Charm City Gets Real

By Hannah Boes

Against the odds, Patapsco Arena tries to be glamorous tonight. The building stands isolated on a sparse block in an infamously jilted south Baltimore neighborhood, its soggy and windowless off-white frame surrounded by crumbling tractor-trailer parking lots, empty body shops and forlorn strip malls. But tonight, from a side door just around the building from the usual bingo games, there emanates an exceptional, glitter-filled commotion: the fourth annual “Know Your Status” Free Ball.

Tonight’s festivities are promoted by the Baltimore City Health Department but largely planned by leaders in the city’s ballroom scene, a community primarily composed of black lesbian, gay, bisexual, transgender and queer (LGBTQ) individuals who attend competitive performance events — or drag balls — in tiaras, sportswear, homemade gowns and street clothes, ready to cheer, talk trash and walk in costume categories against competitors on a runway. The spoils of status, money and trophies have been feeding national rivalries and contests in this community for more than four decades.

The focus this evening is young black men who have sex with men (MSM), a large portion of the ball scene’s participants. It continues with the hopes that the Health Department can earn the community’s trust and that the free testing and non-profit vendors will turn an established scene into a viable habitat for HIV prevention and intervention.

It’s been 34 years since the first report of HIV in our country — 27 since Ronald Reagan publicly said the word “AIDS” for the first time — but the HIV epidemic is raging in Baltimore for some as if no one has noticed. This year, when the Centers for Disease Control and Prevention (CDC) released national data about HIV infection, Baltimore had the third highest estimated AIDS diagnosis rate of any major metropolitan area in the country. Thirty-eight percent of Baltimore’s MSM are infected, with unrecognized status rates estimated around 60 percent — both figures about twice national averages.

Young, black MSM continue to carry the biggest burden of HIV. “They are the last ignored population,” Jordan White, who works as a community liaison for John’s Hopkins School of Medicine, says. As of 2010, after billions of dollars and decades of work, young African Americans made up 55 percent of the new infections in MSM and accounted for more new infections than any other subgroup by race, ethnicity, age and sex. “Baltimore has a huge dearth of resources for these men,” White says. “The fact that we can’t think of any single organization that specifically assists young black gay men, considering the needs we have, is especially telling.”

On paper, Baltimore — which boasts the top public health school in the nation, houses one of the best medical communities in the world and receives the bulk of Maryland’s $96 million of federal funding for HIV — should have all the marks of a vigorous city with thriving and successful health programs. But in 2013, AIDS and Behavior published an analysis of HIV in young MSM in five U.S. cities — Baltimore, Miami, Los Angeles, San Francisco and New York — all showing stable HIV rates except Baltimore, where prevalence increased, especially for black men.

But tonight, at the ball, no one is here to mourn.
The room inside the Patapsco Arena is thin, long and ugly — unsuited for the glamour of thigh-high boots, deep red lipsticks, big hair and bling that fills it. Next to the entrance, two chattering volunteers restock a bar with pink lemonade and water. The vendors, most of them conspicuously white, sit behind wooden tables in the front of the room and wait for people to look at their pamphlets, condoms and freebies. In the middle of the room, there is a wooden stage where the competition will take place. The trophies are lined up and club bass is pumping, which clashes with the rows of fluorescent lighting. Free HIV testing tables are arranged behind a black curtain in the back.

The modern ball scene — and all its rituals and practices — dates back to 1970s New York City. It was an organic, artistic response to the plight of young black men — especially those who were gay, bisexual, or queer — in a post-civil-rights-movement America. As the subculture spread through cities in the country, for the people involved, the balls promised brief chances at freedom, fame and admiration. Drag became something more than cross-dressing: It became a way of recognizing the unanimous performance that was life for any queer black man.

The community was, and still is, organized into houses — nationally recognized names like Revlon, Mizrahi and Ebony — with local chapters. For many, houses represented a place of validation. They offered ball children refuge in new kinship networks, ones that may have contrasted previous social isolation and rejection. “This is the new meaning of family,” Dorian Corey said in Paris is Burning, a 1990 documentary about the New York City ball scene.

