

Attachment C

Population Barrier and Suitability Issues

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Communities of Special Interest

Injectors

In 1997 and 1998, researchers at Denver Public Health conducted a community identification project (CIP)¹ among men who have sex with men who also inject drugs (MSM/IDU). This study showed that this population is quite diverse, including men of different ethnic groups, socioeconomic backgrounds, and education levels. The population also included men who trade sex for money or drugs (“hustlers”). Overall the study showed that the population of MSM/IDU is quite unique, differing significantly from other populations of MSM or IDU, with different drug use and sexual behavior patterns and different psychosocial issues.

Multiple behaviors put MSM/IDU at particularly high risk for HIV, which is evidenced in a high seroprevalence rate (47% of the sample of 100). Though the “sharing” of needles and other injection equipment is significant, the drugs of choice, the high association of drug use with sex, and intervening psychosocial issues add to an overall context influencing high risk behaviors. MSM/IDU tend to use drugs that are more interrelated with sex. Cocaine, which was cited as the first drug of choice among the sample, is considered a “party” drug that stimulates sexual desire. It also is associated with a higher number of injections because the “high” is so brief, which can encourage more needle sharing. Methamphetamine (ranking second) is used to promote sexual stamina and is associated with prolonged sex and multiple partners. Some felt that drug-enhanced sex can become so appealing that it can lead to an addiction in itself. Therefore needle-sharing and an extensive amount of unprotected anal and other kinds of sex with multiple partners tend to go hand-in-hand with the use of these two drugs. Use of these drugs along with marijuana and alcohol were also associated with impaired judgment and lowered inhibitions, which further inhibited the use of condoms.

Various psychosocial issues were cited as being prevalent among MSM/IDU; however, the extent of these is unclear. Problems included: an enhanced need for immediate gratification; heightened sex drives; depression; feelings of insecurity, self-consciousness, and low self-esteem (which were often tied to searches for affirmation from multiple partners); tendencies toward self-destructiveness; and attention deficit disorder. Some mentioned histories of physical, sexual, and emotional abuse as playing a part in their behaviors. Feelings of internal homophobia, lack of gay identification, and denial about having same sex relations were also mentioned as powerful influences. For those with addictions their situations were even more difficult as they were driven to bypass safety in their pursuit of drugs. Some traded sex in order to get drugs or the money to buy them. Some mentioned deep feelings of depression that fueled their self-destructive behavior and feelings of fatalism about their drug use, which some felt would eventually kill them before anything else could.

As part of the study, men discussed their needs and ideas concerning HIV prevention and other types of programming. Some called for educational efforts that would increase people’s perceptions of risk, including some suggestions for fear-based messages and/or ones that highlight other risks besides HIV. Ads and brochures that seem to “preach” about “playing safe” were not seen as effective, nor were messages appealing to those who are HIV positive to not infect others. Some men mentioned the importance of culturally appropriate messages at appropriate education levels. Harm reduction efforts seemed especially important to this population. The need for programs that would “meet them where they are” was stressed. These included programs that would not insist on total abstinence from drugs or unprotected sex and would promote self-esteem by emphasizing successes rather than failures. The need for needle exchange was also emphasized. Finally, community level programs that addressed norms around needle sharing and bleaching and denounced homophobia were also discussed. Major barriers to prevention efforts included a lack of trust of outsiders prevalent in this population due to their being profoundly stigmatized. Another barrier was seen in the fact

¹ Piper, P.; Bull, S.; and Fuhrman, M. 1998. *Community Identification Project – Men Who Have Sex With Men and also Inject Drugs, Final Report*. Denver: Colorado Dept of Public Health and Environment.

that many are not interested in changing their behavior.

African Americans that mistrust institutional public health due to past abuses

Despite its impact on the African American community, AIDS is not typically perceived among African Americans as an issue requiring the same level of intervention and concern as other public health issues, such as violence and drug abuse. One frequently cited reason for this apathy – particularly regarding government-sponsored AIDS education campaigns – is the existence of a lingering “backlash” to the Tuskegee Syphilis Study, one of the most infamous studies of race and disease in the history of American science. The study was designed to observe the progression of syphilis in an untreated study population of some 399 African Americans in Alabama. A small group within the U.S. Public Health Service between 1932 and 1972 administered it. From its inception to its abrupt halt in 1972 as the result of public outrage, the directors of the study refused to acknowledge any ethical responsibility to the study’s subjects or the failure to treat for syphilis when penicillin became available. The Director of Venereal Diseases at the Public Health Service from 1943 to 1948 went so far as to claim in 1976 that, “The men’s status did not warrant ethical debate. They were subjects, not patients; clinical material, not sick people.”² The trust destroyed by this travesty will take generations to rebuild. It has led to widespread beliefs that government invented and continues to spread HIV, and those associated with government cannot be trusted.

Native American/American Indian

In regard to Native Americans/American Indians, it is important to remember the wide diversity within this group, which is composed of many nations, each with its own culture and beliefs. In addition, many of the nations were highly proselytized by missionaries, and their original cultural beliefs about same-sex behavior

² Fullilove, R.E. and M. T. Fullilove. “HIV Prevention and Intervention in the African American Community: A Public Health Perspective,” in *The AIDS Knowledge Base*. Internet document published by University of California San Francisco, <http://hivinsite.ucsf.edu>.

have been partially or entirely displaced by foreign viewpoints. Therefore, no one statement can be made about “Native American gay men” that would be universally true.

In 1998, CWT commissioned a study of the issues and needs of the urban American Indian community in Colorado.³ Major findings were as follows:

- In general, American Indians look to “Spirit” for explanations of HIV and solutions to the disease of AIDS. Public health solutions that emphasize behavior and science are mistrusted and seen as disrespectful.
- HIV is perceived as part of, or resulting from, destruction of native culture.
- HIV prevention planning has relied on modes of communication and rigid agendas that exclude other ways of arriving at understanding and reaching consensus. This discourages American Indian participation.
- Westerners do not respect native customs or medicine, and in some instances indigenous medicine men/women cannot access proper medical supplies because they lack western credentials.

Asian American/Pacific Islander

In regard to Asian/Pacific Islander (API) men who have sex with men, this broad category also contains a vast level of diversity, for which no universally true statements can be made. The Asian/Pacific Islander Coalition on HIV/AIDS based in New York City have developed the following principles they recommend when working with various API communities of MSM:⁴

- Emphasize privacy regarding HIV and sex, especially for East and South Asian cultures.
- Work with social networks and start with non-HIV issues of concern to the population
- Incorporate issues of identity, history, and culture explicitly in prevention materials. In one case, for instance, changing the color of condom wrappers from purple to red was

³ Young, David. 1998. *HIV Prevention Needs Assessment of the Urban American Indian Community of Colorado*. Denver: CDPHE.

⁴ Yoshikazu, H. 1999. *Network-, Setting-, and Community-Level HIV Prevention Strategies for Asian/Pacific Islanders*. New York: Asian/Pacific Islander Coalition on HIV/AIDS, <http://apiahf.org>.

- more consistent with Chinese tradition of New Year giving and was therefore much more effective.
- Incorporate API cultural emphasis on trusting medical authorities.
 - Social familiarity facilitates communication of prevention messages.
 - Create social settings and spaces for community building to facilitate HIV prevention.
 - When available, work with existing API gay communities, understanding the complexities of identification as both gay and Asian.
 - The Internet may be a promising strategy, being popular in some Asian communities and assuring both diffusion and privacy.
 - Degree of assimilation and acculturation among recent immigrants can strongly influence educational attainment, norms regarding safer sex, ideas about disease, and social settings sought out. More recent immigrants tend to have lower HIV knowledge, be more silent concerning sex and HIV, equate condoms with promiscuity, and perceive AIDS as a white disease.

The New York Asian/Pacific Islander Coalition on HIV/AIDS also provides the following insights about reaching API communities: “A consistent finding across all of the focus groups was that peer educators find traditional street outreach to be unfulfilling and rarely successful. The traditional street outreach strategy involves short, one-on-one contacts, often on a one-time basis, in which peer educators approach potential target clients on the street and hand out information and/or condoms. Peer educators reported several reasons why this technique may not be very successful. First, many API cultures frown on exchanging information having anything to do with sexuality with strangers. HIV and AIDS are associated with sexuality, and therefore any indications that materials are about HIV/AIDS were usually met with a blank or negative response. Second, peers noted that condoms are equated with promiscuity and so when it is clear to target clients that condoms are being handed out, they tend not to accept them for fear of being perceived as promiscuous. Many peers observed that this effect was worsened when potential target clients were with family members, friends, or partners. Third, peer educators have reported fatigue and dissatisfaction following such traditional

outreach trips.” The peer educators of the Coalition made seven additional overall suggestions to overcome barriers to HIV prevention for API MSM:

- Develop prevention materials from within-group cultural norms (don’t just translate brochures designed for other cultures).
- Recruit community leaders to raise awareness about HIV prevention.
- Improve print quality and design of media materials
- Use the Internet.
- Sponsor community meetings.
- Staff retention builds trust and effectiveness when dealing with API communities.
- Serve food and provide other incentives.

Transgender and Gender Variant People

Any service – including HIV prevention – that is delivered in a rigidly gender-specific manner creates barriers for people who do not fit into narrow definitions of “male” and “female.” Based on recent research, such barriers may contribute to a growing epidemic among transgender and gender variant people.

From July 1 through December 31, 1997, the Transgender Community Health Project conducted a quantitative study to assess HIV risks among a culturally diverse sample of Male to Female (MTF) and Female to Male (FTM) transgender persons in San Francisco. Major findings were as follows:

- All MTF participants reported some type of abuse and discrimination because of their gender identity or gender presentation.
- Thirty-five percent tested positive for HIV, and the prevalence among African Americans was more than double any other racial/ethnic group.
- Twenty-eight percent of HIV infected MTF individuals with a self-reported T-Cell count less than 200 were not receiving any form of HIV drug therapy
- Sixteen percent of the MTF subjects had been in alcohol treatment, and 23 percent had been in drug treatment
- Lifetime non-injection drug use was high: 90 percent had used marijuana, 66 percent cocaine, 57 percent speed, 52 percent LSD, 50 percent poppers, 48 percent crack, and 24 percent heroin. Drugs used most frequently in the past six months were marijuana (64%), speed (3%), and crack (21%).
- Thirty-four percent of the MTF participants

reported a history of injection drug use. Among these injectors, the most commonly injected drugs were speed (84%), heroin (58%), and cocaine (54%). Recent injection (past six months) was reported by 18 percent, and speed was the most commonly used drug reported by recent injectors (83%).

- Forty-seven percent of the MTF participants who injected drugs in the past six months reported sharing syringes, 49 percent used one syringe to load another, and 29 percent shared cookers.
- Sharing hormones, and sharing needles to inject hormones, was only rarely mentioned.⁵

A series of focus groups conducted in 1996 by Transgender Advisory Committee to the AIDS Office and the San Francisco Department of Public Health found similar results. The executive summary of their report states, "In our analysis of focus group transcripts we found high rates of HIV risk behaviors such as unprotected sex, commercial sex work, and injection drug use. Participants cited low self-esteem, substance abuse, and economic necessity as common barriers to adopting and maintaining safer behaviors. Participants also stated that fear of discrimination and the insensitivity of service providers were the primary factors that keep them (and other transgender people they know) from accessing HIV prevention and health services." In terms of sexual risk, one-fifth of the sample (20%) self-disclosed that they personally engaged in unsafe sexual behaviors and over one-third (34%) discussed unprotected sex as a major issue among their friends and in their respective community. Participants attributed unsafe sexual behavior to the following factors: low self-esteem, low self-worth, economic necessity and/or addiction, exploration of their new gender/sexual identity, dishonesty about HIV status (their own or their partner's), increased sex drive (FTMs who were taking hormones), and equating unprotected sex with a

⁵ Perina, B. A. "Clinical Issues in the Treatment of Chemical Dependency with Individuals of Transgender Experience," lecture delivered at the July 2000 Conference of the National Association of Alcohol and Drug Addictions Counselors. Report Available by calling 718/476-8480.

deeper relationship to differentiate it from commercial sex work.⁶

People with Disabilities

Barriers facing people with disabilities include the following:

(1) Physical barriers

Many property owners have been slow to remove barriers, despite the several years that have passed since the enactment of the American with Disabilities Act (ADA). Although the owners of these facilities deceive themselves with claims that people with disabilities do not use their facilities, or that no complaints have been issued against them, even a single step can be a powerful deterrent. Removing barriers can be inexpensive, can bring in new clients with disabilities, and can alleviate the risk of costly lawsuits. Denver has been nationally recognized for its exemplary accessibility; this may attract more disabled individuals to live in Denver, raising the need for tailored services for disabled Denver residents.

(2) Communication barriers

Much of HIV prevention assumes that MSM with disabilities can receive visual and auditory messages. This assumption has effectively roped-off HIV prevention from MSM who are blind, visually-impaired, deaf, or hard-of-hearing. In addition to this obvious barrier, there are less obvious communication barriers. Due to many reasons (including institutional bias) some MSM with disabilities have been denied equal access to educational opportunities, with resulting low literacy levels. Other disabilities, by their very nature, make reading and comprehension difficult. Unfortunately, in too many cases, materials written at a lower reading level inappropriately assume that the readers are immature and unsophisticated, creating yet another communication barrier.

(3) Attitudinal barriers

Part of the struggle faced by MSM with disabilities involves overcoming entrenched stereotypes and abuse. Too many service providers, particularly in institutional settings, patronizingly believe that people with disabilities are not sexual, or should not be sexual. If a man with a disability is also gay, this attitude toward

⁶ Clements, K., Kintano, K., and Wilkinson, W. *Transgender People and HIV*. San Francisco: San Francisco Department of Public Health, AIDS Office, <http://hivinsite.ucsf.edu>.

sexuality is even more oppressive; general discouragement of sexual expression is then reinforced by homophobia. Conversely, many men with disabilities are sexually exploited in situations where power imbalances are almost insurmountable. Some of these situations involve caregivers in institutional and home settings. Some of these situations involve partners who control not only sexual decision-making, but also shelter and food.

b) Childhood vulnerability extends into adulthood

In general, MSM most frequently endure inappropriate and ineffective sexuality education. This is even truer for MSM who have a developmental or learning disability. The following factors make special education students of all sexual orientations more vulnerable to HIV, STDs, and sexual abuse.⁷ When combined with homophobia, these factors have an even greater impact, and this impact continues into adulthood:

(1) Knowledge

Students with disabilities are generally less knowledgeable than other students about their bodies and their sexuality. This leads to poor decision-making related to their sexuality and an inability to protect themselves. This lack of information can be attributed to the following causes: They have generally been excluded from sex education programs in schools; parents, who are sometimes uncomfortable teaching sexuality to their children, often feel even more insecure teaching a child who has a disability; many students do not know when and whom to ask for help and may lack the cognitive or communication skills necessary for asking questions; students are often unable to get information from written materials, because few publications are written on their reading level.

(2) Misinformation

Some students with disabilities are more likely than other students to believe myths and misinformation because they are unable to distinguish between reality and unreality. They may also become easily confused or frightened by misinformation.

(3) Social Skills

Students with disabilities may have limited opportunity for social development. Their chances to observe, develop, and practice social skills are limited or nonexistent. Many students do not have such basic social skills as knowing how to greet others and how to show affection appropriately.

(4) Power and control

Others easily influence some students with disabilities. These students may do whatever others suggest without question, due to their dependency and desire to please.

(5) Self-esteem

Students receiving special education services may have low self-esteem. In an effort to be accepted by others or to gain attention (either positive or negative) students with low self-esteem are more likely than other students to participate in risky behaviors.

(6) Judgment

Students in special education may have poor judgment, poor decision-making skills, and poor impulse control. Without direct instruction, they are unable to recognize the consequences of their actions.

c) Special concerns regarding the mentally ill

Of all the disabilities, mental illness has been most clearly associated with HIV risk in the research literature. In one study, 792 adult outpatients at a large state psychiatric hospital were screened for HIV risk (43% female; 75% European-American, 22% African-American). Nearly half (49%) of the patients reported being sexually active in the past year, 52 percent used alcohol, and 18 percent used street drugs. Seven percent reported having three or more sexual partners, four percent had been infected with a STD other than HIV, three percent had exchanged sex for money or drugs, and one percent had shared injection equipment. More than one-third acknowledged that alcohol or drugs was a problem. Patients who reported both sexual behavior and substance use during the past year (n = 107; 13.5% of the screened sample) participated in a more detailed assessment that revealed a high level of misinformation about HIV, modest levels of risk perception, and considerable risk behavior. Patients were worried about HIV and AIDS, but

⁷ Virginia Department of Education. 1991. *Family Life Education for Exceptional Youth: Why HIV Prevention Education is Important*. Reston, VA: ERIC Clearinghouse on Handicapped and Gifted Children.

had few formal resources to reduce their risk or allay their concerns.⁸ In another study, 225 adults with chronic mental illness who were sexually active in the past year outside of exclusive relationships were individually interviewed in community mental health clinics using a structured HIV risk assessment protocol. More than 50 percent of the study participants were sexually active in the past month, and 25 percent had multiple sexual partners during that period. Fifteen percent of the men had male sexual partners. In more than 75 percent of occasions of sexual intercourse, condoms were not used. When participants were categorized as at either

high or lower risk for HIV infection based on their pattern of condom use, psychosocial factors that predicted risk level included measures of participants' self-reported efficacy in using condoms, perceptions of social norms related to safer sex among peers and sexual partners, and expectations about outcomes associated with condom use, as well as participants' level of objectively assessed behavioral skills in negotiation and assertiveness in sexual situations.⁹ Borderline and anti-social personality disorders have also been linked to HIV risk, mostly due to the impulsivity and high substance use rates associated with these disorders.

⁸ Carey, M.P., Carey, K.B., Maisto, S.A, et al. "Prevalence of HIV Risk Behavior Among Adults Living With A Severe and Persistent Mental Illness," *International Conference on AIDS 1998*, abstract no. 23544, 12:451.

