next to a run-down car shop and has no sign out front; you just have to know. One evening in October, Cedric Sturdevant walked through the dim front room with Regi Stevenson and James Watson, two 20-something colleagues at My Brother's Keeper. A handful of guys were J-Setting, dancing in the exuberant style that pays homage to the Prancing J-Settes — Jackson State University's famous all-female dance squad — combined with a splash of voguing straight out of Harlem's drag ballroom scene. The three men watched the dancers performing tightly choreographed moves using chairs as props, before greeting their friend Jermerious Buckley, 30, resplendent in green contacts and red four-inch heels, leaning against the bar.

In a too brightly lit wood-paneled back room, Sturdevant and the younger men set up a table, displaying brochures, condoms, lube and a few lollipops. Stevenson and Watson, both open, friendly and handsome, attracted a few guys to the table, but mainly ones who had already heard the protect-yourself-against-H.I.V. spiel. Stevenson pointed out that the crowd was sparse — maybe 50 men and a few transgender women — because so many Jackson residents were attending the annual state fair. "Anyway, it's always hard to make contact in the club," he said. "I

prefer one on one. That way it's not, 'I'm trying to educate you'; we're just talking and having fun. I tell them what I do, and they feel comfortable asking questions."

Stevenson took out his phone and opened Jack'd, a hookup app popular with men of color. He pulled up his "professional" profile — on which he's smiling, clean-cut and buttoned-up amid a sea of bare chests and crotch shots. At the bottom he had put a link to a website with information about PrEP; next to it he'd written: "Inbox me if you want to know more." "I've gotten a bunch of messages asking about side effects, how much it costs and does it work," Stevenson said. He and Watson said they take the medication "just in case."

After an hour they folded up the table and stuffed the condoms and brochures back into a gym bag, dropped it next to Sturdevant, who was sipping a syrupy cocktail from a can, and headed out to the dance floor. A remix of Rihanna's "Where Have You Been" came on, so loud the walls shook. Like everyone else, Stevenson and Watson, who are dance coaches and choreographers, had perfected their moves from watching YouTube videos of the Prancing J-Settes. Stevenson bent and thrust, at once explosive, angular and precise. Watson's face was still as a stone; as he snapped his neck to the side, his waist-length dreadlocks whipped around his head. After a few songs, the music ended as the club prepared for a 1 a.m. drag show. Stevenson, sweaty and breathless, melted into a conversation with other dancers.

Everybody knows everybody else in Jackson's small, tight-knit black gay community, and most men will find their sexual partners in this network. Most scientists now believe that risk of contracting H.I.V. boils down to a numbers game rather than a blame game: If the virus is not present in your sexual network, you can have unprotected sex and not get infected. But if you are in a community, like Jackson, where a high percentage of gay and bisexual men are infected with H.I.V. — and many don't know it and go untreated — any unprotected sexual encounter becomes a potential time bomb. This explanation of "viral load" helps dispel the stubbornly held notion that gay and bisexual black men have more sex than other men, a false perception embedded in the American sexual imagination and fueled by stereotypes of black men as hypersexual Mandingos dating back to slavery.

“Black men are not just out here having unprotected sex willy-nilly; the science disproves that,” said Terrance Moore, deputy executive director of the National Alliance of State and Territorial AIDS Directors in Washington. He pointed to stacks of studies over the years, including a groundbreaking, exhaustive 2006 data dive led by Greg Millett that was published in *The American Journal of Public Health*. In this and other studies, Millett and his colleagues found that gay black men engage in risky sexual practices no more frequently, are as consistent about condom use and have fewer sex partners than their nonblack peers. “It’s that the viral load in communities of black gay men is higher, which puts them at disproportionate risk,” Moore explained. “Plus, these are the same individuals that are dealing with structural barriers around lack of employment, lack of education and opportunities, transportation and, of course, very, very overt institutional racism.”

An elevated viral load in a smaller sexual network (because most people still tend to have sex with people of the same race), amplified by the structural issues that Moore pointed to, also explains why H.I.V. rates have always been disproportionately high in the black community over all. But in the first decades of the epidemic, these ideas and explanations had not been widely accepted to explain the growing body of data pointing to fast-rising numbers of H.I.V. cases among black heterosexuals — in rates unmatched by those of white Americans. In fact, the African-American community was largely in denial about the fact that H.I.V./AIDS was a black issue. Worse, most believed the disease was a conspiracy on the part of the federal government to kill off the race, God’s punishment for homosexuality or simply not a subject for polite conversation, because the disease was thought to be connected to promiscuity and crack and heroin use.