Carlton Smith, president and founder of Baltimore Black Pride, was active in the community in his early adulthood. Now in his 60s, he can reflect on what the ball offered him then and offers others now. “The ball brings visibility to the community,” he says. “It creates an extended family, a network — where young people feel free and are able to express who they are without being discriminated against. They are welcome. They see something close to that modern family that they can embrace.”

The balls themselves have developed similar significance. In Paris is Burning, a man on his way into a ball says, “It’s like crossing into the looking glass, Wonderland. You go in there and you feel, you feel 100 percent right.”

As people trickle in to the arena — in their jeans and t-shirts, platform heels and mini-skirts, suits and dresses — there is an overwhelming giddiness. Attendees walk around in clumps, arm-in-arm, reuniting with old friends. Various houses have claimed their round tables and people gather around them, grooming each other, fixing make-up, arranging hairstyles and catching up. Every once in a while, someone stands up and practices vogue — a style of dance attributed to the 1980s Harlem ballroom scene and characterized by symmetrical, rhythmic movements of the hands, wrists and body.

One particularly glamorous woman with shimmering skin, golden and brown curls and a wide smile sits at a table with her house, tapping away at a smart phone. When asked if tonight is her first ball, she shakes her head, laughing. She has been to almost 20 by now after entering the scene at 18. “The ball really gave me confidence,” she says.

A rotund man one table over, dressed in a red track suit and wearing chains around his neck and wrists, has traveled from Pennsylvania for the nostalgia. He was prominent in the ball scene in the late 1990s. “I found a real family there,” he says.

Kurt Ragin, now a coordinator for Star Track, a Baltimore youth clinic, became an active
member of the House of Revlon in his late teens. He left the scene when the competition and acclaim became too addicting. “But still, there’s no question,” he says, smiling wide and taking a survey of the room. “The ball gave me confidence, it gave me a voice, and it gave me street smart intelligence.”

About 30 minutes after the ball is scheduled to start, Keith Holt, an activist and member of the ballroom scene who helped plan the ball, grabs the mic and welcomes the crowd of about 200. He advises everyone to text their friends and tell them to hurry up.

“Oh, and people, people, people. Let’s remember: Tonight is not just a ball,” he says. “It is a conference. It’s about bringing people together and talking about the issues and getting support.” With that, Holt introduces the vendors and offers them the stage so that they can talk about the services they offer.

Immediately, the crowd is lost. As if on cue, almost everyone starts talking and laughing or becomes distracted by a phone or an outfit assembly.

“…and we offer group counseling, free testing, and referral services...”

The clapping between introductions is sparse, the personal conversations are loud, and the chairs at the HIV testing counter are empty.

“We’re climbing a pretty steep hill,” one of the main organizers at the Baltimore City Health Department, who requested anonymity, said over the phone a couple weeks before the ball. He echoed many others in his field.

Those who dedicate themselves to HIV work in Baltimore — public health officials, counselors, non-profit employees and some members of the community — all have theories about why HIV cripples the young, black MSM community so disproportionately. Many argue that the stigma faced by the black MSM community in Baltimore has blocked them from accessing treatment and prevention solutions. Others suggest that lessened concern about HIV — as the virus has shifted from death sentence to chronic illness — may contribute to the problem.

“There was a morbid, healthy amount of fear and paranoia when AIDS was coming to be, which was a big factor,” says Dr. David Goode-Cross, a counselor at Chase Brexton Health Services with research background in the life stressors of black gay men. “Now, I don’t know that there’s so much of a concern. That issue of grief and loss was so huge then. Now, these young men have some of those needs satiated. In some ways, what they have is good...good enough.”

Others speculate that Baltimore’s black MSM become infected and stay unaware of their status at such high rates because they are missing a sense of "community ownership," or the sort of advocacy that activists in groups like ACT UP promoted in the 1980s at the beginning of the AIDS epidemic.

Ragin, once active in the ball scene in Baltimore and now a full-time employee at a youth clinic in the city, has devoted himself to this example. “I was inspired by a real need for younger faces in my own demographic. We have grown so immune to actually hearing the voices of youth.” Ragin certainly does not stand alone — he is one of many to turn his history in the ball scene into activism and outreach. But, for now, he represents a small collection of outliers. Community activism from the 1980s has been mythicized, not normalized.
The painful truth is that community ownership hardly seems like a fair fight here in Baltimore, where it would be asked of a fragmented, isolated group of men who are often silent about their sexuality and know HIV only as a small part of the cosmic number of institutionalized agents stacked against them.