⁹ Kelly, J.A, Murphy, D.A, Sikkema, K.J, et al. 1995. "Predictors of High and Low Levels of HIV Risk Behaviors Among Adults with Chronic Mental Illness," *Psychiatric Serv.*, 46(8):813-8.

Men who have Sex with Men (MSM)

1. Overall Findings from the 2000 Client Survey
Seventy-three MSM responded to the *2000 Client Survey*, in which they had an opportunity to describe the barriers they face and the characteristics of HIV prevention programs they perceive as suitable.

In terms of service suitability, six criteria emerged as statistically more important to these respondents in choosing an agency as their HIV prevention service provider:

- The agency staff makes me feel comfortable.
- The services are free or low cost.
- The agencies respect my privacy.
- The agencies are set up for gay men.
- The agency staff includes persons living with HIV
- Agency staff understands my issues.

In addition, these respondents were more likely than other respondents to only know one agency to go to for these services.

In terms of barriers, the 73 MSM respondents did report two barriers more often than the non-MSM respondents:

- Agencies providing these services are too far away.
- The agencies in my area make me feel uncomfortable.

It is important to note that only a small number of surveyed MSM expressed these barriers, although these responses were statistically significant as compared to non-MSM respondents.

2. General Barrier and Suitability Issues for MSM

In the *2000 Client Survey*, just over 16 percent of MSM respondents indicated that they had no need for HIV prevention services or materials. A higher percentage of MSM indicated “no need” than the respondents who were IDUs or people at risk through heterosexual contact.

Why might such a relatively high percentage of a very at-risk population perceive no need for HIV prevention interventions? There might be any number of reasons, including problems with the wording of the survey question. However, in

terms of barriers and suitability of services, four possible reasons are cited in research and are worthy of further consideration:

a) **Some men who have sex with men have adopted extremely safe sex or abstinence and do not perceive a need for supportive interventions.**

A certain percentage of men who have sex with men have chosen abstinence or extremely safe behaviors such as mutual masturbation. Level of acceptable risk is a highly personal choice, and some MSM are extremely risk-averse.

In some cases, men who are living with HIV want absolute assurance that they will not be responsible for any new HIV infections. For such men, even the remote risk of transmission during the safest forms of sex is unacceptable.

Although men who hold these beliefs may not perceive any current need for HIV prevention interventions, they may benefit from community support for their decisions. They may also find their choices very challenging to maintain over the long term.

b) **Oppression of men who have sex with men has been internalized as isolation and fatalism.**

In 1994, Communications Technologies conducted an extensive literature review concerning homophobia, which they defined as “the most common way of describing the cluster of stereotypical beliefs, prejudicial attitudes, animosity, and discomfort held by most heterosexuals in our society in reference to gay men, lesbians, and bisexuals.” They found that homophobia is “a pervasive fact of life in the American landscape, observable in personal attitudes and public and private institutions, and reinforced by legal statutes.”¹⁰ The Public Media Center concurs: “The experience of being victimized and abused as a result of pervasive social prejudice against homosexuality is virtually endemic to the experience of being gay in America.”¹⁶

¹⁰ Public Media Center. 1994. *The Impact of Homophobia and other Social Biases on AIDS*. San Francisco: Public Media Center.

Homophobia in Colorado has been particularly virulent. The memory of 1992's Amendment Two, a ballot initiative denying "special rights" to homosexuals, still lingers in the memory of many gay men in the state, creating walls of suspicion and isolation. The subsequent reversal of the initiative by the U.S. Supreme Court did not erase the painful feelings of marginalization that many experienced in the aftermath of the vote. The state's popular media continue to emphasize the conflict between gay communities and the constituencies that reject and ostracize them. High profile political and religious leaders have figured prominently in this ongoing debate.

The 1998 murder of Matthew Shepard, the gay University of Wyoming student brutally slain due to his sexual orientation, was also keenly felt in Colorado, particularly in rural areas. This tragic event called to memory many gay men's experiences of real or threatened violence and reinforced the dangers of being openly gay in a repressive environment.

The interconnection between homophobia and HIV/AIDS is extensive and insidious, with serious implications for MSM and for other people who are living with or affected by HIV. These effects can be grouped under four headings:

- Many MSM have a sense of hopelessness about the future. Because they have never experienced any other model, these men imagine a middle and old age without family of their own and lacking an alternative support system. They mistakenly believe that only youthful, attractive, and wealthy gay men have lives worth living.
- Men who have been shamed and marginalized for their sexual orientation may expect HIV prevention programs to be dehumanizing, and will avoid them.
- Men who have internalized the message "all gay men get HIV eventually" sometimes cease attempting to avoid infection and place their hope in HIV infection becoming an increasingly manageable condition.
- From the beginning of the epidemic in the United States, AIDS has been associated with gay men, and AIDS-related stigma has disproportionately fallen on gay men. To avoid this stigma, men may shun the "gay label" and also cut themselves off from the support of gay community.

Barriers associated with these effects are obvious. Not so obvious are the general barriers that they pose to HIV prevention efforts for all populations. The Public Media Center summarizes the situation as follows: "Just as AIDS-related stigma is the driving force behind our nation's lackluster response to HIV/AIDS, so the unaddressed issue of homophobia remains the unseen cause of the spread of AIDS-related stigma within U.S. society. We believe that until the issue of homophobia is properly and adequately addressed in America, our nation is unlikely to generate an objective, focused response to the epidemic of HIV/AIDS."¹⁰

c) Some MSM have adopted "harm reduction" approaches to HIV prevention, which may be difficult to reconcile with the traditional public health approach.

In focused interviewing of 124 gay men who reported an ongoing practice of unprotected sex, Levine grouped a series of responses under the heading of "justifications." On closer reading, these practices involve varying degrees of harm reduction, reducing the risk of becoming infected or infecting others with HIV. Some of these approaches included:

- Taking the insertive role, or insuring that the uninfected partner takes the insertive role,
- Performing oral sex rather than riskier anal sex
- Medical testing that indicates seronegativity,
- Social evidence of low-risk status (having unprotected sex only with people who claim to have had few sexual partners or claim to have always been the insertive partner or claim to have recently arriving from a low seroprevalence area),
- No transmission of semen and/or preseminal fluids (withdrawal before ejaculation or avoidance of insertion while preseminal fluids were present).

Clearly, all of these approaches involve some degree of risk. Traditional public health approaches to HIV prevention routinely reject all of these approaches due to the possibility of infection. Insertive partners do have some degree of risk of becoming infected; test results may indicate negative HIV status during the "window period" when a person is both infected and infectious; people falsely report few partners and being exclusively the insertive partner; unprotected sex in low seroprevalence areas can and has resulted in infection; ejaculation can be

hard to predict, making withdrawal undependable; preseminal fluids are difficult to observe and avoid. However, it is also indisputable that these harm reduction approaches could reduce the risk when compared to the alternatives (e.g., persons known to be living with HIV taking the insertive role without protection including ejaculation in their uninfected partners).

Levine's interviews took place before the advent of highly active anti-retroviral therapy (HAART). Evidence now exists that some men rely on HAART and its reduction of viral load as a harm reduction strategy for HIV prevention. See Chapter Nine for further discussion and caveats concerning this approach.

"Safer sex burnout" has become a reality among MSM that HIV prevention providers must deal with. Men who adopt "harm reduction" approaches are at least willing to minimize their risk of infection, if only slightly, over the longer term. At a minimum, people who have adopted behaviors that lessen but not eliminate HIV risk need factual information delivered in an understandable, non-judgmental, culturally competent manner. They should also be informed of the risks of other sexually transmitted diseases, some of which are incurable and are more easily transmitted than HIV (such as HPV and genital herpes). Some of these clients, even when fully informed, will continue to rely exclusively on these practices despite the risk of transmitting or acquiring HIV. Insisting on less risky behaviors may alienate such clients and have no HIV prevention benefit. Other clients, when fully informed of the continued HIV risk, will find their current level of unprotected risk unacceptable and will want support to practice safer behaviors.

d) Some men who have sex with men have fundamental sexuality, relationship, and substance use concerns that supercede their concern about HIV.

Some of the MSM interviewed by Levine "generally felt that their sexual conduct was risky but attributed their behavior to forces they were unable to control."¹¹ These forces, grouped

¹¹ Levine, M. 1992. "Unprotected Sex: Understanding Gay Men's Participation." In *The Social Context of AIDS*. Joan Huber and Beth Schneider, eds. Newbury Park, CA: SAGE Publications.

under the following five headings, translate into major barriers for HIV prevention.

(1) The influence of alcohol or other drugs

Levine found the following: "The most commonly cited excuse for unprotected sex was the use of drugs or alcohol. Almost all of the respondents offering this excuse insisted that unprotected intercourse was atypical behavior that occurred only when they were 'high' or 'stoned.' These men contend that drugs or alcohol impaired their judgment, lowered their inhibitions, or reduced their ability to resist a partner's urging or pressure to engage in unprotected oral or anal sex."

A forum on substance use and sexual health convened in Denver in October 1999 confirmed Levine's findings locally.¹² The men who attended this forum described how alcohol and other drugs play prominent, though varying, roles within the highly diverse population of MSM, and how the reasons for and patterns of use seen among this population vary markedly. Use patterns range from very moderate social consumption to heavy weekend bingeing to true addiction. The extent of use among this population has been highly debated and often over-represented, however it does appear that substance related problems in this community do exceed those of the general population. Though the extent of alcohol use is about the same, fewer gay men abstain from use, and they tend to use later in life. They also tend to use other drugs at a higher rate.

Some men use simply because it is fun. Others are masking a mental illness or the harm caused by childhood sexual, physical and/or emotional abuse. For men who are HIV infected, substance use is often a way of escaping the harsh realities of having a life-threatening disease. Many men at the conference cited the pain that comes from growing up in a homophobic environment and its impact on their sense of self worth as the central reason for their abuse of substances. For some, growing up gay meant learning that everything about who they were was bad and sinful and that their lives did not matter. Few were given the

¹² Colorado Department of Public Health and Environment. 2000. *The Interrelationship Between Substance Use and Sexual Health in the Lives of Men Who Have Sex With Men: Results of a Community Forum*. Published by and available from CDPHE.

tools to understand their sexuality in any positive way at an early age, which meant many grew up feeling very isolated. Drugs and alcohol allowed them to temporarily escape the pain and put aside feelings of shyness and internalized homophobia. However, for those who become addicted, low self-esteem is often exacerbated and is accompanied by another complex set of physical and emotional harms.

Other prominent factors discussed by the participants concerned social and structural factors within the gay community. Foremost among these was the key role that bars have long played in that community as centers of social activities and primary meeting places. Further confounding this has been the consistent targeting of the gay community by alcohol companies seen in the proliferation of bars and liquor stores, the sponsoring of gay events, and the glamorization of alcohol use in the gay media. Some felt that certain cultural dynamics in the gay community influenced their use of substances. An overemphasis on youth and beauty as well as conflicts over the meaning of “masculinity” influence many to feel undesirable or insecure, something that drinking and/or using drugs can help to temporarily overcome. Given that much of gay identity is tied to sex, many men feel social pressure to be hypersexual and to pursue numerous anonymous and/or casual sexual encounters as opposed to making more meaningful and intimate connections with other men even if they do not feel good about it. As one participant put it, “Drugs and alcohol lubricate sexual identity.” For those MSM who do not identify as being part of a gay community substances were often used to deal with feelings of isolation and to facilitate temporary linkages with that community.

It is critical to keep in mind that the relationship between substance use and sex is complicated, and many variables need to be considered. Substance use obviously affects judgment and obscures a sense of consequences when engaging in activities that put one at risk for getting or spreading HIV. However, a more complex understanding of the interrelationship between substance use and sex-related risk is key to the development of appropriate and effective HIV prevention and substance abuse treatment programming for men who have sex with men. Many say they have sex while they are high simply because it is fun and it feels good, and they stress that it has nothing to do with dealing

with feelings of shame or low self-worth. For many others, however, the relationship is much more intense and next day regrets are commonplace.

For some sex and drug/alcohol use have always gone hand-in-hand and have always been a part of their realities as MSM. Many use substances to mask insecurities and feelings of shame and to get the courage to go into environments like gay bars or bathhouses and/or to have same-sex relations. This may be especially the case for men who do not gay identify. Some claim that such use makes it possible for them to engage in activities that they normally would not pursue such as anonymous sex, anal sex, fisting, or those related to sadomasochism. Also, some men use drugs as a means to lure in partners. Many at the conference discussed the use of drugs as a way of enhancing sex. Poppers and Ecstasy are frequently used for such purposes. Men particularly discussed methamphetamine and its use in increasing sexual prowess and prolonging and enhancing sexual pleasure, often for many hours at a time. Though some claimed to be able to practice safer sex while high, for many, substance use complicated their ability to use protection or helped them to forget that protection was even an issue to consider.

Issues concerning substance use and sexual health vary markedly according to factors such as ethnicity, age, socioeconomic status, geographic region, and sexual identity, and bias and discrimination are prevalent within the gay community. Drugs of choice and use patterns often vary according to ethnicity, age, and socioeconomic status and according to what drugs tend to be available in a particular area. Since much of gay community life as well as the gay media have focused on white, urban, middle-class men, others often do not feel the same connection to the community or feel that they are welcome members. Much more of the attention and resources given to the HIV epidemic and its prevention has historically been targeted to this segment of the population as well. Transsexuals and their issues are seldom addressed within the HIV prevention arena even though their risks can be quite high. Some make their living selling sex and then use drugs to dissociate themselves from that and from the pain that comes with lack of acceptance by the wider society. Many also use and share needles to inject hormones (see further discussion of transgender issues, below). Experiences of rural men and MSM of color also

varied widely (also discussed in further detail below). Overall men at the conference felt that the population of MSM was unfortunately quite segmented in spite of the commonalities which some thought should override the differences. Yet the differences in experiences could not be ignored.

Poverty and homelessness are often overlooked among MSM. Yet many addictions grow out of feelings of not measuring up to social standards, and socioeconomic differences can be powerful influences in substance use. Furthermore, substance use can make one temporarily forget that he is homeless or that he is trading sex to meet survival needs. Much less outreach has been done around HIV issues in communities of color and among the poor, leaving some with the impression that it is not a disease that widely affects them, in spite of epidemiological data showing the contrary. Young gay men also often do not see HIV as something that affects men in their age group in spite of the increasingly high infection rates. Others feel that substance use and HIV are inevitable parts of their reality as gay men that they just need to accept.

A large segment of the conference focused on the problems and the needs associated with both HIV prevention and substance abuse treatment programming. Of major concern was how to best integrate the two topics of HIV and substance use in effective programming in each of the arenas, something that most felt had not been accomplished in Colorado.

In addition to lack of funding, most providers felt it was increasingly difficult to keep the attention of gay men, and some saw a complacency within the gay community, resulting from the availability of better treatments for HIV. Though many strengths can be found in community building efforts and community level interventions, the need for basing programs on sound formative evaluation and building them from the ground up rather than using top down planning approaches was stressed. People mentioned a general fear of incorporating diversity into programming and a failure to significantly adapt programs according to the diverse needs of men of varying backgrounds. Also stressed was a need to make the prevention messages more realistic, more inclusive, and better adapted to the multiple situations of diverse segments of the population. As examples, such messages should vary not only according to ethnicity, age, and geographic

location, but also according to factors such as HIV serostatus, sexual identity, drugs of choice, and even personality types. As one participant put it, "You don't use scare tactics with a thrill seeker. They don't work".

In general, conference participants felt that most HIV prevention providers have little in-depth knowledge of substance abuse, and often do not know when and where to refer clients to substance abuse-related services. The lack of linkages to substance abuse services and ability to make sound referrals seems especially problematic. Few HIV prevention providers deal with the relationship between substance use and HIV risk to any degree of complexity, with most simply emphasizing how being high can cloud judgment around sex. Another significant problem cited was the lack of needle exchange in Colorado or viable options to needle exchange.

Suggestions for programming offered by the participants included the need for more holistic approaches to HIV prevention that linked it with other health and life issues affecting men who have sex with men, including substance use issues. Programs need to be harm reduction oriented, be based on the expressed assessments and needs of various communities, be peer led wherever possible, and be tailored according to all relevant factors. Programs need to address the principle reasons men cite for their risk behaviors in ways that are sensitive and realistic. Substance use needs to be integrated into programming in a complex, thoughtful, and non-judgmental way. Specific examples of strategies which were suggested by the group included: 1) the use of forums or support groups where men could get a chance to talk openly about what they do and their life experiences; 2) one-on-one interventions through which men could find someone to listen to them and help them sort out their issues surrounding substance use and risk (these could include the use of a buddy or mentor system); 3) the use of role models, including men who have dealt with their substance abuse and HIV issues in a positive way; 4) substantive referrals to related services; 5) safe places to gather outside of bars, and 6) more sensitive and effective public information campaigns.

As the group looked at substance abuse treatment services, several principal themes came to light. First was the general lack of appropriate and sensitive treatment available for MSM if they are HIV negative. Some participants discussed their

experiences with treatment as being highly homophobic and disrespectful, and in no way venues where they could discuss their issues openly and comfortably. Access to effective treatment was better for those who were HIV infected. A second theme concerned the lack of a harm reduction orientation within the treatment arena. Most programs are abstinence based and providers can be quite judgmental (and occasionally punitive) about continued use. There were virtually no programs available for men who still wanted to use or programs that would meet people where they are and help them back out of their use at their own pace. A third problem cited had to do with the lack of substantive HIV prevention offered as part of substance abuse programs, something that the high level of turnover among counselors exacerbates. Finally structural issues were discussed concerning the managed care system that governs the treatment system. As structured, the system is highly motivated by money, and there is little incentive to provide better services for men who have sex with men. There are also few viable mechanisms available for client complaints to be heard, taken seriously, and addressed. Suggestions from the group for more effective programming included: 1) the incorporation of both holistic and harm reduction approaches which include stronger linkages to the HIV prevention system and other related services; 2) the incorporation of HIV prevention standards into their efforts or use of referrals to specialists; 3) the basing of programs on formative evaluation with users and ex-users and the subsequent tailoring of programming; 4) the development of gay-specific, respectful, confidential, and affordable treatment; and 5) the establishment of an advocacy group that can effectively address treatment-related complaints.