The community’s awakening came in 1991, when Magic Johnson tearfully announced, “Because of the H.I.V. virus I have obtained, I will have to retire from the Lakers today,” and warned, “It can happen to anyone.” By 1994, AIDS had become the No. 1 killer of all African-Americans ages 25 to 44. The virus was 16 times as common in black women as in their white counterparts — and the gap would widen over the next few years. I was an editor at *Essence* in 1994 when the magazine’s editor in chief, Susan L. Taylor, insisted that we shine a light on the disturbing increase of H.I.V. among African-American women by putting Rae Lewis

Thornton, a Chicago woman who described herself as “young, educated, drug-free and dying of AIDS,” on the cover.

I had been writing about AIDS in the black community since the mid-'80s but had never seen anything like the coordinated efforts that started in the late '90s, when civil rights groups, politicians, clergy, fraternities and sororities and celebrities stepped up to encourage testing and distribute prevention information. All the major black publications collaborated in a highly visible campaign to spotlight the disease as a major health crisis. Black churches created AIDS ministries and offered H.I.V. testing — and the number of congregations participating in the Black Church Week of Prayer for the Healing of AIDS ballooned to more than 10,000.

During the 2004 election, the PBS journalist Gwen Ifill brought the issue to the mainstream stage as the moderator for the vice-presidential debate. She asked the candidates Dick Cheney and John Edwards what they planned to do to end the spread of H.I.V./AIDS — “not about AIDS in China or Africa, but AIDS right here in this country” — among black women. Cheney replied that he was not aware of the numbers, while Edwards spent more than a minute discussing AIDS in Africa. In 2006, I attended the International AIDS Conference in Toronto with a delegation of black journalists, civil rights leaders, government officials, politicians and celebrities, including the singer Sheryl Lee Ralph, Representatives Maxine Waters and Barbara Lee, the Rev. Jesse Jackson and Julian Bond, chairman of the N.A.A.C.P., who famously announced, “Now is the time for us to face the fact that AIDS has become a black disease.”

Most of the lock-step mobilization efforts focused on preventing the disease in black women, who, for the most part, were contracting the virus through sex with male partners. Though the C.D.C. and other agencies offered plenty of alarming statistics confirming the high and growing numbers of H.I.V. cases and deaths among black women, there was a lack of empirical evidence to clearly explain why the rates were so high. Experts in academia and government researchers tried to unravel a knotted tangle of factors: Women were contracting the virus from bisexual men; higher rates of sexually transmitted infections among black women facilitated the spread of H.I.V.; socioeconomic issues drove up the rates of all disease. The lack of research to create a coherent explanation was further confounded by a reluctance

on the part of some scientists and activists to perpetuate the dangerous myth of black women as sexually promiscuous — another holdover from slavery.

Given the confusion, it was simplest to latch onto the most provocative idea: that black gay men, who we knew were also contracting H.I.V. in high numbers, provided a “bridge to infection” to black heterosexual women, a phrase I first heard from researchers at a medical conference. As the theory went, closeted black gay men were using women as unsuspecting “cover girls” to hide their sexuality and then infecting them with H.I.V. In my reporting for both *The Times* and *Essence*, I found no shortage of anecdotal accounts of H.I.V.-positive women who were infected by male partners who had been having sex with other men in secret. As a black lesbian myself, I understood the stigma, shame and fear that could drive black gay men to create seemingly straight lives while sleeping with men — and end up unwittingly infecting their female partners with H.I.V. This idea made a certain amount of sense in the frustrating absence of scientific data.

In retrospect, the high rate of H.I.V. infection among African-American women was a result of a complicated combination of all these factors, as well as the reality that after decades of denial and neglect, the viral load piled up in black communities, making any unprotected sexual encounter with anyone a potential “bridge to infection.” But two decades ago, in the midst of a very scary, fast-growing epidemic, the down-low brother became the AIDS boogeyman. I first heard about the “D.L.” from J.L. King, an author and self-proclaimed sex educator whom I interviewed in 2001. He had just warned a rapt audience of health care providers and H.I.V. educators at an AIDS conference in Washington: “I sleep with men, but I am not bisexual, and I am certainly not gay. I am not going to your clinics, I am not going to read your brochures, I am not going to get tested. I assure you that none of the brothers on the down low like me are paying the least bit of attention to anything you have to say.”