Sara McClean, who has worked in Baltimore as a community dietitian for a non-profit that provides health services to low-income people with HIV, has spoken out about these embedded structural issues. She experienced the racial and economic divide between community organizations and the populations they aspire to help, as well as the steady supply of stigma and blame cast in the direction of many HIV-positive African American MSM.

“If you’ve had sex, even protected sex, even once, you still have risk,” McClean says. “A tattoo, blood transfusion, surgery...all of these things introduce risk. Even though they are small, the point remains: When you engage in anything that can exchange fluids, you still have risks. So many of us have made choices that could have given us HIV. A huge reason I and so many other privileged people don’t have it boils down to luck, not choices.”

In a critical review of almost 200 studies, Dr. Gregorio Millet at the CDC found that black MSM are actually less likely than non-black MSM to engage in unprotected anal intercourse, have a high number of male partners in their lifetime or have a high number of male partners within the past year. According to the data garnered, black MSM were more than twice as likely to use condoms and had a 50 percent higher chance of having been tested for HIV within the past 12 months.

Millet found that the factors contributing to the unbalanced prevalence of the disease in African American MSM are inseparable from social contributors. Among the 69 known risk factors he studied, Millet found that HIV-positive black MSM were more likely to be undiagnosed, lack health insurance, have limited access to drug therapy, see a health provider irregularly and have drug regimen adherence problems. These rates at which black MSM have unrecognized HIV-statuses particularly work to raise a black male’s risk at every sexual encounter. At the end of his study, which was presented at the 2012 International AIDS Conference, Millet and his colleagues conclude: “HIV epidemics in black MSM are inextricably linked to social and economic environments that should be considered and addressed to successfully stem disparities in HIV infection.”

Goode-Cross has anecdotally noticed these patterns in his clientele and through group therapy he facilitates. “It’s not like white men are any more protected from this disease,” he says. “But, by and large, they aren’t sleeping with Baltimore’s black men. These guys have a small pool of sexual partners with a pretty high percent of infected folks.”

“We love to moralize about the way people make decisions to engage with these activities and other people,” Sara McClean remarks. “But that is not science. That is social. And it makes it so damn difficult to fight this disease. People stigmatize and moralize and point fingers because it’s easier to believe that someone else got what they deserved. We need to fight that kind of thinking vehemently.”

Moralization and related stigma go past the shaming and social isolation of black MSM communities: It is woven into the decisions people make about safe sex, too. A 2006 literature review in the Journal of Health Disparities highlighted a body of research that strongly links stigmatization and a lack of social support — both especially common for black MSM — with risky sexual behavior. Experience with stigmatization is also related to depression, low self-
esteem and poor coping skills, all predictors of risky sexual behavior. According to a 2006 study, HIV-positive MSM report ostracism and stigmatizing attitudes from others within their community who are HIV-negative. Over 50 percent of young MSM of color experience violence or harassment because of their sexual behavior.

Goode-Cross argues this is another issue that makes being a black MSM in Baltimore especially difficult. “Race plays into everything,” he says. “And we see something different here, too, at the community-level. There is tolerance of homo-negativity within African American communities. We don’t talk often enough about how racism exists in the day-to-day elements that make it more likely that a black man will only be able to have relationships within this small community of high-risk folks.”

Once the stone has been turned over, the effects of community and structural discrimination seem inexhaustible. Goode-Cross, who is relatively new to the city, also argues that Baltimore’s black MSM experience severe, lasting effects of institutionalized racism, which produces what he calls the “ghettoized” presence of HIV in the African American MSM community.

White agrees and argues that the biggest takeaway from every conversation about HIV is that the health needs of these men will not be met until the structural issues are addressed.

“All of these issues — employment, basic needs, housing — determine the decisions people make in their lives.” Black American MSM often lack access to healthcare, jobs, sexuality education and social support experienced by whites or heterosexuals, who have rates of infection that are about one-third those of black MSM, despite the fact that blacks account for only 12 percent of the U.S. population.