(2) *Sexual passion*

Levine's findings were as follows: "Nearly all the men offering this excuse felt their behavior was uncharacteristic of them and attributable to uncontrollable urges, which overwhelmed their intent to use protection."¹³

When it became obvious that HIV was a sexually transmitted disease, the early messages tended to be categorical and simplistic: "use a condom every time – until there's a cure." Gay men developed an unprecedented safer sex culture in a very short time. However, it soon became clear that such a simple message was not universally accepted, often because condoms were perceived as incompatible with sexual passion. For instance, at the point in sex when the condom is used, the partners become reminded of disease and death, which are unpleasant intrusions into the sexual experience. The next evolution of the message has involved an attempt to eroticize safer sex. While this has worked with some segments of gay men, it runs contrary to the experiences of many other gay men, for whom it is not a long term sexual alternative.

It is becoming increasingly clear that the once optimistic "until there's a cure" may well stretch far into the foreseeable future. Gay men, like all other sexually active people, will choose sustainable sex lives that satisfy their needs for sexual passion, intimacy, escape, and many other complex needs. This will involve some level of risk, which must be an informed, uncoerced, carefully considered choice for both partners in every sexual encounter.

(3) *Emotional needs*

Levine's findings were as follows: "Some men explained incidents of unprotected sex as an expression of love, affection, or acceptance. Typically these men participated in unprotected intercourse to demonstrate their emotional feelings for their partners who were usually their lovers or boyfriends. Many described their behavior as a sacrifice made for their partners, which was attributable to understandable and even altruistic motives."¹⁷ Some of the interviewees expressed concern that their lovers not "feel like pariahs," and that willingness to

¹³ Levine, M. 1992. "Unprotected Sex: Understanding Gay Men's Participation." In *The Social Context of AIDS*. Joan Huber and Beth Schneider, eds. Newbury Park, CA: SAGE Publications.

take risks was “psychologically important for the relationship.”

In the context of a relationship, sexuality builds a sense of connection and trust. Some gay men find non-sexual ways to meet these emotional needs. In other cases, men want at least one relationship in their lives to be completely accepting, for themselves and their partner. For them, the need for mutual acceptance and trust is more powerful than the need to be protected from HIV.

(4) Partner coercion, including deception, domestic violence, and rape

Levine’s findings were as follows: “Other men claimed that their partners coerced them into engaging in unprotected intercourse. Generally these men perceived themselves as victims of either other men’s pressure or their deceptive conduct. They insisted that they intended to use protection but that their partners undermined their resolve. . . There were two subgroups among these respondents. The first included respondents who were pressured into participating in unprotected sex. . . The second group consisted of a handful of men who were deceived into having unprotected receptive anal sex. These men usually thought the insertive partner used protection but later discovered that this was not the case.”¹⁷

Because most domestic violence occurs against women in heterosexual relationships, the possibility of abuse within male/male relationships is ignored or minimized. However, homophobia may increase the likelihood of such abuse. Threats of being exposed as a gay man, wanting to preserve a relationship because of the difficulties in finding partners, and the *mistaken* belief that “gay relationships are inherently flawed” are all attributable to homophobia, particularly internalized homophobia, and lock men into coercive, unhealthy relationships.

(5) Inability to remain in the “crisis mode” indefinitely

Although not mentioned by Levine, twenty years of viewing HIV/AIDS as a “health crisis” has exhausted many gay men and their service providers. An entire generation of young MSM has only known “sex that can kill.” For them, the situation is normal, not a health crisis. An increasing number of gay men are calling for a more holistic approach to gay health, with HIV being addressed along with – and in the context

of – other concerns such as mental health, substance use, nutrition, and issues of aging.

3. Barrier and suitability issues for MSM who do not gay-identify

Most of the early HIV prevention materials developed for MSM assumed that the readers would identify with the label “gay.” As these materials have been introduced to a more diverse audience of MSM – men who reside outside major cities, men of color, etc. – it has become clear that this assumption is invalid. There are many men who have sex with men but do not gay-identify.

Four reasons may exist for gay non-identification, each of which has different implications for HIV prevention.

a) Some MSM believe that identification as gay would preclude them from desired sexual involvement with women.

Some men perceive “gay” as meaning no sexual desire for or sexual involvement with women. This is the image of gay-ness that is most predominant in the gay media, particularly in regard to urban, well-defined gay communities. For some gay men, this image of gay-ness does not match their lives, which may occasionally or predominantly involve bisexuality. For this reason, these men reject the label “gay” and may, in fact, identify as either heterosexual or bisexual, or both. As a result, these men will reject materials and programs they perceive as designed for gay men.

b) Some MSM are at a stage in the “coming out” process that makes it difficult to admit that they are gay, to themselves and to others.

Cass¹⁴ identified six stages of coming out. Men who have sex with men could be at any of these stages, the first two of which involve rejection of gay identity. The six stages are identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis. In stage three, the tolerance phase, gay men begin to recognize the needs arising from their orientation, but they are unlikely to seek out community resources until stage four, the acceptance stage. Therefore, it might be said that four of the six coming out

¹⁴ Cass, V. 1979. “Homosexual Identity Formation: A Theoretical Model,” *Journal of Homosexuality*. 4, 219-235.

stages involve barriers to seeking out support. These earlier stages of coming out can be prolonged for those who live in a harshly homophobic environment.

c) The gay movement arose within, and continues strong association with, a community of white urban men who are extremely “out” in their communities.

As discussed in more detail below, rural men and MSM of color have a unique set of perceptions, needs, and challenges. For men of color, acceptance of the label “gay” may feel like a rejection of core aspects of their identity as African American, Latino, Asian American, or Native American. The definition of “gay sex” is also variable; for some people, as long as it’s only oral sex, or as long as you are not penetrated, it is not considered “gay sex.” Rural men may also see the gay community as distant and irrelevant to their daily life. Being equally “out” in their communities could subject them to physical harm and other realistic losses.

d) Some MSM in certain circumstances, which may never reoccur.

Some MSM only in very specific circumstances (in prison, as survival sex, etc.) or as an immediate, recreational episode that they may or may not re-experience; such experiences are often unrelated to gay identity, being more related to experimentation or immediate necessity.

4. MSM who are also injectors

[See page 17, Injectors.]

5. Barrier and suitability issues for MSM of color

Eighteen of the 73 MSM who responded to the 2000 Client Survey were men of color. These men of color cited “building community support” and “free condoms” as their most significant prevention needs, though their differences when compared to the other MSM respondents were not statistically significant. In terms of suitability, MSM of color cited very similar issues as MSM not of color: free/low cost services and respect for privacy emerged as most important. As would be expected, availability of services in languages other than English was a strong issue for Latino MSM. MSM of color were less likely to cite the barrier “too many things going on in my life” as compared to other MSM.

Even though most substance abuse occurs within the white middle class, it is often portrayed by the media as being more prevalent among the poor and communities of color. For MSM of color, a complex history of combined social inequalities, including racism, influences a set of life experiences that are quite different from that of white men, constituting a different context for substance use and HIV risk and calling for different approaches to prevention. Many feel that the prevalence MSM who do not gay-identify is higher in these communities, offering further challenges to HIV prevention efforts. Added to this is a historic lack of trust of government institutions and its agents, which makes many men of color reluctant to access services.

In general, MSM of color must cope with two forms of oppression: oppression due to their sexual orientation and oppression due to racial bigotry. The overlap of these oppressions is particularly challenging: their neighbors of color reject them due to homophobia, and their fellow gay men reject them due to racism. Aside from this commonality, it is important to recognize the unique experiences of the diverse communities that fall under the heading “communities of color.”

a) Latino MSM

Diaz¹⁵ summarizes four psycho-cultural factors facing Latino MSM, each of which has important HIV-related implications. Diaz coined the phrase *psycho-cultural* to underscore “the fact that cultural values and social structures become internalized in human development, giving shape to individuals’ construction of their sense of self and their relation to the social world.”¹⁵ Although Diaz’s research was not exhaustive, and did not reflect the realities of all communities of Latinos; his findings are corroborated by other researchers. His four factors are:

(1) Machismo’s double bind

Latino youth are told, from an early age, that being male is an advantage, that masculine attributes are superior, and that “real men” must

¹⁵ Diaz, R. M. 1997. “Latino Gay Men and Psycho-Cultural Barriers to HIV Prevention,” in *In Changing Times: Gay Men and Lesbians Encounter HIV/AIDS*. M. Levine, P. Nardi, and J. Gagnon, eds. Chicago: University of Chicago Press.

prove their status through sexual conquests involving penetrating their partners. Latino MSM who are the passive partners find this factor particularly difficult to reconcile.

(2) *Passion and control*

“The belief that Latino men are supposed to experience intense feelings, urges, and sensations that cannot or should not be controlled.”¹⁵

(3) *La Familia*

Enormous regard for, and high value on, family life and interpersonal relations among family members. However, when families view homosexuality as sinful and shameful, it is extremely difficult for Latino MSM to confront these homophobic attitudes and possibly bringing shame to their families. More likely, Diaz notes, these men experience “internalized homophobia, a sense of personal shame, separation of sexuality and affective life, and lack of a gay referent group.”¹⁵ A strong religious orientation in the family has tended to further complicate this situation.

(4) *Sexual silence*

The difficulty of Latino men to discuss sexual matters arises from the Latino value of *simpatia*, which stresses the importance of smooth, conflict-free, and non-confrontational interpersonal relations. As Diaz notes, “In many cases, acting simpatico toward a desirable potential sex partner, especially an unfamiliar person, and protecting their partners from uncomfortable feelings seems to take precedence over protection from HIV infection.”¹⁵ *Simpatia* can also result in silence around sexual abuse and infidelity.

In addition, research indicates that Latino culture includes a fairly powerful homophobic component. In a national survey of unmarried Latino adults, 62 percent reported that sex between two men was definitely not acceptable. Men must often choose between their culture and their sexuality, so that some men turn to the mainstream gay community for support, thus losing their Latino identity, while others remain immersed in a culture that views their behavior as reprehensible, often hiding their sexual orientation from family and friends. Internalized and community homophobia may contribute to a negative self-concept and rejection of their sexual behavior in Latino gay men, which can lead to anonymous sexual encounters and sex under the influence of drugs and alcohol.

Homophobia in Latino men reporting sex with men is correlated with sexual discomfort, which in turn is correlated with lower confidence in their ability to use condoms. Currently, levels of homophobia mean that Latino young people with homosexual feelings and fantasies will feel fearful and rejected by their peers. Consequently, many may experience severe depression, leading to suicidal ideation or attempts, or they may engage in more risky behaviors, such as drug and alcohol use and anonymous sexual encounters.¹⁶

b) African American MSM

Peterson¹⁷ conducted similar reviews of existing studies to determine the factors associated with high risk MSM behavior among African American men. Factors where African Americans tended to differ from other MSM were cited as follows:

(1) *Low perceived risk*

African American MSM have tended to view AIDS as a white, gay male and IDU issue, and even those who identify as gay or bisexual have tended to report a lower willingness to change behavior. This perception has been confounded by widespread misinformation about HIV, its origins, and its prevention that competes with public health messages delivered by mistrusted institutions (see further discussion below).

¹⁶ Van Oss Marin, B. and C. Gomez. 1998. “Latinos and HIV: Cultural Issues in AIDS Prevention,” in *The AIDS Knowledge Base*. Internet document published by University of California San Francisco, <http://hivinsite.ucsf.edu>.

¹⁷ Peterson, J. L. “AIDS-related Risks and Same Sex Behaviors among African American Men Who Have Sex with Men,” in *In Changing Times: Gay Men and Lesbians Encounter HIV/AIDS*. M. Levine, P. Nardi, and J. Gagnon, eds. Chicago: University of Chicago Press.

(2) *Social background*

Variations in social background, especially education and income, may have important consequences for African American MSM. Some studies have shown that African American gay and bisexual men with lower income, less education, and more unskilled occupations were more likely than others to engage in unprotected anal intercourse.¹⁷ However, higher income and advanced education do not automatically translate into HIV knowledge and behavior change.

(3) *Mistrust of institutional public health due to past abuses*

[See page 18, *African Americans that mistrust institutional public health due to past abuses.*]

(4) *Strong avoidance of stigma*

There appears to be a heightened concern about sexual identity among African American MSM, which Peterson attributes to “acceptance of Judeo-Christian views in African American religion and traditional gender roles in the African American family.”¹⁷ Other studies have noted the tendency of African American men to attribute their same-sex behavior to reasons other than homosexual orientation (e.g., recreational homosexual behavior to satisfy physical pleasure, situational homosexual behavior for economic reasons [commercial sex work or imprisonment]). Other behaviors associated with avoidance of “gay stigma” include engaging in frequent anonymous sex or preferring to take the insertive role in oral and anal sex. Studies have also shown that African American MSM are more likely than other MSM to report their self-identity as bisexual.¹⁸ Some African American men shun any and all labels, and thus avoid the associated stigma.

(5) *Inconsistent roles of African American churches*

As stated in the Linkages Chapter of this *Plan*, African American churches could play a powerful leadership role in the fight against HIV. However, over the course of the epidemic, while some churches have been helpful and proactive, other churches have contributed to complacency, shame, and misinformation about HIV. Churches

have found it particularly challenging to address underlying issues of homosexuality and drug use.

(6) *Sexual venues and social networks*

Peterson emphasizes that an African American man’s degree of gay-identification dictates his choice of venues and networks and that “the rates of HIV risk behavior may vary among the locales in which homosexually active African American men meet to form sexual liaisons because the norms regarding sexual behavior differ across social contexts and consequently affect the tendency toward sexual risk taking.”¹⁷ For instance, men who meet their potential partners in bars are more likely to have engage in higher risk sex than those men who meet their partners through friends, even when adjusting for alcohol consumption.

(7) *Resources for help-seeking and social support*

Some studies indicate that African American MSM are less likely to seek HIV-related help, and are more likely to turn to peers or health professionals (e.g., physicians). HIV positive African American MSM were especially unlikely to turn to family for support. In seeking out services, African American MSM have avoided situations where they would be the only African American participants.

c) Native American/American Indian MSM

[See page 18, *Native American/American Indian.*]

Just as the public health approach to HIV comes into conflict with native ways, so also do western notions of “gay” and “straight.” The term “two-spirit” is a relatively new term, but it draws on an ancient native tradition. Implicit in the term is a fluidity of identity, neither rigidly feminine nor masculine, and not defined by sexual behavior alone. As one American Indian put it, “We started to use this term because we didn’t feel comfortable in many cases in simply defining ourselves by the colonizer’s culture, which said that you were now going to be either gay or lesbian or bisexual. The idea of the Kinsey scale from zero to six, zero being completely heterosexual and six being completely homosexual, it seems to be part of the definition of being gay or lesbian or bisexual. You’re at one point on the line. Well, in our communities, in many of our communities, the tradition of sexuality is that you’re at one point on a circle,

¹⁸ Peterson, J.L. and A. Carballo-Diequez. 2000. “HIV Prevention among African American and Latino Men Who Have Sex With Men,” in *Handbook of HIV Prevention*, J. Peterson and DiClemente, eds. New York: Plenum Publishers.

and that all the points are connected, and you can be at any point on that circle at any one period in your life, and you don't necessarily have to be at one end of the line. And I think that's a major difference between many of our cultures and the cultures of the colonizers, is that it is a circular and connected sense of tradition as opposed to a linear, with really no options and no way for the ends of the spectrum to ever be connected."¹⁹

d) Asian American/Pacific Islander MSM
[See pages 18 – 19, *Asian American/Pacific Islander*]

6. Barrier and suitability issues for rural MSM

Thirty of the 73 MSM who responded to the 2000 Client Survey were rural men. These men cited "building community support" and "groups" as their most significant prevention needs, though their differences when compared to the other MSM respondents were not statistically significant. Rural MSM expressed more need for needle exchange, substance abuse treatment, and discussion of other STDs as compared to their urban counterparts. In terms of suitability, rural MSM cited very similar issues as urban MSM, but "agency hours of operation" and "agencies not turning them into the police" emerged as more important for the rural respondents. As would be expected, the greatest barrier for rural MSM was agencies being located too far away. Rural MSM also noted a high level of concern over privacy as a service barrier, as compared to urban MSM. Rural MSM express a desire for service provider staff who are, themselves, living with HIV; this imposes major challenges to rural providers, who are hard-pressed to recruit qualified staff.

Gunter²⁰ substantiates rural MSM concerns about privacy. He points out that "confidentiality is a difficult issue within the rural environment. Because of the limited geographic boundaries and 'incestuous' nature of the systems, personal associations, work and leisure time activities and work patterns are usually well known to all in the community. The high level of visibility places the individual in jeopardy, particularly when receiving health and welfare services." Gunter also stated that in rural communities, due to funding problems, many agencies utilize paraprofessionals and volunteers as staff members. In these agencies there is a legitimate fear on the part of the individual seeking services that he/she may be disclosed by these paraprofessionals to others both within the agency and to community members. "For some reason, paraprofessionals, volunteers and nonprofessional workers in rural communities appear not to feel bound by the rules of confidentiality." It must be noted that Gunter's indictment of paraprofessionals is by no means universally true, and professionals have also been guilty of violating client rights to confidentiality.

In general, the damaging effects of a homophobic environment and isolation from "gay community" have had a devastating impact on rural men who have sex with men. The need for rural providers to be diligently non-judgmental and honoring of confidentiality is paramount.

Men who have sex with men in rural areas often do not feel the same freedom to be open about their sexual orientation as men in cities do. Some can be totally lost in knowing what to do with their attractions to other men in communities that can be so unaccepting. There are rarely any designated places where men can meet (such as bars or coffee houses) and providing access to condoms and other means of protection can be problematic in an environment where it is critical to maintain one's confidentiality. Less information about HIV and its prevention is available in these environments as well. Overall, it is extremely difficult to specifically target

¹⁹ Harris, Curtis and Leota Lone Dog. 1993. "Two Spiritied People: Understanding Who We Are As Creation," *New York Folklore*, Vol. XIX, Nos. 1-2, pp. 155-164.