King’s subsequent 2004 book, “*On the Down Low: A Journey Into the Lives of Straight Black Men Who Sleep With Men*,” appeared on the *New York Times* best-seller list for a number of weeks and spawned two “Oprah” shows, an episode of “*Law & Order S.V.U.*,” a BET documentary, a sequel by King and another book by his ex-wife. Ta-Nehisi Coates jumped into the fray in a 2007 essay for *Slate* that

questioned why the myth of the “on-the-down-low brother” refused to die, referencing a controversial 2003 cover story in this magazine by a white writer who went into the scene to uncover closeted black men who lead double lives.

Keith Boykin, a former Clinton White House aide, became so incensed by the down-low hysteria that he wrote a 2005 best-selling book, “Beyond the Down Low: Sex, Lies and Denial in Black America.” “Because the whole down-low story was doing a disservice to the black gay community and creating a racially troubling narrative that black men who have sex with men were villains, I felt I had to step in and correct the record,” said Boykin, a CNN commentator who teaches at Columbia University’s Institute for Research in African-American Studies. “I think the near-decade-long obsession with the down low diverted our attention into what was really a side issue.”

In 2010, after Oprah Winfrey ran her second show about the down low, again featuring King, Dr. David J. Malebranche, a black physician and one of the country’s foremost experts on H.I.V. and black gay and bisexual men, wrote a heartfelt open letter to the talk-show host. “We are not all self-loathing, secretive, unprotected-sex-having, disease-ridden liars,” Malebranche wrote. He posted the letter on Oprah’s website, and after it was removed, posted it on his own Facebook page. People all over the world shared the post, and it received hundreds of comments.

In the end, the organized H.I.V. outreach and education that proved successful to black women never translated to black gay men — and the excessive focus on the down low sucked away critical time, energy and resources. Between 2005 and 2014, new H.I.V. diagnoses among African-American women plummeted 42 percent, though the number of new infections remains unconscionably high — 16 times as high as that of white women. During the same time period, the number of new H.I.V. cases among young African-American gay and bisexual men surged by 87 percent.

On Wednesday evenings once a month, Sturdevant runs an H.I.V./AIDS support group in a stark conference room near the State Capitol in Jackson. The meetings end promptly at 7:30 p.m., so the dozen or so young men can race home to watch “Empire.” Sturdevant began October’s gathering with a prayer. “Hold hands and bow your heads — and take off that hat,” he said to Tommy Brown, who had

rushed in from his job at Popeyes. The willowy young man snatched off his baseball cap, embroidered with the fast-food chain's red-and-orange logo, and lowered his head. "Gracious God, we want to thank you once again for the unity that we have here, Lord," Sturdevant intoned in his gravelly baritone. "Thank you for showing us how to love each other and love ourselves. We ask that you bring more people in that need somebody to talk to. That need the laughter. That need the understanding."

As the men settled into their seats, Sturdevant asked them to go around and "check in." Jermerious Buckley, watchful behind black rectangular glasses, with no sign of the makeup and colorful pumps he wore on weekends at Metro, told the group, "I'm doing a whole lot better." Last year, he said, "Daddy," as he called Sturdevant, had pulled him back from the dead, after he had shrunk to 85 pounds, his arms covered with Kaposi's sarcoma lesions, his kidneys failing. He felt like a "zombie," he said, too weak and hopeless to bother with his meds. Now Buckley thought he was finally strong enough to get back onto the pageant circuit where he competed. From his phone, he pulled up a picture of himself as "Akeelah," unrecognizable in a shimmering white body-hugging gown and towering wig. "November in New Orleans — y'all wish me luck," he said.