“People have this idea that it’s okay for someone to live in these conditions,” White says. “If we had these large numbers of white women who were dealing with HIV, it would be a completely different situation.”

It also seems that the young, black MSM population could be paying the price twice for structural inequalities: More poor blacks might also mean less minority representation in influential roles, like those of doctors and other clinicians.

“This is not a city with a particularly present black middle class, and this has huge effects,” Goode-Cross says. Indeed, according to U.S. Census data from 2008, in Baltimore City, half of all African American households bring home less than $35,000, though only one-third of white homes fall under this level. And the incidence of poverty for African American city residents is almost double that of white residents. Goode-Cross attributes this, along with other factors, to his inability to find many culturally competent therapists and clinicians of color to serve black MSM in Baltimore.

This issue has also gotten national attention in the field of physician care. While one in eight Americans is black, only one in 15 doctors is. It is well documented that racial concordance between doctors and patients is correlated with quality of care and patient trust and satisfaction. And this has particular consequences for the HIV-infected African American population.

A 2011 study appearing in AIDS and Behavior by Mary Beach et al. summarized findings of the past decade: Racial minorities have stronger relationships with same-race providers, most minorities do not see same-race providers, better relationships with providers correlates to more drug therapy, better adherence and better outcomes, and black providers have tended to
introduce new HIV drugs to black patients quicker than white doctors do with their black patients.

In a 2005 survey of providers, study authors concluded that racial biases affect treatment decisions and adequate prescription care for minority patients. When African American patients received care from a provider of the same race, the pre-treatment gap was 348 days. However, when African Americans received care from white providers, the gap increased to 459 days. The doctors concluded this gap could be accounted for by provider biases about African American patients’ treatment adherence.

Dr. Lisa Cooper, professor and researcher at Johns Hopkins School of Medicine, authored a 2012 study of Baltimore doctors’ implicit associations about race and found that doctors had a moderate implicit bias against blacks and associated whites more strongly with compliance even though they had no consciously negative attitudes toward minorities.

As Dr. Carl Latkin from Johns Hopkins’ Bloomberg School of Public Health says: “It’s one thing to say that everyone should play by the rules. But the game is not the same for [African American MSM], and neither are the consequences.”

During the recent decades of the HIV battle in Baltimore, tension and distrust have also transcended racial boundaries. According to one senior public health advisor at the Baltimore City Health Department, competition for limited money and resources has created Darwinian antagonism between community organizations in the city.

“When everyone sits down to write grant proposals, no one collaborates. There is no trust. It’s all a cult of personality with these leaders.” Indeed the 2012–2014 Maryland HIV Plan, published by the Prevention and Health Promotion Administration, cited reports from community meetings that “the referral system that exists between providers, if it exists at all, is ineffective and outdated. Rather than combining resources...clients report little-to-no collaboration between providers.” Other people who contributed to the report cited a “competitive” atmosphere between providers and community organizations that stems from cuts to funding.

Other skirmishes arise from conflicting beliefs about what constitutes progress. Researchers and health professionals — those with the most funding and resources — are often at ideological odds with other organizations.

“The big guys are all about numbers and data,” Ragin says. “And at the end of the day, I don’t think you should treat these youth as numbers. They are people. They have feeling and emotions. And youth have grown so used to being treated this way so now they are numb. We need to get the organizations to come together and start treating this population like a group of people.”

Ultimately, one of the greatest disservices to Baltimore’s most vulnerable HIV population might be the very way in which the city approaches helping them.

The ball is more than an hour behind schedule, though the crowd has noticeably swollen in the last hour, when Phyllis Burnett, a silver-haired woman with a country accent, takes the stage. She makes a final plug for safe sex tonight by pointing out the truckload of condoms strewn about the room.

Glen Olthoff, who has been the Free Ball’s main planner at the Baltimore City Health
Department, stands comfortably in the middle of the crowd surrounding the lifted stage. He is tall and lean with white hair and wears jeans, an event t-shirt and black skater shoes. He shrugs when asked how he feels tonight is going, but not out of indifference.