²⁰ Gunter, P. 1988. "Rural Gay Men and Lesbians: In Need of Services and Understanding," in *The Sourcebook on Lesbian/Gay Health Care, Second Edition*, M. Shernoff and W. Scott, eds. Washington, DC: The National Lesbian/Gay Health Foundation.

MSM in rural areas, and providers often find it more feasible to target their services in an “orientation-neutral” manner, and including women among intervention participants. Venues such as alcohol and other drug treatment and corrections may also provide access to higher risk MSM, but are still generally “orientation-neutral”.

Many rural MSM go to the cities to party with other men, but often do so without the same knowledge and tools as their urban counterparts.

Two issues concerning confidentiality can also impact the effectiveness of certain methods of intervention. First it tends to be a barrier to Group Level Interventions (GLI) in communities where it is unacceptable to identify with a group so stigmatized by the local population, and secondly it tends to be a barrier to GLI to discuss matters of personal risk in group settings where every one knows each other. In such cases, information obtained from interviews and focus groups in District four and eight has shown that potential clients prefer Individual Level Interventions (ILI).

Need for safer sex materials distribution/availability based on needs assessment results, low socio-economic status of rural communities and confidentiality issues.

Rural communities need availability of safer sex materials even if that must be provided as a “stand alone” intervention.

Due to difficulties in reaching specific target populations combined with very limited funding availability, adding HIV prevention interventions to existing programs for substance issues, domestic violence and other mental health issues, where viable, would be advised. Collaborations with these other providers might take the form of training their personnel on HIV issues for incorporation into the programs or by directly providing an “HIV segment” for the existing programs. Where these types of arrangements have been successfully implemented, providers of the existing behavioral change programs have reported increased interest by participants enhancing program effectiveness.

7. Barrier and suitability issues for young men who have sex with men

As noted in a position paper issued by Advocates for Youth, “Homophobia and fear of encouraging sexual activity among young people make many adults even more reluctant to address sexual health in regard to young MSM. Because of the social stigma attached to a gay or identity and the threat of violence, many young men conceal their same-sex sexual behavior.”²¹ Their heterosexual male peers are particularly homophobic and AIDS-phobic; in recent surveys, college student males responded more often than females that “people with AIDS got what they deserved” and that “AIDS is proof that homosexuality should be illegal.”²² Significant numbers of lesbian, gay male and bisexual youths report having been verbally and physically assaulted, raped, robbed and sexually abused, making them particularly leery of any situation where they might be forced to self-disclose. Trust, particularly of adults, is difficult for the youth to give and for adults to earn under such circumstances. These are clear barriers when trying to reach YMSM with effective, appropriate HIV prevention interventions.

Young MSM practice behaviors that could result in HIV infection, sometimes at greatest rates than adult MSM. In a 1994 study among San Francisco’s Young MSM, 28 percent of those 17 to 19 years-old and 34 percent of those 20 to 22 years-old reported engaging in unprotected anal intercourse during the previous six months.¹⁵ A similar study in Los Angeles later found 55 percent of young MSM reporting unprotected anal intercourse in the previous six months.¹⁵ In a 1996 study, 38 percent of young MSM reported having unprotected anal sex, and 27 percent reported having unprotected receptive anal sex.¹⁵ More recent research is even more troubling. The Young Men’s Health Study published July 12, 2000, involved over 3,400 young MSM in seven US metropolitan areas and had the following major findings:

²¹ Advocates for Youth. 1999. *Young Men Who Have Sex With Men: At Risk For HIV and STDs*, www.advocatesforyouth.org.

²² Advocates for Youth. 2000. *Adolescent Males: Sexual Attitudes and Behaviors*. Published online, www.pcisys.net/~health_ed/adolescentmales.html.

- Prevalence of HIV was much higher than expected, 7.2 percent overall
- HIV was significantly higher among the African American youth, those that reported mixed or other race, those who had more than 20 partners, and those who reported anal sex with a man.
- Only 18 percent of those who tested positive as part of the study knew their HIV status beforehand.
- 41 percent reported having had unprotected anal intercourse in the prior six months
- 13 percent of the HIV-infected young MSM who knew they were infected still had unprotected, insertive anal intercourse during the past six months.²³
- finding safer sex difficult to practice,
- having suffered forced sexual contact,
- being high on amphetamines or alcohol during sex,
- having little social support,
- having a steady sex partner in the past six months,
- having only male sex partners in the past six months,
- feeling that there is little or no chance of avoiding HIV infection.³¹

Adolescence and young adulthood are times of experimentation and overwhelming role confusion, especially for gay youth. Of male adolescents who reported same-sex intercourse, one study found that 54 percent identified themselves as gay, 23 percent as bisexual, and 23 percent as heterosexual. In part, this is due to the nature of the “coming out” process when one’s peers display high degrees of homophobia (see discussion above). Other youth may have not yet considered the question of sexual orientation, or are simply experimenting with different sexual behaviors, too often without condom use.³¹

Many young MSM perceive AIDS to be a disease of older gay men, often lack peer or other social support to encourage safer sex behavior, often do not consider their peers to be at high risk, and believe they can determine the HIV status of others by their appearance. Some YMSM lack adequate communication and assertiveness skills to negotiate safer sex. Some feel unable to refuse unwanted sex or feel compelled to exchange sex for money, food, or shelter.³¹

A 1998 nationwide study of 15 to 22 year-old young MSM indicates that predictors of unprotected anal intercourse include the following:

Street youth have particularly difficult barriers to overcome. Transportation is difficult; moving a program even a few blocks, away from areas where they congregate and live, can be an insurmountable barrier. Young MSM practicing survival sex must constantly fear police harassment as well as violence in other forms. As with other homeless people, these young MSM have more fundamental needs that supercede their need for HIV interventions, such as food, shelter, and safety.

Schools are one of the few venues available to educate large groups of adolescents about HIV/STD prevention. However, local school district policies restrict sex education in schools and limit what teachers, health educators, and invited speakers can say to students, including discussing condom use, drug use and homosexuality. A Colorado law also requires parents to “opt in” students for sexuality education classes, and this is expected to discourage attendance in these courses. Exclusive insistence on abstinence, which predominates as a matter of policy at Colorado Department of Education and other statewide and local agencies, is not conducive to open and frank discussions of HIV shown to be critical components of effective programming.

Older MSM were targeted from the early 1980’s with materials and programs designed to address their particular risk behaviors. Young gay and bisexual males today have not experienced an amount of personal loss of friends and lovers that would compel them to modify their risk behaviors.³¹

²³ Valleroy, L., MacKellar, D., Karon, J., et al. “HIV Prevalence and Associated Risks in Young Men Who Have Sex With Men,” *Journal of the American Medical Association*, Vol. 284, No. 2, July 12, 2000, pp. 198–204.

8. Transgender and gender variant people [See page 19 – 20, *Transgender and Gender Variant People*.]

9. Disabled MSM

a) **General barriers faced by MSM with disabilities**

The first barrier that MSM with disabilities must face is the perception that they do not exist. This is partly due to the fact that predominant images of gay men come from popular gathering places (many of which are inaccessible) and the gay media (which portray extremely narrow views of beauty). Gay community has not fully embraced the gay disabled, contributing to social isolation and its damaging effects on health. Disabled persons may also be more prone to the use of drugs (prescription and non-prescription) for the alleviation of pain, and drug use has been demonstrated to be highly related to HIV risk.

Other barriers faced by MSM with disabilities can be found on page 20 – 21, “People with Disabilities.”

A quote from an article written by a gay man with mental illness summarizes it as follows: “I know the experience of crying for help and no one hearing . . . Being gay with mental illness puts us in a difficult position. The gay community stigmatizes us for being mentally ill, and the mental health communities stigmatize us for being gay. Though things are getting better, we remain a forgotten, service-less population. Like all stigmatization, the labels hide the fact that many who attend the ZS groups [for gay men with mental illness] are highly educated, connected and attractive. Gay services have successfully secured services for gay health problems, and mental health advocates have promoted improved mental health services, but neither one have addressed the special needs of gay people with chronic mental health problems alone.”²⁴

10. Barrier and suitability issues for HIV positive MSM

Until recently, MSM living with HIV received little visible support for practicing safer sex. As primary prevention campaigns are developed for MSM living with HIV, their messages must not promote stigma or discrimination against HIV infected people, nor make people feel shamed for their desires to be sexual. Sexuality is part of a normal, healthy life – for positives and

negatives.²⁵ Sexuality is tied to complex human needs, including the need for intimacy and love. HIV infected MSM wrestle with competing emotions, including altruistic concern for their communities; burnout from years of thinking about their infection; uncertainty about the expectations of their partners; and loss of control in sexual situations due to coercion, economics, power imbalances, or drug and alcohol use (see above). Any HIV prevention provider must be prepared to adopt harm reduction strategies that do not simplistically demonize “bare backers,” but instead utilize behavioral interventions with MSM who are diagnosed with other STDs and deal competently with drug use, mental illness, and other deep seated factors.

MSM who are living with HIV are a tremendous, vastly underutilized resource in HIV prevention. As these men experience improving health status due to HAART, many are returning to the workforce. Their experience, drive by necessity, has given them powerful insights into the social, cultural, and personal factors that contribute to HIV risk; they are also extremely knowledgeable about the complexities of living with HIV and remaining adherent to medications. Such skill and insight could expand and improve our HIV prevention and care efforts. However, few of these men are actively recruited as staff members of HIV-related agencies.

Public policy set by federal, state, and local governments has a direct effect on the lives of MSM with HIV and on the ability to deliver meaningful prevention to them. On a structural level, policymakers need to examine the opportunity to use treatment programs as settings for HIV prevention interventions.

²⁴ Coffman, B. 1999. “Being Gay and Mentally Disabled,” *New York City Voices*, Jan/Feb, 1999, www.newyorkcityvoices.com/jan99d.html.

²⁵ Morin, S., Coates, T., Shriver, M. 2000. *Designing Effective Primary Prevention for People Living With HIV*. San Francisco: AIDS Research Institute, University of California, San Francisco.

Unsafe Heterosexual Contact

1. **Overall Findings from the 2000 Client Survey**
Twenty-two people at risk through heterosexual contact (HET) responded to the *2000 Client Survey*, in which they had an opportunity to describe the barriers they face and the characteristics of HIV prevention programs they perceive as suitable.

Compared to the other respondents, the HET respondents were significantly more likely to indicate three HIV prevention needs: counseling, testing, and referral; free condoms/dental dams; and discussion of other STDs.

In terms of barriers, statistically significant items voiced by the HET respondents were as follows:

- Agencies are too far away
- Inconvenient service times
- Service cost too high
- Only deal with HIV, not other issues
- Concern for privacy
- Too many things going on in client's lives
- Agencies don't understand client's issues.

In terms of program characteristics that make them suitable for HET, statistically significant items voiced by the HET respondents were as follows:

- Services come to me or are close
- Free/low-cost services
- Injector-specific agencies
- Women-specific agencies
- Agencies won't turn me in to police
- Agencies won't turn me in to INS
- Staff speaks my language.

During 1999, a community identification project (CIP) was conducted in Denver by researchers from Denver Public Health and the Empowerment Project with a subgroup of HET at significant risk: low-income women of color who use crack and other forms of cocaine.²⁶ In assessing the needs for programming for these women, certain factors appear particularly critical. Foremost is the need for programs to address a complex set of needs in conjunction

with HIV prevention. These would include basic needs such as food, housing, childcare, and transportation. Training, education, and employment-related assistance could also play a key role in helping women to become more self-sufficient and less dependent on unhealthy relationships. Access to appropriate and effective substance abuse treatment as well as mental health services could help women break the cycle of addiction, combat depression, and raise self-esteem.

Women participating in this Denver CIP frequently expressed a need for support from other women who are empathetic and who could offer them structure and on-going (intensive, at times) assistance in meeting their goals. Women who have similar life experiences to theirs were deemed the most appropriate in providing such support. Programs must emphasize the role of addiction and address HIV risk along with other risks, focusing, in part, on the root causes of sexual risk behavior. Other program-related ideas include considering the role of families (both positive and negative), addressing the impact of abuse and loss, and recognizing the power relationships facilitated by addiction. When possible and appropriate, HIV prevention could also be facilitated by engaging families in drug prevention with young children, intervening early with victims of abuse and loss, and capitalizing on the aspirations that women have for their children.

2. General Barrier and Suitability Issues for Women Who Have Sex With Men

Any woman who has unprotected sex with a man is at theoretical risk of becoming HIV infected. However, there are several factors that move this risk from the theoretical to the actual. The first factor is the HIV status of her partner. Some men – those who inject drugs, and those who also having sex with other men – are more likely to be infected because of where HIV is concentrated in Colorado. Other factors relate to the socio-cultural context for a woman's life, imposing barriers on her ability to make life-affirming choices, including the choice to seek out HIV prevention resources. For purposes of planning, we will look at five of these major socio-cultural factors as if they were distinctly separate from one another: low socioeconomic status, trauma from early and ongoing abuse,

²⁶ Colorado Department of Public Health and Environment. 1999. *Summary of the DPH/Empowerment CIP with Low-Income Women of Color Who Use Crack and other Forms of Cocaine*. Denver: CDHPE.

substance use, mental illness, and power imbalances in relationships. In actuality, these five factors are complexly interrelated. When they are “layered” in a woman’s daily reality, they conspire to produce chaos, dehumanization, and, too often, HIV infection.

a) Low socioeconomic status

Every decision about change involves a cost, and for women living in poverty, immediate probable costs often outweigh theoretical future costs, leading to a continuation of her vulnerability. Worth²⁷ describes the immediate probable costs as:

- Disruption in a relationship through violence,
- Loss of economic support,
- Loss of a ‘father figure’ for her children,
- Loss of a place to live.

In light of immediate, devastating costs such as these, HIV infection and death due to AIDS seem like improbable future costs to a woman living in poverty. To survive a life of extreme poverty, a woman soon learns to make choices that allow her to survive today’s threats while suppressing thoughts about tomorrow’s possible threats, to avoid sinking into despair.

The 1999 CIP⁴¹ describes how sex is often what women in poverty use to obtain the drugs and/or money they need. In many cases, low self-esteem combines with certain demands of survival to discourage women from using protection when they have sex, though this is not always the case. Risk reduction strategies such as condom use, washing after sex, having oral sex (instead of vaginal or anal), limiting needle sharing, and cleaning needles are used occasionally by some.

b) Trauma resulting from early and ongoing abuse

As mentioned above in section a, women who have survived sexual coercion are significantly more likely to engage in behaviors that place them at higher risk of HIV infection. This finding was confirmed by the 1999 CIP, which found that sexual risk behavior among these women was driven by the complex interaction between their history of abuse and trauma,

²⁷ Worth, D. 1989. “Sexual Decision Making and HIV/AIDS: Why Condom Promotion among Vulnerable Women is Likely To Fail,” *Studies in Family Planning* 20(6, part 1): 297-307.

addiction, and low self-esteem. A large percentage of the women in the study reported a history of physical, sexual, verbal, and/or emotional abuse. Some had also suffered the traumatic loss of a loved one. This history, combined with the dynamics of addiction, had led to low self-esteem and frequent suicidal tendencies in many of the women interviewed.⁴¹

Multiple studies have shown that the majority of women living with HIV have lived lives of domestic abuse, including mental and emotional abuse, predating their HIV infection. One of these studies concluded that long histories of physical and drug abuse “leave many women believing that they cannot control their lives or bodies – especially in transactions with men involving sex or drugs.” National studies show that 78 percent of sex workers interviewed underwent forced sexual intercourse before the age of fourteen.²⁸ Unfortunately, in Colorado, HIV education and intervention is an optional, but not mandated component of domestic violence programming.

Growing up in an abusive household, particularly when drugs or alcohol are involved, enhances vulnerability to HIV. A number of reasons for this vulnerability have been noted, including: a) lack of parental modeling of healthy relationships; b) a strong sense that abandonment is possible or probable if one does not submit willingly; c) a pattern of being silent about abuse, neglect, and betrayal; d) sex and affection being viewed as rewards or punishments; and e) high prevalence of incest in households where one or both parents are alcohol or drug dependent.²⁹

²⁸ Farmer, P; Connors, M.; Fox, K.; and Furin, J., eds. 1996. “Rereading Social Science,” in *Women, Poverty, and AIDS: Sex, Drugs, and Structural Violence*, P. Farmer, M. Connors, and J. Simmons, eds. Monroe, ME: Common Courage Press.

²⁹ Starhawk. 1996. *Characteristics of Adult Children of Alcoholics*. Available online at wysiwyg://zoffsitebottom.61

c) Substance use

The 1999 Denver CIP found a strong relationship between substance use and women's vulnerability to HIV.⁴¹ Substance abuse and addiction influenced by childhood trauma and/or dysfunctional relationships were common threads linking the women in the CIP. For many, substance use became the means of escape at an early age from immediate trauma and painful memory of past trauma.