The group turned toward Benjamin Jennings, who wore a serious expression, with a shock of long hair in dreadlocks flipped to the side. When he said it was his first time there, everyone clapped. "I was diagnosed July 8 of this year, and my goal is to learn everything that I can about this thing," said Jennings, 21, talking in a tumble of words as he pulled at his cropped T-shirt. "The first person I told was my mom. Thank God — I am so lucky to have her in my life." He paused, looking into the faces of the men around the table and speaking more slowly. "I used to keep my feelings bottled up, but then I started opening my mouth on it," he said. "I did everything to prevent this disease, but because of one slip-up I have it. Now I want to help anyone I can in any type of way. My goal is to not to let anyone judge me or let this disease own me."

The bias that black gay and bisexual men still face poisons the H.I.V. picture in Mississippi and throughout the South. In 2016, Gov. Phil Bryant of Mississippi signed **HB 1523**, the Protecting Freedom of Conscience From Government Discrimination Act, one of the country's most sweeping and repressive anti-L.G.B.T.

laws. Though currently blocked by federal court and under appeal, the legislation, if allowed to proceed, would allow churches, religious charities and private businesses to deny services in a broad variety of contexts to L.G.B.T. people.

Many say rejection feels most acute and painful from the institution that should offer sanctuary and support: the black church. Individual congregations, religious organizations and clerics have made strides in openness and acceptance, but in general the black church remains largely absent from and often hostile toward the L.G.B.T. community. An African-American pastor in Jackson, the Rev. Edward James of Bertha Chapel Missionary Baptist Church, became a cringe-worthy symbol of homophobia in December 2014 for his protest against same-sex marriage equality. News outlets and social-media accounts shared a photo of him in his clerical robe, holding a sign that read: “Marriage is one man and one woman. Anything else is a perversion,” next to a horse clad in a white wedding dress. “The church is someplace to go for release and spiritual comfort, but the church is actually fearful for me,” said Buckley, who, growing up, attended Baptist services with his grandmother in the delta. “Now I stay at home on Sunday. It’s too hard.”

All too often, when people living with H.I.V. in Jackson lack the support of their families, community and the church, they end up in Grace House, a homeless facility on a sleepy block in the midtown section of the city. A cluster of four suburban-looking houses, Grace House originally functioned as a hospice, where the sick came to die. Now that the infected are living longer — and the numbers of gay and bisexual men with the virus continue to creep up — more and more young men are seeking shelter.

Until recently, Justin Huff, a former Jackson State student, shared a room on the second floor of Grace House’s main facility. He was infected with H.I.V. a year and a half ago, when a man he met on Jack’d sexually assaulted him. He received his diagnosis just after his 21st-birthday celebration. “I was throwing up and couldn’t eat anything for a few days; I thought it was from the drinking,” Huff said. “When I went to the doctor, he was like, if I hadn’t made it in the next two days, I would’ve been dead.”

Frightened and overwhelmed, he eventually landed on the doorstep of Grace House. “I couldn’t believe I was living in a shelter,” said Huff, who is now couch-surfing, applying for jobs at fast-food outlets and retail shops and attending Sturdevant’s support group, determined to stay healthy. “I felt like I had no one. Off and on, I got tired of living, because all I was doing was basically dying trying to stay alive.”

Behind Grace House is a small, quiet makeshift graveyard that holds the cremated remains of 35 or so residents whose families did not pick up their bodies after they died. Ceramic angels, pieces of glasswork and other mementos left by friends in memory of the deceased dot the patch of earth at the base of a pecan tree. Stacey Howard, 47, the director of programs, remembers one of the last people buried there, a young man who was H.I.V.-positive and addicted to crack, who had lived off and on at Grace House before he was found dead on the street in the spring of 2016.

“They had him at the local funeral home and were getting ready to turn his body over to the state, because no one would claim his remains,” Howard explained as she leaned against the tree. “We got in touch with his family, who didn’t want anything to do with him but at least signed the paperwork. I think it’s part of our responsibility that when someone in our community passes away, we give them the dignity of a place to rest.”

On a late, lazy Sunday afternoon in early April, Sturdevant, in cutoff fatigues and a white tank top stained with barbecue sauce stretched over his generous belly, was flipping chicken and rib tips on his grill. He had gathered his family — nearly two dozen sons and daughters, some related by blood, most not — to his house in South Jackson for a family barbecue. His daughter Tenisha, who had moved in with her two children in November, handed off 6-month-old Kory Cedric to her father. Sturdevant nuzzled his grandson’s chubby cheek before passing him to one of his unrelated “sons,” Cord, who lifted the laughing baby high over his head.