“Most of this event is just about proving that we care and that we will keep showing up. And we have done that for four years now. And, yes, we’re still not where we need to be. But if we can forget this ‘cultural competency’ stuff for a minute, look people in the eye and talk to them like humans and they leave the ball feeling positive and good, that means something. It’s just another reason I don’t mind making this happen.”

Still, since the annual ball started four years ago, the numbers haven’t changed. Five hundred people attend this year’s ball, and about 100 will get tested. Almost 18 percent of tests will come back positive, which makes for an uneventful comparison to the 112 tests and 15 percent positivity rates from the first ball.

This prompts skepticism about the Free Ball from some, though at about $7,000 — a tiny portion of the city’s $1.4 million outreach budget — the cost of the ball makes it a relatively efficient method of testing.

“Just because you’re young and black and gay doesn’t mean you’re in the ball scene,” said Dr. Karin Tobin, who researches black MSM social networks through the Bloomberg School of Public Health. “There are folks who wouldn’t be comfortable with formal structures or networks for a variety of reasons.”

White, too, says the “ball community is a piece of the story and a small niche that does not represent everyone in the larger community.”

But these opinions exhaust Olthoff. He sighs heavily when asked about his challengers. “Sure, this is a small group,” he says, gesturing to the people around him who are cheering and clapping or taking videos on cell phone as ball community leaders walk to represent their houses on the stage above them. “It is also not a rich one. These people need help. Not everything positive you can do can be measured. People are always asking each other what the best thing is to do, what will get the most results. And everything is expensive. Say you test 10 out of 100 people and get 10 results. How much is that worth? No one can give me a good answer to that.”

Ragin, who has attended the Free Ball every year and who used to be active in the scene, commends the effort and says he has noticed differences, some of which escape measurement. “The Free Ball introduces people to the ballroom scene and introduces the ballroom scene to a cause that they can take part in. And, what’s more, the BCHD has gone to great lengths, even with mixed reviews from other organization, to show that they believe in this community, not just what the funders say.”

A couple hours in, the audience still encases the stage to clap, laugh and cheer with electric, contagious energy. The vendors and volunteers abandon their tables to watch from the peripheries. People take the stage and strut with tangible empowerment.

Dance dominates some categories, where participants freestyle on the stage with extreme endurance, vying for the most eye-catching and outrageous moves, and antagonizing their competitors with movement.

Other categories are “open to all,” and gender and sexuality plays no role — muscular men in thongs go up against full-figured women in body suits and platform heels. Tonight, many of the
categories have attempted to incorporate safe sex and HIV testing themes. To compete in the “Sex Siren” category, for example, participants dress the color of their favorite condom package. For “Realness with a Twist,” contestants find a creative way to add a magnum condom to their outfits.

Each round, when the music stops, the audience whoops, laughs and claps into the buoyant atmosphere of the arena, while the MC shouts over the vigorous crowd, sweating and pacing across the stage.

Over and over, as contestants are slowly narrowed down and eliminated within a category, the finalists dance, vogue and blow kisses to the judges until a trophy is released from its display and sent with its winner to the house it belongs. In the fluorescent room, the ball feels like the center of everything.

It won’t go perfectly. At one point, a fight will break out. A couple women will lunge at each other until their house brothers and sisters form a wall around them that leads out the back of the arena, security following close behind.

Nikia Revlon, a composed 29-year-old ball veteran in a revealing leather dress and velvet-red hair, will sigh and say: “I don’t really know what’s going on, but at the end of the day, these girls always want to fight. This is why I don’t like to come out. There’s just hatred and jealousy. This is all supposed to be fun and love, and it’s about getting tested for HIV. You know, because there are a lot of girls here that have it.” She starts to strut for the camera in front of her, smiling and laughing, and the brief, tense moment is passed.

Into the morning hours, after the Ball is over, Revlon and another grand and curvy woman in a tight yellow dress leave the arena. They chat at a video camera that leads them out the door. They are discussing the Realness category, a title Revlon walked for earlier in the night. The large woman argues that Revlon embodies the title perfectly because she bartends, works and lives her life as a woman.

“There’s life outside of this,” she continues. “Deal with it.”