For a woman with children, drug use is a particularly painful double bind. To escape its grip, which harms both herself and her children, she must admit her drug dependence to mistrusted institutions, which can result in the loss of custody of her children. As the 1999 CIP noted, "for the women with children, a continued source of stress was seen in how their drug use jeopardized both their rights to their children and their parenting abilities."⁴¹

Findings from national studies further underscore the complex relationship between drug use and HIV risk among women:

- (1) Women are likely to begin or maintain cocaine use in order to develop more intimate relationships, while men are likely to use the drug with male friends and in relation to the drug trade.
- (2) The onset of drug abuse is later for females and the paths are more complex than for males. For females there is typically a pattern of breakdown of individual, familial, and environmental protective factors.
- (3) Abuse and substance use are closely related for women. Approximately 70 percent of women in drug abuse treatment report histories of physical and sexual abuse with victimization beginning before 11 years of age and occurring repeatedly. A study of drug use among young women who became pregnant before reaching 18 years of age found that 32 percent of the women had a history of early forced sexual intercourse. These adolescents, compared with non-victims, used more crack, cocaine, and other drugs (except marijuana), had lower self-esteem, and engaged in a higher number of delinquent activities.
- (4) Although many women who partner with injection drug users are not themselves injection drug users, they are often users of other drugs including crack/cocaine.
- (5) Addiction to crack among women is associated with high-risk sexual behaviors,

such as the exchange of sex for drugs or money with concomitant increased risk for HIV infection and other sexually transmitted diseases.³⁰

d) Mental illness

Early studies provide evidence of unprotected sexual activity among women with mental illnesses, as indicated by the tripling of the birth rate among women with psychotic disorders since deinstitutionalization. Studies of family planning in the 1970s and early 1980s further substantiate this, indicating that most women with mental illnesses who are sexually active do not use contraceptives.³¹ This may relate in part to their lack of access to family planning services and gynecological care. In studies of sexual behavior related directly to HIV and AIDS, there is some indication that women with mental illness tend to have more partners than men. Among psychiatric outpatients, 42 percent of the sexually active women reported more than one partner, as compared to 19 percent of the men.³¹ Kim and colleagues found that, among a sample of psychiatric inpatients with a history of crack cocaine use, women continued to have more partners than men despite a reduced sex drive following regular crack use. This may relate to the fact that these women exchange sex for drugs or the money to buy them.⁴⁶

Trauma and substance use, as described above, are highly related to mental illness. Abuse and trauma shape a woman's perceptions of reality. If untreated, trauma can result in the severe psychological condition known as Post Traumatic Stress Disorder. Seeking to avoid any possible return of the abuse or trauma, women can become isolated, dissociated, and in search of a "protector." Tragically, this can also make them more vulnerable to future manipulation and abuse. In addition, women who experience a major depressive episode, generalized anxiety syndrome, panic attack, or agoraphobia (fear of being in an open space) in the past year are several times more likely to also have been

³⁰ Center for Substance Abuse Prevention. 1997. *Making the Connection Between Substance Abuse and HIV/AIDS for Women of Color and Youth*, www.health.org/sa-hiv/facts.htm.

³¹ Goldfinger, S.M.; Susser, E.; Roche, B; and Berkman, A. 1996. *HIV, Homelessness, and Serious Mental Illness: Implications for Policy and Practice*. Delmar, NY: National Center on Homelessness and Mental Illness.

dependent on non-prescribed drugs in the past year.³⁰

e) Power imbalances in relationships

Sexism pervasively affects the lives of women in Colorado. Increasingly, some women are rising above this oppression and defying the forces that constrain them. However, for some women, barriers to self-determination are daunting, and the forces constraining them overwhelm the forces supporting them. These women are the most vulnerable to HIV. Women of all socioeconomic classes struggle with sexism, but the oppression falls disproportionately on women in poverty. As one report put it, “The common denominator for poor, drug-using women appears to be their limited power to control the course of their lives. Women fare much worse than men not because of their gender but because of sexism: unequal power relations between the sexes. More often than not, assertion of power (no matter what context) is not even an option for poor women.”²⁸ Simply put; women in poverty stay entrapped in abusive relationships with men because they have few other options.

Locally, the 1999 CIP found that some women had supportive families, but for many, family and partners were sources of violence and, often, the catalysts for the initiation and maintenance of drug and alcohol use. A woman with dependent children is particularly vulnerable to domestic abuse, including abuse that involves HIV risk. She will endure high level of abuse if she believes the alternative –homelessness, in particular – will be worse for her children.⁴¹

Therefore, it’s important to realize that women have sex with men under a wide variety of circumstances. If one naively assumes that her only male sexual partner is her husband or long-time boyfriend, with whom she needs to learn “assertiveness skills” or simply “walk away from a bad relationship,” our services run the risk of being irrelevant to her living situation. She may, for instance, be exchanging sex for drugs or money, or she may be in a relationship based primarily on exploitation and violence.²⁷

f) Social isolation

Compared to other groups who have been disproportionately affected by HIV (gay men and IDUs), women living with or directly affected by HIV tend to have more difficulty finding peers with whom they can share concerns and from whom they can receive support. However one defines “peers” – age, culture, socioeconomic status, etc. – there are few groups and individuals reaching out to women and earning the trust of women.

3. General Barrier and Suitability Issues for Men Who Have Sex With Women

a) Low perception of personal risk

Perception of personal risk has long been associated with changing risky sexual practices. In the case of men who have sex with women, this perception is often very low; many men who have sex with women do not feel that they are at risk of HIV infection, even if the sex is unprotected. To some degree this perception is based on a widely held but erroneous belief that AIDS is exclusively a disease of gay men and injectors; thus, homophobia dissuades heterosexual men from seeking any prevention services. To some degree, however, this perception is also based on biological reality. Certain studies suggest that per-exposure transmission from man to woman during genital-genital intercourse is two to five times more efficient than from woman to man. Other investigations have prompted researchers to argue that HIV is up to 20 times more efficiently transmitted from men to women than vice versa. HIV is more highly concentrated in seminal fluids than in vaginal secretions and may more easily enter the bloodstream through the extensive convoluted lining of the vagina and cervix. Vulnerable penile surface area is much smaller – in circumcised men without genital ulceration, only the urethral meatus is involved; in uncircumcised men, this area as well as the skin under the foreskin are potentially vulnerable.³²

If men are less likely to become infected from their female partners, and they know they are less vulnerable, fear of infection is unlikely to prompt their safer behavior. For the more risk-

³² Simmons, J.; Farmer, P.; and Schoepf, B. “A Global Perspective,” in *Women, Poverty, and AIDS: Sex, Drugs, and Structural Violence*, P. Farmer, M. Connors, and J. Simmons, eds. Monroe, ME: Common Courage Press.

averse men, any degree of risk will be unacceptable, and they will protect themselves and their partners. For other men, only an exaggeration of risk will be sufficient, placing HIV prevention providers in a position that challenges their ethical responsibility to be accurate.

This biological reality calls into question recent legislation, in Colorado and elsewhere, which depicts female sex workers as “reservoirs of HIV” and “vectors” who pose imminent risk to uninfected, unsuspecting male customers. In reality, these women are at far greater risk of *becoming infected* by male customers who use physical and economic coercion to discourage condom use.

Of course, fear of HIV infection is not the only motivation for practicing safer sex. Some men are concerned about other possible consequences of unprotected sex: other STDs (including incurable viral STDs such as HPV and genital herpes) and unintended pregnancy are realities that men do face, and many men have peers who have faced these challenges. This calls upon STD clinics, family planning, and pregnancy prevention programs to not only target men, but to also employ behavioral interventions utilizing motivations that are meaningful to these men.

Some men also genuinely care about their partners and do not want to infect them. If they know they are infected with HIV, or have uncertainty about their infection status, they will correctly and consistently use condoms because they feel it is the right thing to do.

b) Substance use

Studies have consistently shown that injection drug use is the most common way that heterosexual men become infected. However, use of other, non-injected drugs have also been correlated with higher HIV rates among these men.

Why do heterosexual men use substances? In fact, heterosexual men (like gay men and women) use substances for a wide variety of reasons. The following non-exhaustive possible list of reasons was compiled by Milton Luger: some wish to relieve boredom; some think it exciting to taste forbidden fruits; some find that drugs relax them and diminish their stress and anxiety and prevent premature ejaculations; some think that they need the stimulation of the

drug for the energy and drive to tackle difficult tasks; some use drugs to feel more at ease socially, to lubricate their communication skills, and to convince themselves that they ‘belong,’ despite some perceived personal shortcomings and lack of self-confidence; some are convinced that drugs make them more aware of issues and give them ‘insights’ into, and a better understanding, of their baffling world; some seek hedonistic, pleasurable experiences with drugs; some are convinced that they are less hostile and angry under the influence of drugs; some mentally disturbed individuals self-medicate in an attempt to control their personal emotional chaos; some continue using drugs to avoid withdrawal symptoms; some use drugs to punish others of significance in their lives, whom they find it difficult to confront directly about past sexual, physical or emotional abuse; some have so much psychic pain from such abuse early in their lives that drugs help temporarily to block out the resultant feelings of worthlessness and self-hatred; some are convinced that they deserve the relaxed, winding-down effects of drugs after competing in their daily cut-throat jobs; some need drug euphoria to convince themselves that they are not failures; some are basically anti-social and rebellious in nature - drugs satisfy their need to make that statement; some individuals wish to drop out of a society in which they believe they have no stake, encouragement or future. Substance abuse also gratifies the need of some families to keep one of its members infantilized, dependent, or as a target for their scape-goating. These are the families who sabotage efforts at treatment. Furthermore, drug use serves the unscrupulous, criminal, and corrupt elements in society who reap its vast profits.³³

c) Heterosexual men, masculinity, and safer sex

To fully understand the dynamic between men and their female sex partners, one must understand the nature of masculinity, which varies considerably by culture and by region. No universal statement about masculinity can be made. However, in many cultures, a dominant form of masculinity is “culturally exalted.”

³³ Luger, M. 1989. “What Needs do Drugs Gratify? Alternative Ways of Meeting Those Needs.” Presentation at the November 1989 Drugs, the Law, and Medicine Summit, www.adocfund.org/library/drugs/drugs_summit.html.

While not all men conform to this dominant version, those who do not often find themselves discriminated against. Those who do subscribe to it benefit from what Connell calls “patriarchal dividend,” which includes honor, prestige, the right to command, and material advantage over women.³⁴ This, in turn, strongly colors gender relations and sometimes imposes barriers for intervening in practices that are risky.

Greater freedom, power and control characterize male sexuality across a wide spectrum of different cultures. Consider the following list of issues arising from “culturally exalted masculinity” and “patriarchal dividend:”

- (1) Some men cite “masculinity” to legitimize not only unequal roles and relationships between women and men, but also between men. They encourage us to see men who challenge this situation as effeminate, weak, subservient or immature. Despite being ostracized, some men will continue the challenge to change prevailing gender relations and inequalities. Other men will be silenced by the criticism.
- (2) Cross-cultural research suggests that men, in general, usually have a greater lifetime number of sexual partners and that there are clear double standards regarding the behavior of men and women. For example, while in many cultures women are expected to preserve their virginity until marriage, young men are encouraged to gain sexual experience. Indeed, having had many sexual relationships may make a man popular and important in the eyes of his peers.
- (3) Male sexuality is often thought of by both men and women as unrestrained and unrestrainable, and among some men an STD is considered a badge of honor that confirms manhood.
- (4) In some cultural contexts, the roots of homophobia are not about sex per se, but more about “men taking the role of women” and thus becoming subservient.
- (5) Heterosexual anal sex is commonly assumed to be a method of preserving virginity and preventing pregnancy. However, recent studies suggest that for some men at least, anal sex may also be symbolic of increased

power and control over women. For men interviewed, anal sex was seen as a ‘conquest’ to be equated with ‘taking’ a woman’s virginity for a second time.

- (6) Some have suggested that masculinity itself is threatened by condom use. There are several reasons for this: first, if condom use is requested by a woman this allows women to define the terms of sexual engagement; second, condom use may involve men having to deprioritize their own sexual pleasure; third, for men to demonstrate a degree of control over sexual behavior may be feminizing since male sexuality is most usually understood as uncontrollable; and finally, risk-taking in itself is considered to be typically masculine.
- (7) Some men may be reluctant to use condoms with regular sex partners because this necessitates addressing fidelity issues, both in terms of admitting additional sex partners or condoning multiple partners of female sex partners.
- (8) Non-penetrative sex is rarely an option in heterosexual relationships since vaginal sex tends to be understood as adult sex, and other forms of sexual pleasure may be seen as a kind of backsliding into adolescence. This may explain, at least in part, why HIV prevention programs very rarely suggest “giving up vaginal sex” as a viable risk-reduction option for heterosexuals, but commonly suggest “giving up anal sex” as a viable option in programs designed for men who have sex with men.

Rivers⁴⁹ summarizes the situation as follows: “In order to avoid the problems which come from failing to conform to dominant gender stereotypes, women risk the damage associated with conformity. Men on the other hand may find that by conforming to stereotypical versions of masculinity, they place themselves and their partners at heightened risk. These contradictions need to be exposed so as to identify the dividend that accrues to both women and men when existing gender roles are transformed or cease to be obeyed. By working to show how many men do not meet idealized forms of masculinity, discussion about how some men are marginalized can begin to take place.”

In a similar vein, Cornwall³³ observes “If gender is to be everybody’s issue, then we need to find constructive ways of working with men as well

³⁴ Rivers, K. and Aggleton, P. 1999. *Men and the Epidemic*. London: Thomas Coram Research Unit, Institute of Education, University of London, www.undp.org/publications/gender/mene.htm.

as with women to build confidence to do things differently.”

d) MSM who have sex with women

AIDS case reports and behavioral studies based on convenience samples suggest that behaviorally bisexual men use condoms inconsistently with male and female partners, seldom disclose their bisexuality to their female partners, and are more likely than exclusively homosexual men to report multiple HIV risk behaviors. Male bisexuality may present greatest HIV risk in the context of a) male prostitution, b) injecting drug use, c) sexual identity exploration, and d) culturally specific gender roles and norms such as those that may characterize some African American and Latino communities in the United States.³⁵ For instance, a survey of men who have sex with men and women found that 54 percent of their female partners did not know about their homosexual activity and 65 percent of the men had engaged in unprotected sex with their female partners.

e) Male injectors who have sex with women

According to published research, most male IDUs are sexually active and heterosexual, and significant proportions have multiple female partners.³⁶ In one sample, while white males were about as likely to have an IDU partner as a non-IDU partner, only a third of the African-American males reported having a female IDU partner during the preceding year, while 85 percent reported having a female non-IDU partner. African-American males were more likely than white males to have sex with a non-IDU female and were more likely than whites to have multiple non-IDU female partners. This is NOT to say that women of color are less likely to be infected. Rather, it means that white males were more likely to have multiple IDU female partners.

Several studies have reported the low use of condoms among heterosexual male IDUs. Ross and colleagues compared IDUs across sexual orientation groups and reported that, compared to

gay and bisexual male IDUs, heterosexual male IDUs were the least likely to use condoms. Reported rates of condom use vary by study; however, most report nonuse at more than two-thirds.⁵¹

Watkins and colleagues⁵¹ compared in- and out-of-treatment IDUs on their sexual risk behaviors. Out-of-treatment IDUs reported significantly more partners than in-treatment IDUs and more often exchange sex for money or drugs. Alcabas and colleagues⁵¹ also compared in-treatment to out-of-treatment IDU samples and found that the out-of-treatment IDUs tended to be younger, male, and African American. However, associations between HIV-1 seropositivity and a series of demographic and drug-using characteristics were similar in direction and magnitude among subjects currently in treatment and those not in treatment. Lewis and Watters⁵¹ reported that sexual risk-taking behavior in a sample of IDUs was associated with recent increases in both injecting and smoking cocaine.

4. Barrier and suitability issues for people of color

a) Latinos/as at risk through heterosexual contact

Researchers Marin and Gomez³⁷ have noted the following characteristics of Latino culture that relate to HIV risk and barriers to risk reduction:

(1) Men in Latino communities may have more sexual partners

When surveyed, Latina women report fewer sexual partners in the previous twelve months as compared to non-Latino whites of either gender or Latino men. Marin and Gomez conducted a nine-state phone interview that found twice as many married Latino men reported multiple sexual partners in the previous year as non-Latino white married men (18% versus 9%). In addition, the interview found that 60 percent of unmarried Latino men reported multiple sexual partners in the past 12 months.⁵²

(2) Condom use is not popular among Latinos and Latinas

³⁵ Doll, L.S. and Beeker, C. 1996. “Male Bisexual Behavior and HIV Risk in the United States: Synthesis of Research with Implications for Behavioral Interventions,” *AIDS Education and Prevention*, 1999 June, 8(3): 205-25.

³⁶ Stephens, R.C and Alemagno, S.A. *Injection and Sexual Risk Behaviors of Male Heterosexual Injection Drug Users*. NIDA Monograph 143.

³⁷ Van Oss Marin, B. and C. Gomez. 1998. “Latinos and HIV: Cultural Issues in AIDS Prevention,” in *The AIDS Knowledge Base*. Internet document published by University of California San Francisco, <http://hivinsite.ucsf.edu>.

Latino men and women who have multiple partners are equally likely to report condom use with a secondary partner, but they are far less likely to use condoms consistently with a primary partner. Studies suggest that men in Latin American countries perceive condoms as more appropriate outside of marriage. Less acculturated Latinas report carrying condoms less frequently and using condoms less as compared to more highly acculturated women. Those Latinas who reported less condom use with steady male partners also reported higher expectations that the partner would be angry if condom use were requested, were more likely to use some other birth-control method, had less confidence in their ability to use condoms, reported a more negative attitude toward condom use, had fewer friends who use condoms, and had less knowledge of how to use a condom than those who reported more condom use.⁵²

(3) *Anal sex, while not exclusive to Latinos and Latinas, is perhaps more common among Latinos and Latinas.*

A national representative survey of men's sexual behavior found Hispanic men far more likely than non-Latinos to report anal sex, with more partners, and occurring more frequently.⁵² In a broad national study conducted by Laumann,³⁸ 12.5 percent of Hispanic women reported engaging in anal sex in the last year, compared to 8.4 percent of White women and 6 percent of Black women. Laumann's study also showed that 18.9 percent of Hispanic men reported engaging in anal sex in the last year compared to 8.3 percent of White men and 9.7 percent of Black men.