Sturdevant had gathered the crew to announce that he was taking a new job. He would be the manager of the SPOT — Safe Place Over Time — a new program located on the third floor of the Jackson Medical Mall in a former eyewear shop, funded by ViiV Healthcare, a pharmaceutical company that produces a dozen H.I.V.

medications. He would continue to provide services and support for young gay and bisexual men and transgender women and still consult for *My Brother's Keeper*. The new gig offered Sturdevant autonomy, but also \$8,000 more per year. "I had to wait until after Christmas to get presents for the children and grandchildren," he said, sipping cognac and Coke, ice cubes bouncing against the sides of a coffee mug, his cheeks rosy with cheer. "I always want to be able to take care of my family," he added, "to be able to say, 'Don't worry; I got you.'"

Despite the persistent anti-L.G.B.T. stigma and entrenched social and economic issues that cling to the South, Sturdevant feels a complicated, bone-deep tie to the people and the place. When he encourages his "sons" and "daughters" to take care of themselves and others, he is echoing the love and acceptance he received from his own large family. After years of hiding, when he came out to his mother in his 20s, she told him, "I love you regardless." When his family eventually found out that he was sick, his mother and sister drove up to where he was living in Memphis, along with six carloads of aunts, uncles, nieces, nephews and cousins. They tried to serve him plates laden with down-home food that he was too ill to eat and did their best to love him back to health. In the hospital, he finally admitted to his mother he had AIDS. "She told me, 'Boy, you gonna be all right; God got you,'" he recalls, tearing up. In the end, they took him home. He moved back to his mother's house in Metcalfe, with somebody from the sprawling network of nearly 100 family members always close by, until he recovered. "They saved my life, and I'll never forget that," he said.

Black gay and bisexual men and the organizations and activists that support them have come to the painful realization that the nation and society have failed them and that they must take care of themselves and one another. Their group names and slogans reflect a kind of defiant lift-as-we-climb self-reliance: *My Brother's Keeper*; *Us Helping Us* in Washington; the *Saving Ourselves Symposium* that takes place in Jackson this week; *Our People, Our Problem, Our Solution*, the tag line of the **Black AIDS Institute**. Since last October, the young men in Sturdevant's orbit have been supported by the fragile scaffolding that "Mr. Ced" has constructed around them and with them. Jordon has gained weight and is up and walking. Marq has promised to stay on his meds and has begun calling Sturdevant "Dad." Benjamin Jennings has a new job as a corrections officer at a prison north of

Jackson. Jermerious Buckley is “mother,” as he puts it, to six gay “children” of his own.

But even Sturdevant knows he can’t save everyone. A shadow passes over his face and his voice grows low when he talks about the one young man he couldn’t save. He remains haunted by him. A few years ago, a co-worker, Dot, suggested Sturdevant talk to a quiet fair-skinned man who was struggling with his H.I.V. diagnosis. “I told him my story and let him know, ‘You can do this, too,’ ” Sturdevant recalled. “He was in denial and very secretive, but still, he got into treatment and was doing good.”

But when Sturdevant saw him again in January 2016, he had stopped taking his meds and had taken a bad turn. “He was nothing but skin and bones,” Sturdevant said, looking down at his hands. “His eyes were bloodshot red. It almost looked like they were bleeding. We took him to the clinic, but the doctor said, ‘Get him to the hospital immediately.’ ”

For the next two months, Sturdevant and Dot kept a close eye on the young man, scolding, nagging and pleading with him to stay in treatment and to tell his family the truth so he would have someone to support him. On a Friday in March 2016, Sturdevant arranged to visit him and take medication to his house. But when he arrived, there was no answer. “I banged on the door, and then constantly called him all weekend,” Sturdevant said. “On Monday, they told me he had passed away.”

Sturdevant was devastated. Sometimes when he closes his eyes, he said, he still sees the smiling, fit and slender 27-year-old. “I felt like I had failed,” he said, choking up. “I kept thinking, He was going to get better, so how could this happen?” He took a breath, looking uncharacteristically tired, his eyes focused on a point off in the distance. “Listen, I know I can’t be there night and day for everyone. But at this point now, I feel like I can’t lose another young man to this disease.”

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