(4) *Discomfort discussing some sexual matters, especially condom use, is part of Latino culture.*

Privacy issues appear to be more sensitive in Latino culture than in non-Latino white culture. Sexual issues are often avoided even between sexual partners. In traditional Latino households, the "good" woman is not supposed to know about sex, discouraging her to bring up subjects like AIDS and condoms. Latinos report significantly more discomfort regarding sexual matters than non-Latino whites. In a national survey, 19 percent of unmarried Latinos

surveyed reported feeling uncomfortable discussing condoms with a sexual partner, a rate of discomfort significantly higher than among non-Latino whites.³⁶ Such sexual discomfort and embarrassment has been associated with less frequently carrying condoms and with lower perceived ability to use condoms.⁵² Despite a strong emphasis on family interactions, Latinos are currently less likely than other groups to provide their children with critical information about sex and AIDS.⁵² Overall, this barrier appears related to four areas: sexual socialization, lack of information about sexuality, degree of openness about sexual behaviors, and other pressing issues.⁵²

(5) *Latinos tend to subscribe to very traditional beliefs about gender roles.*

According to traditional gender role beliefs, Latino men are to be highly sexual.⁴⁸ In a survey of the 10 states in which 87 percent of Latinos reside, 69 percent of unmarried Latino adults agreed that "Men want to have sex more often than women" and 51 percent disagreed that "Men can control their sexual desires as easily as women."⁵² There is strong evidence that traditional gender roles in Latino culture condone sexual coercion.⁵² In a 10-state survey, 30 percent of men reported lying to get sex, while more than 50 percent said they insisted on sex when their partner wasn't interested (and a comparable proportion of women reported their partners insisted on sex when they weren't interested).⁵² Those men who reported more traditional gender role beliefs also reported greater sexual coercion, defined here as lying and pressuring a woman to have sex when she's not interested. Marin and Gomez express their concern about a core set of beliefs, including "beliefs about the inability of men to control sexual impulses and the belief that women should please men rather than consider their own desires and needs, beliefs that simultaneously make men more coercive and women more submissive. These beliefs are so widespread that many Latino men and women would probably not perceive as coercive a situation in which a man insists on sex when the woman is not interested." Latino men who reported multiple sexual partners in the 12 months prior to interview reported even greater levels of traditional gender roles and sexual coercion than those who reported only one partner.⁵²

b) African Americans at risk through heterosexual contact

³⁸ Laumann, E.O.; Gagnon, J.H.; Michael, R.T.; and Michaels, S. 1994. *The Social Organization of Sexuality: Sexual Practices in the United States*. Chicago: University of Chicago Press.

(1) *African Americans mistrust institutional public health due to past abuses ostensibly preventing sexually transmitted diseases.*

[See page 18, *African Americans that mistrust institutional public health due to past abuses.*]

Interventions obviously targeting African Americans (such as condoms with “African motif” wrappers) are viewed with suspicion, and when AIDS drugs produce side effects, they are suspected as causing AIDS.

(2) *African Americans are disproportionately affected by social upheaval and displacement, which are directly linked to enhanced vulnerability to drug use and HIV.*

HIV among Colorado’s African American citizens is highly concentrated in urban Denver. Wallace⁵⁴ has studied social upheaval in rapidly changing urban environments such as Denver, and has come to a number of conclusions about its relationship to the HIV and substance use epidemics among African Americans.

Such communities are overwhelmed with a multitude of social ills, from violence to homelessness, and residents find it difficult to rally scarce resources to deal with concerns like HIV, which seem to be less immediate. With people moving quickly in and out of neighborhoods, little community cohesion develops. Programs must attempt to constantly educate and re-educate an ever-changing community, and such programs are also extremely difficult to establish and maintain in neighborhoods that lack people who plan to remain for the long term. When people do move to other locations, they often take a long period of time to adjust to their new neighborhoods. During this transition time, they tend to be socially isolated from friends, peers, extended family, and potential service providers.

(3) *African American male IDUs tend to have non-IDU sexual partners.*

As mentioned previously, only a third of the African-American males in one study reported having a female IDU partner during the preceding year, compared to about half of white male IDUs.⁵¹ In the same study, 85 percent of African American IDUs reported having a female non-IDU partner. African-American males were more likely than white males to have sex with a non-IDU female and were more likely than whites to have multiple non-IDU female partners.

(4) *Although poverty is highly linked to HIV in heterosexuals of all races and ethnicities, poverty rates among African American women living with HIV are notably higher.*

In a study of 2,898 persons living with AIDS in 11 states (including Colorado), African American female people living with AIDS (PWAs) infected heterosexually were more likely to have completed less than 12 years of education (51%), be unemployed (89%) and be living in households with incomes under \$10,000 (81%). In comparison, these same rates were much lower among white women living with HIV (31% with less than 12 years of education, 81 percent unemployed, and 49 percent living in households with less than \$10,000 income). In both cases, however, these rates were much worse than national averages for women (22% with less than 12 years of education, 7% unemployed, and 15% living in households with less than \$10,000 income).³⁹

In a California study, it was found that the cumulative incidence of AIDS among African American, Latina and White women is highest for women residing in zip codes with the lowest median household income level. However, the survey also found that for African American women, residing in the higher income zip code areas did not appear to reduce the risk of AIDS compared with those living in a lower income zip code areas. As zip code income level increased, the cumulative incidence of AIDS did not steadily decrease among African American women. This was only true for African American women; AIDS incidences significantly decreased as income increased for all other racial/ethnic groups of women.⁴⁵

(5) *Young African Americans continue to be challenged by gang and social activities that involve drug use and substantial HIV risk.*

House parties, sometimes known as “orgy parties,” are increasing in popularity in African American communities. Gang initiation is also a common occurrence. Both of these activities often involve young people involved in high risk sexual and drug use behaviors, usually without condoms or other risk reduction.

³⁹ Diaz, T.; Chu, S.Y.; Buehler, J.W.; et al. 1994. “Socioeconomic Differences Among People With AIDS: Results From a Multistate Surveillance Project,” *American Journal of Preventive Medicine*, 10(4), pp. 217–22.

Substantial drug experimentation is driving this increasing “party culture.” New mixtures of cocaine, codeine, and fruit juices or soft drinks have come into vogue. These drugs can enhance sexual risk taking and encourage sexual exploitation of women.

c) Native Americans/American Indians at risk through heterosexual contact

[See page 18, *Native American/American Indian.*]

The general health status of Native Americans is lower in almost every national health indicator. Substance use, primarily alcohol use, accounts for most of the top ten causes of early death, either directly or indirectly. STDs such as gonorrhea, syphilis, and chlamydia are, on average, twice as high for Native Americans as for the US population as a whole; in some areas, the rates are seven to ten times higher. Sexual activity starts early, as evidenced by teen pregnancy rates; 20 to 25 percent of Native American babies are born to mothers 18 years of age or younger. As noted by the National Commission on AIDS, “STD rates may be higher for Native Americans because of high rates of substance use, overall poor socioeconomic conditions, and lack of access to the level of health care enjoyed by other Americans. It has been only within the past year that any movement has occurred within the Indian Health Service to begin an aggressive campaign to prevent STDs and to intervene early in the course of the infection.”⁴⁰

d) Asian Americans/Pacific Islanders at risk through heterosexual contact

[See pages 18 – 19, *Asian American/Pacific Islander*] Additional principles recommended when working with API at risk through heterosexual contact:

- Target settings associated with health (e.g., traditional Chinese pharmacies).
- For API women, protecting family and community may be a compelling reason to reduce risk. In addition, strategies should consider empowering women with their male partners present, incorporating parenting skills, and targeting entire

residential buildings or apartment complexes where there are many API families living.

- Leadership may be where it is not usually expected (e.g., grocery store owners in API neighborhoods).
- To work through API social networks, repeated contact is essential.
- Power imbalances and gender role ideology are particularly evident in some API cultures, particularly among recent immigrants.

5. Barrier and suitability issues for rural residents

Rural communities can provide their members both strong support and strong condemnation at times. In rural areas, low perceptions of HIV risk, traditional moral values, conformity to community norms and intolerance of diversity can be strong. In some cases, HIV education for the community in general is hindered due to homophobia, racism, sexism, and stigmatization of people with AIDS, homosexuals, minorities and drug users.⁴¹ Over time, stigma attached to one or more of these groups rises and falls, but never disappears entirely.

Confidentiality can be hard to maintain in rural areas, yet is crucial for many residents due to fear of stigmatization. Testing for HIV, accessing HIV-related care, discussing sexual practices with clinicians, obtaining drug treatment, or buying condoms in local stores—all important preventive activities—can be difficult to do confidentially in rural areas.⁵⁹

Two issues concerning confidentiality can also impact the effectiveness of certain methods of intervention. First it tends to be a barrier to Group Level Interventions (GLI) in communities where it is unacceptable to identify with a group so stigmatized by the local population, and secondly it tends to be a barrier to GLI to discuss matters of personal risk in group settings where every one knows each other. In such cases, information obtained from interviews and focus groups in District four and eight has shown that potential clients prefer Individual Level Interventions (ILI).

⁴⁰ National Commission on AIDS. 1992. *The Challenge of HIV/AIDS in Communities of Color: The American Indian and Alaskan Native Community*, http://hivinsite.ucsf.edu/topics/native_americans/2098.2b78.html.

⁴¹ Center for AIDS Prevention Studies, University of California, San Francisco. 1997. *What Are Rural HIV Prevention Needs?* San Francisco: UCSF.

Health care providers are the primary source for health education and prevention counseling in many rural areas. However, rural clinicians may believe that HIV is not a problem in their area, may not conduct proper risk assessments of patients, and may not properly diagnose cases. Rural physicians may also be reluctant to become known as “the AIDS doctor” for fear of scaring off other patients.⁵⁹

In addition to addressing prevention issues in their own areas, rural service providers must also address issues surrounding residents who travel to urban areas and may engage in high risk sexual or drug using behavior while there. Rural health care and prevention providers are also burdened by the migration of HIV positive patients who may have become infected in urban centers and returned home to rural areas for family support.⁵⁹

Geographic and climactic conditions can hinder access to preventive services, especially in rural Colorado. Many rural residents do not have access to transportation, and for those who do, rugged topography, severe winters and long distances between towns can mean traveling several hours for medical care, HIV prevention, or social services.⁵⁹ Due to rural economic conditions, establishing new services is often not feasible, nor is it possible to expand services that are highly related to HIV, such as one-on-one counseling and services for women in abusive relationships. It is certainly not because such services are not needed; for example, Laumann’s large-scale study of sexual practices found a higher rate of forced sex reported by rural women (18%) compared to urban women (16%).⁵³

Schools are one of the few venues available to educate adolescents about HIV/STD prevention in rural areas, but are even more likely to be closed off due to the factors described in section six, below.

For many seasonal migrant farm workers, poverty, lack of access to health care services and isolation have hampered HIV prevention efforts. Recent anti-immigrant laws, including mandatory HIV testing, have driven many at-risk migrant workers into an underground way of life and have made it hard to offer services to these workers.⁴³

Need for safer sex materials distribution/availability based on needs assessment results, low socio-economic status of rural communities and confidentiality issues.

Please see notice regarding need for safer sex materials in rural areas as described on page 34.

6) Barrier and suitability issues for young men who have sex with women and young women who have sex with men

Unprotected sexual intercourse puts young people at risk not only for HIV, but also for other sexually transmitted diseases and unintended pregnancy. Currently, adolescents are experiencing skyrocketing rates of STDs. Every year three million teens, or almost a quarter of all sexually experienced teens, will contract an STD. Chlamydia and gonorrhea are more common among teens than among older adults. Some sexually active young Latinas and African American women are at very high risk for HIV infection, especially those from poorer neighborhoods. A study of disadvantaged out-of-school youth in the US Job Corps found that young African American women had the highest rate of HIV infection, and that women 16 - 18 years old had 50 percent higher rates of infection than young men. Another study of African American and Latina adolescent females found that young women with older boyfriends (three years older or more) are at higher risk for HIV.⁴⁵

Adolescence is a developmental period marked by discovery and experimentation that comes with a myriad of physical and emotional changes. Sexual behavior and/or drug use are often a part of this exploration. During this time of growth and change, young people get mixed messages. Teens are urged to remain abstinent while surrounded by images on television, movies and magazines of glamorous people having sex, smoking and drinking. Double standards exist for girls, who are expected to remain virgins, and boys, who are pressured to prove their manhood through sexual activity and aggressiveness. And in the name of culture, religion or morality, young people are often denied access to information about their bodies and health risks that can help keep them safe.

A recent national survey of teens in school showed that from 1991 to 1997, the prevalence of sexually activity decreased 15 percent for male students, 13 percent for White students and

11 percent for African American students. However, sexual experience among female students and Latino students did not decrease. Condom use increased 23 percent among sexually active students. However, only about half of sexually active students (57%) used condoms during their last sexual intercourse.⁴²

Not all adolescents are equally at risk for HIV infection. Teens are not a homogenous group, and various subgroups of teens participate in higher rates of unprotected sexual activity and substance use, making them especially vulnerable to HIV and other STDs. These include teens that are gay/exploring same-sex relationships, drug users, juvenile offenders, school dropouts, runaways, homeless, or migrant youth. These youth are often hard to reach for prevention and education efforts since they may not attend school on a regular basis, and have limited access to health care and service-delivery systems. Youth who are not in school have higher frequencies of behaviors that put them at risk for HIV/STDs, and are less accessible by prevention efforts. A national survey of youth aged 12 - 19 found that nine percent were out-of-school. Out-of-school youth were significantly more likely than in-school youth to have had sexual intercourse, have had four or more sex

partners, and have used alcohol, marijuana and cocaine.⁶⁰

School district policies restrict sex education in schools and limit what teachers, health educators, and invited speakers can say to students, including discussing condom use, drug use and homosexuality. A Colorado law also requires parents to “opt in” students for sexuality education classes, and this is expected to discourage attendance in these courses. Exclusive insistence on abstinence, which predominates as a matter of policy at Colorado Department of Education and other statewide and local agencies, is not conducive to open and frank discussions of HIV shown to be critical components of effective programming.

a) Young men who have sex with women

Overall, messages delivered to and internalized by young men pose serious challenges to anyone attempting to minimize their risk of acquiring or infecting their female partners with HIV. Young men are seldom mentored about respectful sexual behavior, that sex should never be abusive to themselves or their partners. Instead, for too many of these young men, consequences are minimized and sexual exploits are celebrated with no discussion of responsibility.

While males initiate sexual activity earlier than females, overall patterns are similar, with dramatic increases in sexual activity occurring at age 14 for males and age 15 for females; the percentages become equal around age 16. Adolescent males are four times more likely than adolescent females to report having three or more sexual partners; those who report more than two sexual partners in the last year are significantly less likely to use condoms consistently. Almost 20 percent of teen males report never using condoms while only 30 percent use them at every sexual encounter. In a national survey, only seven percent of teen males reported their partner using female-controlled contraceptive methods. Both young men and women agree that when condoms are used, males generally are the ones to obtain and provide them.⁶⁰

Adolescence and young adulthood are times of experimentation and overwhelming role confusion. Of male adolescents who reported same-sex intercourse, one study found that 54 percent identified themselves as gay, 23 percent as bisexual, and 23 percent as heterosexual. In

⁴² Advocates for Youth. 2000. *Adolescent Males: Sexual Attitudes and Behaviors*, www.pcisys.net/~health_ed/adolescentmales.html.

part, this is due to the nature of the “coming out” process when one’s peers display high degrees of homophobia. Other youth may have not yet considered the question of sexual orientation, or are simply experimenting with different sexual behaviors.⁴³ Too often, this form of exploratory sex is not protected.

Only about half of young males in one survey discussed sexuality issues with a parent compared to 75 percent of young females. Parent and daughters communicated far more frequently than parents and sons on sexual facts, sociosexual issues and morality. Only 45 percent of teen males surveyed said they had studied the topics of biology, birth control, AIDS, and negotiation skills; five percent said they had studied none of these topics.⁶⁰

Adolescent males (84%) are significantly less likely to report feeling comfortable refusing sex than are females (91%). Among college students, males are less likely than females to believe that men are always responsible for their own actions regardless of how sexually provocative they find a situation. Adolescent males (26%) are significantly more likely than females (seven percent) to feel pressure from friends to have sex; whereas teenage women report more often feeling pressured into sex by male partners. Thirty-two percent of teenage males say they have non-forced sexual experiences that they have regretted, compared to eight percent of teen females.⁶⁰

A survey of California high school students found that more males than females knew about STD prevention and correct condom use. Seventeen percent of teenage males report worrying about AIDS “all the time” and 22 percent worry “frequently”. Only six percent think they have a “very strong” or “strong” chance of HIV infection. Frequency of worry about AIDS was significantly associated with condom use. One survey found that over 90 percent of high school males thought preventing HIV was equally (46%) or more (48%) important than preventing pregnancy. As knowledge regarding AIDS increased, the young men placed less importance on pregnancy prevention.⁶⁰

⁴³ Advocates for Youth. 1999. *Young Men Who Have Sex With Men: At Risk For HIV and STDs*, www.advocatesforyouth.org.

A 1993 survey found that 76 percent of boys have been sexually harassed in school compared to 85 percent of girls. While girls are likely to suffer more emotional effects from harassment, boys are more likely to be harassed in locker rooms, to be called gay, and to avoid telling anyone. National estimates indicate that 15 percent of males have been sexually abused as children compared to the estimate of 28 percent for females. *Male victims of childhood sexual abuse are at twice the risk of HIV infection as male non-victims and are at increased risk of substance abuse.*⁶⁰

Adolescent males are three times more likely than females to accept the rape myths common in our culture and to find coerced sex more acceptable in more situations. Such rape myths include belief that their female partners provoked the rape and that they will be able to evade consequences even if accused of rape. While 70 percent of male college undergraduates in one study did not believe that date rape was a serious offense, another study found that educating adolescent males about rape can be effective in changing attitudes about coercive sex.⁶⁰

b) Young women who have sex with men

Young women who have sex with men experience many of the same barriers and challenges mentioned earlier in this chapter. Domestic abuse, both physical and emotional abuse, is a pervasive reality, particularly when their boyfriends are older than they are. They experience pressure to submit to sex or become unpopular, and the boundaries between girlhood and womanhood are becoming increasingly blurred. They receive messages, directly and indirectly, that being female is inferior. They receive messages that virginity is highly prized – and that it can be preserved through risky, unprotected anal sex. They also receive contradictory messages – that being a virgin indicates that a girl is not popular with the boys.

Voices of a Generation: Teenage Girls on Sex, School, and Self, a report released by the American Association of University Women (AAUW) Educational Foundation, describes and analyzes differences among girls’ responses by race, ethnicity, and region. This report is based on Sister-to-Sister Summits sponsored nationwide by AAUW to bring together teenage girls ages 11 - 17 to talk openly with each other about the most important issues they face today. From November 1997 to November 1998, girls

participating in these summits answered six questions about their daily lives. The report is a detailed analysis of responses by 2,100 girls.⁴⁴

According to the report, girls want to learn how to say no to sex and still say yes to intimacy. Sex and pregnancy are the number one issues facing teenage girls today. While the majority of girls list sex and boys as major issues in their lives, only a handful of girls discuss “love” or “sexuality.” One girl suggests that schools should “educate everyone that there are other ways of showing affection besides sex.” Girls say they need the tools to learn how to say no and how to negotiate emotionally charged relationships.

The report also reports that girls admit that sexual pressure comes not just from boys but from other girls, from their friends, and from the media. Astoundingly, the only age group not to mention “pressure to have sex” at all is the 11 year-olds. While the pressure on teenage girls to have sex at an early age knows no ethnic, racial, or geographic bounds, African American and Hispanic girls cite pregnancy as an issue in their lives more than white and Asian American girls and do so at a younger age. African American and Hispanic girls describe pregnancy as a “choice,” though not one they generally condone, while white and Asian American girls describe it as an “accident” and caution against the “risks” and “dangers” of sex. These results call for strengthened linkages with pregnancy prevention programs.

Only a small number of girls voice concern about birth control, abortion, and AIDS despite all their talk about sex. As noted in *Voices of a Generation*, “Girls want to learn how to say ‘yes’ to relationships without automatically saying ‘yes’ to sex. They don’t want sex to be an all or nothing issue. They’re missing the middle ground of affection, intimacy, and relationships.”

Teenage girls face many conflicting pressures – pressure to fit in, to look and act a certain way, to have sex, do drugs, and drink. The pressure to be popular and cool competes against the hidden “authentic” self that many girls admit they repress to be included. White and Asian

American girls talk about the “pressure to fit in” far more than Hispanic and African American girls. A number of girls talk about the climate of sexual harassment in schools. Girls frequently cite incidents of boys as young as 12 or 13 calling girls “bitches,” “sluts,” and “whores” or making crude requests for sex. One 13 year-old writes: “Once someone told me to have sex with them, and when I didn’t because I’m not that kind of girl ... they called me a bitch and a lesbian.”

Girls feel torn between a traditional view of femininity and the contemporary realities of being a woman. As one girl writes, “Girls need a clear definition of girls or women. We are encouraged to be assertive through TV, magazines, and some adults, but we’re punished indirectly by the world when we do.” The report also finds that many girls point their fingers at the media for promoting a very narrow, restrictive image of women and girls as skinny, sexually alluring, and popular to the exclusion of more important attributes and values. A summit participant writes, “...Media messages tell us to be a certain shape and size, our friends and peers want us to like certain things, our parents wish we’d act a specific way. With all the different messages from all different angles, it is sometimes hard for a girl just to find the person she really is.”

Many girls note that the problems and issues they face are related to boys. The girls propose innovative boy-girl summits to address these issues together and better learn to understand each other.

Girls need real tools to help them navigate the stormy waters of teen sexuality. They call on schools to move beyond “just say no” and abstinence training to help them better understand the complex social and emotional nature of relationships, not just the basic anatomy and biology of sex.

7. Transgender and gender variant people

[See page 19 – 20, *Transgender and Gender Variant People*.]

8. Disabled people at risk through heterosexual contact

a) General barriers faced by people with disabilities

[See page 20 – 23, *People with Disabilities*.] In addition, disabled persons may be more prone to the use of drugs (prescription and non-

⁴⁴ American Association of University Women. 1999. *Voices of A Generation: Teenage Girls on Sex, School, and Self*. Washington, DC: AAUW Educational Foundation.

prescription) for the alleviation of pain, and the drug use has been demonstrated to be highly related to HIV risk.

9. Barrier and suitability issues when one or both sexual partners are living with HIV

A recent study of 175 serodiscordant opposite-sex couples⁴⁵ revealed important information about the barriers they face, which fall under four general headings:

- Communication about HIV
- Keeping sex alive
- Involving/engaging the male partner
- Providing support and counseling to the HIV negative partner.

a) **Communication about HIV**

“Outside” response to a couples’ serodiscordance was a common concern. Stigma was experienced at the level of family, friends, and community. Some struggled with the public exposure of the relationship, and many felt unsupported in their relationship by some family members and friends: Difficulty with disclosure of both the HIV positive partner’s status and the mixed serostatus in the relationship were frequently mentioned. Internalized stigma impacted couple’s ability to communicate about HIV in their relationships.

Managing HIV meant managing identification in the relationship as either the HIV infected or uninfected partner. Differences in roles and identities of the HIV negative and HIV positive partner was alienating at times and impeded communication about HIV.

b) **Keeping sex alive**

Many participants received skills and support through the Partner Study to lead a healthy and active sexual life after the HIV diagnosis of a partner. This was an important validation for those who felt pressure to end all sexual activity or their relationship because of HIV. Many HIV positive partners described a process of sexual abdications immediately after testing HIV positive.

There were many couples in which HIV positive partners reported worry and fear about infecting their HIV negative partners. This presented an on-going struggle with the role of sex in the relationship. Even participants who consistently practiced safer sex, described the struggle between the “rationality” of lower risk safer sex and the “irrationality” of fear and guilt associated with sexual intercourse with negative partners.

The Partners Study helped alleviate sexual loss through risk reduction counseling, regular HIV testing for the negative partner, and epidemiological knowledge about HIV transmission. This knowledge helped to normalize HIV in sexual relationships, combating stigma and increasing relationship comfort.

Overall, HIV risk management strategies ranged from the adoption of consistent safer sex practices for some couples to the perception of immunity from HIV infection for others. Regular study visits provided an opportunity to talk about HIV and a “reality check” that helped maintain safer sex practices for some couples. Participants described the challenge of translating the knowledge about HIV into their sexual relationship as a double-edged sword that could help or harm their ability to consistently practice safer sex. Couples use of knowledge of HIV transmission illuminated the conflict between generalized epidemiological facts and behavior in a single serodiscordant relationship. Ever changing “facts” about HIV also created problems within couples in the management of HIV (such as inconsistent messages about the relative safety of oral sex).

c) **Involving/engaging the male partner**

Both women and men interviewed explained that the woman partner in the relationship was responsible for involving her male partner in the study. Study participation helped women to engage otherwise unresponsive male partners. Study participant’s statements were particularly enlightening in this regard:

“It [the Partner Study] was his only contact with anything to do with HIV. It was very minimal, but at least it was something and I think that’s it. (HIV positive woman)”

“It was very difficult to get my husband to do anything. So it was the only thing actually that

⁴⁵ van der Straten A; Vernon KA; Knight KR; Gomez CA; Padian NS. 1998. "Managing HIV among serodiscordant heterosexual couples: serostatus, stigma and sex." *AIDS Care*, Oct, 10(5):533-48.

I could do for myself and indirectly he could benefit. (HIV negative woman)”

“My husband’s not a real social creature and, so I think it was really important for him to be involved in just getting this information, but I think it was really important to me. I tend to be the conduit through which we stay connected to things. (HIV negative woman)”

Though not specifically cited in the study, other possible reasons for male reluctance to fully participate in HIV prevention programs might be fear of losing one’s female partner and being unable to find a new one and discomfort accessing services from a “gay-identified” provider.

d) Providing support and counseling to the HIV negative partner

The management of HIV was a “couple issue.” Yet, many participants reported feeling that appropriate couple services, particularly for heterosexuals, were unavailable. This was particularly true of HIV negative women who expressed a great need for counseling and support.

Sharing of Needles and Other Injection Paraphernalia

1. Overall Findings from the 2000 Client Survey and 1997 Community Identification Project

Ten injectors responded to the *2000 Client Survey*, in which they had an opportunity to describe the barriers they face and the characteristics of HIV prevention programs they perceive as suitable. This is a very small sample, and generalization should be done only with caution.

As might be expected, the injector respondents expressed a strong need for free, clean needles and affordable, respectful substance abuse treatment. These respondents were also over five times more likely than non-injectors to indicate a need to meet with a counselor one-on-one to deal with life problems that are more important to them than HIV (i.e., PCM).

In terms of service suitability, two criteria emerged as more statistically more important to these respondents in choosing an agency as their HIV prevention service provider:

- The agencies are set up for injectors.
- I know the agencies won't turn me into the police.

In terms of barriers, the ten injector respondents were over six times more likely than non-injector respondents to voice the barrier "The agencies only deal with HIV, and I need other services, too."

In a separate 1997 community identification project (CIP) studying injectors in nine Colorado communities, respondents cited a number of additional barriers:

- No perceived need for services
- Lack of money
- Not knowing where services are
- Services perceived as ineffective
- Lacked of medicated detoxification in the state
- Stigma associated with going to health care settings
- Won't access services until desperate for help
- For female IDUs, fear of losing their children.

When asked what would make services more suitable, respondents cited the following:

- Lowering of costs

- Granting clients more respect
- Assuring clients that there will be no consequences
- Syringe exchange available
- Expanded hours of service, possibly at night or on weekends
- Better inpatient treatment
- Increased advertising
- More convenient locations
- Better referral system.⁴⁶

2. General Barrier and Suitability Issues for Injectors

Pervasive social and cultural attitudes about drug use impose strong barriers dissuading injectors from accessing prevention services and subsequently reducing risky behaviors.

a) Barriers due to the perceptions of drug use and drug treatment practices

To effectively prevent HIV infection due to the sharing of needles and other injection paraphernalia, it is necessary to have some level of understanding of drug use and drug dependence. Without extensive training, HIV prevention providers cannot be expected to become drug treatment and drug prevention experts. However, without at least minimal grounding in the broader field of addictions, HIV prevention providers may take approaches that are neither effective ways to minimize the harm of drug use nor compatible with effective HIV prevention.

Over time, various models have dominated the addiction field, each of which has shaped treatment practice, especially at the time of its pre-eminence. The earliest model, the Moral Model, focuses on drug use as sinful and/or criminal behavior, implying that drug users required moral direction and social sanctions. The Temperance Model, which emphasizes the harmful nature of the drug itself, and the need for prohibition and other supply reduction followed this chronologically. The next model, the Disease Model, holds that people who are addicted to drugs have irreversible constitutional abnormalities, for which lifelong abstinence is the only answer; the Alcoholic and Narcotics

⁴⁶ Wolff, Wendy. 1997. *Cooperative Research Project*. Denver: Colorado Dept of Public Health and Environment.

Anonymous movements arose from this model. The Disease Model has been subsequently expanded to include educational, psychotherapeutic, operant conditioning, and biomedical interventions provided in a medical or quasi-medical manner (diagnosis, prescription, cure or long-term supervised disease management). The main alternative to the Disease Model has been the Sociocultural Model, which attempts to modify environmental factors and cultural norms that are associated with drug use, mostly through community interventions and social policy change. In recent years, hybrids of the Disease and Sociocultural Models have emerged, acknowledging that addiction is, in fact, an individual disease with complex cultural and environmental aspects that must also be addressed.

The Harm Reduction Model flows from this new, hybrid approach. The Harm Reduction Coalition describes the key aspects of this model as follows:

- Accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them, and both affirms and seeks to strengthen the capacity of people who use drugs to reduce the harm associated with their drug use.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's

vulnerability to and capacity for effectively dealing with drug-related harm.

- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.⁴⁷

Although the efficacy of the Moral and Temperance Models in treating drug addiction is poorly supported by research, with some research indicating harmful results, these early models are still very commonly encountered, both in popular opinion and in drug treatment practice. These models continue to dominate the criminal justice system (law enforcement, sentencing, probation, etc.) and are often the rationale underlying repressive laws and regulations. Programs built on these models tend to alienate and marginalize users, complicating the delivery of effective HIV prevention. For instance, one of the reasons commonly cited for the sharing of needles is the fear of being arrested for possession of drug paraphernalia, which involves painful detox and withdrawal; to avoid arrest, users would rather rent or share equipment, regardless of resultant HIV risk. Other effects of repressive laws are cited in section d, below.

Not all injectors share needles and other drug paraphernalia. Studies have shown a number of characteristics to be more likely for injectors who share compared to injectors who do not share:

- Multiple drug use
- Use of a “shooting gallery ” (locations, usually in urban areas, where injectors go to rent equipment when they do not have access to their own)
- Higher score on drug use severity test,
- Cocaine use (mostly because the shorter effect time of cocaine requires more frequent injection)
- Amphetamine use
- Younger in age (in the 1997 Colorado community identification project, described below, 62% reported starting injecting at age 14 - 21)
- Perception that peers will be insulted by refusal to share
- Heightened sensitivity to withdrawal symptoms

⁴⁷ Harm Reduction Coalition. 2000, www.harmreduction.org/prince.html.

- Psychiatric symptoms (especially somatization, interpersonal sensitivity, depression, hostility, and anxiety)
- Economic motivation to share
- Do not own injection equipment
- Fatalism about eventually developing AIDS.⁴⁸

In 1997, CDPHE commissioned a community identification project (CIP) studying injectors in nine Colorado communities.⁶⁹ This study identified a number of barriers to behavior change arising from injecting practices themselves. For instance, syringe re-use is very common, and is linked to both community norms and equipment availability. Almost half of the users in this study reported giving or loaning syringes to someone else between one and 480 times in one month. Only 22 percent reported using a new syringe every time. Reported reasons for re-using syringes were:

- Having no money to purchase syringes
- The point on the syringe is better once you use it a few times
- Wasteful not to re-use a syringe
- Only use it with my shooting/sexual partner or by myself
- Store hours are inconvenient
- Don't want to run out.

Among those who reported using someone else's syringe, the most commonly cited reasons were:

- Too concerned about getting high
- Friend had a syringe so they didn't need their own
- The place to get a new syringe was too far away or too inconvenient
- The illegality of carrying syringes, and fear of facing detox in jail
- In a hurry, or it was a spur of the moment decision.

Different levels of risk are associated with different injectable drugs. Heroin injection is the drug most commonly associated with IDU; however, cocaine and other stimulant use is common among people living with or at high risk of HIV. Cocaine abuse is associated with a high risk of HIV infection because of greater frequency of cocaine injections as compared with opiate use. Because of its shorter half-life and lack of depressant effects, cocaine can be

injected ten or more times per day, in contrast to the usual three to five times per day in heroin addiction. The link between cocaine use and HIV transmission may be especially strong among heroin addicts because they may be more likely to inject cocaine than smoke it, thus increasing the chances for infection with shared needles.

Methamphetamine abuse is a serious and growing problem in the United States. Deaths involving methamphetamine use have increased 61 to 73 percent between 1992 and 1993. Methamphetamine has been closely tied to increased high risk HIV behaviors; in fact, methamphetamine users have the highest rates of HIV seroconversion of any group of drug users in San Francisco. The risk for HIV infection is due to several factors. Methamphetamine's activating effects may enhance sexual behavior for some individuals and increase impulsivity and sexual risk-taking. Among the reported sexual effects of methamphetamine use are prolonged intercourse and more frequent sex with casual partners. In cities such as San Francisco and Seattle, injection is the dominant route of administration. When methamphetamine is injected, it can lead to the exchange of blood if syringes or other injection materials are shared. Moreover, methamphetamine use appears to be especially popular among gay men, who already have higher rates of HIV risk behaviors than the population at large. Studies have shown that among gay and bisexual men, those individuals who use methamphetamine have significantly higher levels of HIV seroprevalence than other groups at risk. In a study by Harris et al.,⁴⁹ for example, HIV infection was three to four times higher among methamphetamine injectors than among those who did not use methamphetamine. Methamphetamine is prominent among substance-abusing men who reported a close association between drug use and high-risk sexual behaviors, such as unprotected receptive anal intercourse. Methamphetamine use may also serve as a conduit for the spread of HIV from gay men to heterosexual drug users as the latter come into needle-sharing contact with gay or bisexual men.⁵⁰

⁴⁸ Stephens, R.C and Alemagno, S.A. *Injection and Sexual Risk Behaviors of Male Heterosexual Injection Drug Users*. NIDA Monograph 143.

⁴⁹ Harris NV, Thiede H, McGough JP, et al. "Risk factors for HIV infection among injection drug users: Results from blinded surveys in drug treatment centers, King County, Washington, 1988-1991." *J AIDS* 1993;6(11):1275-1282.

⁵⁰ Batki, S and Sorenson, J. "Systems of Care for HIV-Infected Injection Drug Users," in *The*

As mentioned above, when Colorado injectors were asked why they did not utilize drug treatment and other services, a common response was “these services are ineffective.” To some extent, these sentiments are substantiated by outcome effectiveness research. With the exception of heroin, other injectable drugs do not have treatment that involves chemical replacement, and efficacy of different treatment approaches varies widely. For instance, in regard to cocaine addiction, 60 percent of cocaine-addicted clients who attended a relapse prevention program in New York were continuously abstinent from cocaine during the six to 24-month follow up period, but only 36 percent of cocaine-using clients of a neurobehavioral therapy program were abstinent from cocaine six months after entering treatment.⁵¹

For heroin users, methadone is currently available in Denver, Boulder, and Colorado Springs. Some clients of methadone programs have successful outcomes, stabilizing the effects of their addiction while avoiding the harmful effects of tainted heroin. There also appear to be strong HIV prevention benefits from the availability of methadone; multiple studies have concluded that length of time in methadone treatment results less likelihood of becoming infected with HIV.⁵² However, there are numerous barriers and difficulties associated with methadone which interfere with its effectiveness as an HIV prevention strategy:

- Cost can be a serious barrier, averaging \$140 per month in the Denver area. Subsidies exist for injectors living with HIV, but not for those at high risk who are HIV negative. Non-payment of fees results in serious consequences, including sudden loss of access to methadone and rapid (often very painful) detox procedures; when payments

AIDS Knowledge Base. Internet document published by University of California San Francisco, <http://hivinsite.ucsf.edu>.

⁵¹ Government Accounting Office (GAO). 1996. *Cocaine Treatment: Early Results from Various Approaches*, www.druglibrary.org/schaffer/govpubs/gao/cocaine_treatment.htm.

⁵² Ward, J.; Mattick, R.; and Hall, W. 1992. *Key Issues in Methadone Maintenance Treatment*. New South Wales, AU: University of New South Wales Press.

are late, the situations is discussed not only with the administrative staff, but will also be raised by the therapist, leading to the perception that “money is what really matters to the clinic.”

- Some providers of methadone exhibit a high degree of bias against drug users (see further discussion below).
- Appropriate dosing is critical. Inappropriately low methadone doses have been associated with HIV infection, because patients on lower methadone doses are more likely to be currently injecting.⁷⁴
- Methadone is not a cure for drug addiction; it is a highly addictive chemical substitute for heroin. Withdrawal from methadone is as difficult, if not more difficult, than withdrawal from heroin. Methadone also has serious side effects over time, such as liver damage.
- In the for-profit methadone clinics, the other necessary services are often minimalized as cost-saving procedures, or an additional fee is required.
- For those who want to live “drug free,” the success rate following detox from methadone is not hopeful; more than 80 percent of addicts resume drug use within one year after stopping methadone treatment.⁷³

In regard to the other effects of drug use in the life of an injector, the 1997 CIP report stated the situation as follows: “Drug use is paradoxical. On the one hand, drug users commented on how it is related to uninhibited sexual activity, temporary feelings of self worth, sense of community, and the avoidance of difficult situations. On the other hand, though seldom recognized by the users but expressed in other terms, drugs act to prohibit long term intimate relationships, discourage real belonging, and add to feelings of worthlessness. Further, when users are high, condom use is often neglected. Moving beyond the behavioral to understanding the significance of patterns and practices of drug use will be essential if HIV intervention agencies are to succeed. Merely handing out condoms, or syringes for that matter, does not encourage the type of change in the individual or the social scene that is necessary for developing a reduced risk community.”⁶⁹

The most common strategy employed when needle exchange is not available has been distribution of bleach kits and instruction on use

of bleach to disinfect injection equipment. To prevent both HIV and HCV infection, up to three minutes of soaking and rinsing is now advised. This relatively time-consuming process poses a formidable barrier; only extremely motivated injectors will take the time necessary for this technique to be effective.

b) The social network of IDUs

A common prevention message delivered to injectors has been “Do not share.” One of the barriers involved in the acceptance of this message is the social nature of injection drug use, both sharing of drugs and sharing of equipment. In the 1997 Colorado CIP, 88 percent of respondents reported sharing and/or buying drugs with other people in the past 30 days versus by themselves. Only four percent of respondents said that they never shared drugs with others. Of the 88 percent who shared or purchased drugs with someone else, 73 percent shared with a relatively small network of one to four people; only eight percent shared or purchased with 10 – 20 people. Typically, the circle of drug users stays the same over time; 63 percent of respondents reported getting high with the same group of people over the past six months.⁶⁹

“Shooting galleries” appear to be less common in Colorado than in other, more urban locations such as Los Angeles or New York. The 1997 CIP states, “The individuals interviewed claimed that the places they typically inject were either their own home, a friend/relative’s house, and/or hotel.” This is further confirmed by the finding that only 15 percent of the injectors reported that they rented or bought a used syringe, a common practice in shooting galleries.⁶⁹

As mentioned above, drug sharing is a very common practice in Colorado. Grund⁵³ suggests deep roots for drug sharing: “Sharing drugs facilitates contact and communication, smothers conflict, and reinforces enduring relationships... Ultimately, drug sharing is aimed at maintaining the subculture.” If the equipment used to divide and mix the drugs is shared, there is a danger of HIV transmission.

In couples, Murphy⁵⁴ points out that needle sharing may substitute feelings of sexual intimacy and represent an intimate part of their relationship. Some female injectors are dependent on their male partners to inject them, with the male partner exerting control over her access to drugs and injection equipment. The 1997 CIP also found that it was “very common for a sexual partner to also be an injector.” Some interviewees also reported that they shared with people other than their main partner, but did not tell their main partner about this additional sharing.⁶⁹

Needle sharing appears also to be related to initiation to injecting drug use. In part, this is because novice users seldom have their own equipment (initial injection usually being unplanned and spontaneous). It may also constitute a rite of passage, movement from non-IDU to IDU status.⁷¹

c) Pervasive bias against drug users

In the 1997 Colorado CIP, a number of injectors reported that “the moment service providers see track marks on a client’s body, this is the moment that respect gets diminished.”⁶⁹ The bias against drug users, particularly injectors, is pervasive in our communities. As mentioned above, this is partly a remnant of the Moral Model, which condemns drug users as sinful or criminal. Clearly, this bias creates barriers for injectors who must self-identify in order to access HIV prevention and substance abuse treatment services.

A experience described by a Denver injector reflects the high degree of bias that dehumanizes and alienates injectors from health service providers. Due to tainted heroine, his arms had become highly infected and required immediate surgery. Just as the surgeon at the publicly funded hospital was beginning the operation, he told the injector, “I am an excellent surgeon, but I wonder if it’s worth it for me to be doing this surgery on an addict like you.” This injector’s complaints, filed through the appropriate official channels, were dismissed and ignored.

The popular media often perpetuates the following roots of bias against drug users with little or no chance for dispute or clarification:

⁵³ Grund, J-P. 1993. *Drug Use as a Social Ritual: Functionality, Symbolism, and Determinants of Self-Regulation*. Rotterdam: Instituut voor Verslavingsonderzoek, 177-195.

⁵⁴ Murphy, S. 1987. “Intravenous Drug Use and AIDS: Notes on the Social Economy of Needle Sharing,” *Contemporary Drug Problems*, 14:373-395.

(1) *Fear of criminality associated with drug use*
To fund the expense of purchasing drugs, injectors do resort to illegal acts, especially property crime. Gang activity, and its violent aftermath, are also linked to drugs. Injectors, even former injectors in methadone programs, are often cast in this negative light.

(2) *Belief that “people get what they deserve”*
Support for behavior health resources is generally lower than support for other health resources. A sizeable portion of our society sees drug addiction as willful behavior that can be changed if sufficiently desired by the addict. Those who die from the effects of drug abuse or from HIV or HCV are thus seen as “getting what they deserve” for not changing as they should.

(3) *Classism*
A sizeable portion of injectors are homeless or living in very low socioeconomic conditions. Predominant public opinion tends to be highly critical of public entitlement programs, as evidenced by widespread support for welfare reform and scaling back and narrowing of benefits for the disabled. Programs for poor injectors are seen in a similar, negative light.

(4) *Racism*
Although Caucasians in Colorado actually constitute the largest single segment of the injector population, there is a popular misconception that drug use is predominantly a people of color issue. General bias against people of color therefore acts against meeting the needs of injectors in general.

Biases such as these drive injectors into hiding; many injectors will avoid contact with HIV prevention or drug treatment agencies for fear of being oppressed. When they do make contact with a provider, they will look for evidence of these biases, and many will walk away, preferring the dangers of substance use to the corrosive effects of institutional abuse.

d) Effects of restrictive laws

The 1997 Consensus Statement issued by the National Institutes of Health states the following position on needle exchange, with which CWT concurs:

“An impressive body of evidence suggests powerful effects from needle exchange programs. The number of studies showing

beneficial effects on behaviors such as needle sharing greatly outnumber those showing no effects. There is no longer doubt that these programs work, yet there is a striking disjunction between what science dictates and what policy delivers. Data are available to address three central concerns:

1. Does needle exchange promote drug use? A preponderance of evidence shows either no change or decreased drug use. The scattered cases showing increased drug use should be investigated to discover the conditions under which negative effects might occur, but these can in no way detract from the importance of needle exchange programs. Additionally, individuals in areas with needle exchange programs have increased likelihood of entering drug treatment programs.
2. Do programs encourage non-drug users, particularly youth, to use drugs? On the basis of such measures as hospitalizations for drug overdoses, there is no evidence that community norms change in favor of drug use or that more people begin using drugs. In Amsterdam and New Haven, for example, no increases in new drug users were reported after introduction of a needle exchange program.
3. Do programs increase the number of discarded needles in the community? In the majority of studies, there was no increase in used needles discarded in public places.

There are just over 100 needle exchange programs in the United States, compared with more than 2,000 in Australia, a country with less than 10 percent of the US population. Can the opposition to needle exchange programs in the United States be justified on scientific grounds? Our answer is simple and emphatic-no. Studies show reduction in risk behavior as high as 80 percent in injecting drug users, with estimates of a 30 percent or greater reduction of HIV. The cost of such programs is relatively low. Needle exchange programs should be implemented at once.”⁵⁵

It is unfortunate that, in Colorado, political expediency has prevailed over science and sound public health practice in regard to needle exchange. To reiterate the NIH position – Needle

⁵⁵ *Interventions to Prevent HIV Risk Behaviors. NIH Consensus Statement 1997 Feb 11-13; 15(2): 1-41.*

exchange programs should be implemented at once.

As mentioned previously, the possession of injection equipment in Colorado is illegal. As a result, injectors hesitate to carry their own equipment, leading to more sharing, and thus more HIV risk.

Criminal justice and public health have extremely different approaches to HIV. Increasingly, as part of their “war on drugs,” the criminal justice system has been demanding expanded access to drug treatment records. Those who violate a judge’s expectation of total abstinence from drug use are often reported by drug treatment facilities for violations, and thereby suffer severe consequences. Public health is about the support of healthier behaviors, not punishment – but, too often, providers of services are legally obliged to do things that jeopardize their ability to practice effective public health.

Given the high degree of stigma attached to injection drug use and HIV, the passage of laws or regulations that may ultimately breach confidentiality are likely to alienate injectors from the HIV prevention system. Injectors are particularly sensitive to laws that allow the criminal justice system to access and make use of information divulged to HIV prevention providers in order to pursue sentence enhancement or prosecution.

e) Special concerns of women who inject

Women who inject are less likely than their male counterparts to enter treatment. Recent research suggests that these women are often single mothers who are forced to earn money through commercial sex work or directly from the drug trade. They suffer severe discrimination both inside and outside the drug subculture. A partner who injects may also victimize them, keeping women locked in relationships of sexual abuse as well as continued drug use. Therefore, their abstinence from injection drug use would necessitate major life restructuring, and most HIV prevention programs are ill equipped to assist in meeting the resultant multitude of needs.

Among injection drug users, women who have sex with women have higher HIV rates than do women who have sex with men only. A study of female IDUs in 14 US cities found that, compared to heterosexual women, women who

have had a female sex partner were more likely to share syringes, to exchange sex for drugs or money, to be homeless and to seroconvert.⁵⁶ In light of this evidence, women who have sex with women are at risk through injection behaviors, and programs must be tailored to their unique needs.

3. Barrier and suitability issues for people of color

In general, people of color who are also injectors must cope with two forms of bias: the bias against drug users and the bias arising from racism. Aside from this commonality, it is important to recognize the unique experiences of the diverse communities that fall under the heading “communities of color.”

a) Latinos and Latinas who inject

In regard to Latino injectors, the *2000 Epidemiologic Profile* reveals a disturbing trend: 39 percent of the HIV cases diagnosed among injectors in 1998 – 1999 were Latino, reflecting an increasing trend among IDUs.

According to a report issued by the National Council of La Raza,⁵⁷ barriers faced by Latino injectors are formidable, and include the following:

(1) Barriers due to stigma

Many Latino drug users, especially undocumented individuals, lead secretive lives desperately trying to avoid the discovery and consequences of their addiction. For example, many drug users fear that if their addiction is known, their partners will leave them. This lack of disclosure makes it harder to target and reach a sex partner with prevention education.

Many Latino drug users are reluctant to participate in HIV/AIDS programs because they fear others will assume they are HIV positive or they will have problems with the police. Many avoid drug treatment programs because they may have been admitted several times before or may have been picked out for abusing drugs on the

⁵⁶ Young RM, Weissman G, Cohen JB. (1992). Assessing risk in the absence of information: HIV risk among women injection drug users who have sex with women. *AIDS and Public Policy Journal*, 7:175-183.

⁵⁷ Peters-Rivera, V.; Martinez, G.; Drone, A. 1995. *Injection Drug Use in the Hispanic Community*. Washington, DC: National Council of La Raza.

premises and fear that staff will treat or judge them harshly.⁸⁰

(2) Special concerns of undocumented and recent immigrants

Undocumented individuals may be less likely to seek services because of their fear of deportation. Even those who have documented status may face deportation if they are found in violation of the law, which is a real concern to drug users who, besides using illicit substances, may be selling them in order to earn money.

Isolation from their families, ethnic group, and culture may contribute to the drug addiction of some Latinos and Latinas who leave their homeland to come to the mainland United States. Marginalization is highly stressful and may result in feelings of alienation and loss of identity, placing Latinos in this situation at a greater risk for drug abuse.⁸⁰

(3) Barriers faced by Latinas

Female drug users in the Latino community may need special services, such as child care, to successfully participate in HIV/AIDS programs. In a national study of drug treatment facilities, most Latino clients receiving substance abuse treatment are male. This may be due to the fact that most programs are specifically designed for males and do not address barriers to treatment many women face. For example, many women with children have nowhere to leave them during drug treatment, especially residential care. Feelings of embarrassment or disapproval of a jealous partner may also deter women.⁸⁰

(4) Barriers faced by non-English speaking Latinos

Latino drug users with limited English skills may find it difficult to use available mainstream social services. There may be no Spanish-speaking staff to help them, and they may be intimidated if they do not speak English well. Many also may have limited literacy skills and are unable to fill out necessary forms without appropriate help.⁸⁰

(5) Barriers due to predefined notions of "drug use"

Latinos in Colorado, especially recent immigrants, also inject vitamins, antibiotics, and other medicine, reflecting a common practice in Mexico. In some cases, needles are shared extensively, especially within families. HIV prevention programs built exclusive around

"illicit drug use" will fail to address these other risky behaviors.

(6) Barriers due to lack of cultural-specific substance abuse treatment

As stated by Victoria et al, "Hispanic drug users may have limited access to mainstream drug treatment facilities. According to national data on drug treatment facilities, Latinos in drug treatment received fewer substance abuse services than drug users as a whole. According to the 1991 figures, aftercare follow up, family therapy/counseling, and crisis intervention were the services least available to Latinos. Only 56.5 percent of Latino clients received aftercare follow up services compared to 71.7 percent of all clients. Only 60.4 percent of all Latino clients received family therapy/counseling compared to three-quarters (75.9%) of all clients. Latinos (42.0%) were also less likely than the total client population (56.4%) to receive crisis intervention services. The services most available to Latinos were individual therapy/counseling, group therapy/counseling, and referrals, usually available through community-based programs."

Providers must recognize the importance of family and cultural values such as 'respecto,' 'dignidad,' 'orgullo,' 'verguenza,' 'machismo,' and fatalism when addressing the issue of HIV/AIDS and injecting drug use. Providers should use their professional reputation and knowledge to help overcome community prejudices against drug users to provide effective outreach.

Latinos have tended to underutilize drug treatment facilities, but much of this underutilization may be explained by treatments that are inappropriate to Latino culture. In some ways, Latino culture can be incompatible with help-seeking for a drug problem. In Latino culture, difficult and embarrassing problems like drug abuse are solved within the family whenever possible. Traditional approaches to drug treatment (detoxification, methadone maintenance, and therapeutic communities) may be very unattractive to Latino drug users. Methadone maintenance has been criticized as an "easy way out," because the client remains addicted, which contradicts a "macho" image. In therapeutic communities, the recovering-addict community becomes the addict's "family," which is culturally inappropriate for Latinos who place special emphasis on their families and cannot substitute them easily.⁸⁰

b) African Americans who inject

The barrier and suitability issues for African American injectors include the following:

(1) Disproportionate impact of repressive laws and their enforcement

African American communities frequently have been the target of police drives to enforce drug laws. According to federal crime statistics, among whites there were five arrests per year per 100 users of heroin and cocaine in 1996; among blacks, there were 20 arrests per 100 users. In other words, the arrest rate for black users was four times higher than the arrest rate for white users.⁵⁸

As stated in a recent national report, “We can now begin to see why the number of injection-related new AIDS cases is so high among blacks: arrests for possession are higher. This means that the legal system, via the police, is more likely to confiscate the personal needles of blacks. Also, because black users know (correctly) that they are vulnerable to arrest, these users are likely to “choose” not to carry their own clean needles. Users who do not carry their own needles all too often end up sharing the needles and blood-borne diseases of others.”⁷⁸

(2) Mistrust based on past abuses of African Americans by institutional public health.

[See page 18, African Americans that mistrust institutional public health due to past abuses.]

(3) Barriers due to lack of cultural-specific substance abuse treatment

Effective substance abuse treatment for African Americans should explicitly incorporate African American culture into the treatment experience. Such opportunities are rarely available to Colorado’s African American communities.

(4) African Americans are disproportionately affected by social upheaval and displacement, which are directly linked to enhanced vulnerability to drug use and HIV

HIV among Colorado’s African American citizens is highly concentrated in urban Denver. Wallace⁸⁰ has studied social upheaval in rapidly changing urban environments such as Denver,

⁵⁸ Day, D. *Health Emergency 1999: The Spread of Drug-Related AIDS and Other Deadly Diseases Among African Americans and Latinos*. Princeton, NJ: The Dogwood Center.

and has come to a number of conclusions about its relationship to the HIV and substance use epidemics among African Americans.

Such communities are overwhelmed with a multitude of social ills, from violence to homelessness, and residents find it difficult to rally scarce resources to deal with concerns like HIV, which seem to be less immediate. With people moving quickly in and out of neighborhood, little community cohesion develops. Programs must attempt to constantly educate and re-educate an ever-changing community, and such programs are also extremely difficult to establish and maintain in neighborhoods that lack people who plan to remain for the long term. They also create an ecological niche for shooting galleries and other anonymous injection sites, where large scale sharing threatens to quicken the spread of HIV and HCV.

When people do move to other locations, they often take a long period of time to adjust to their new neighborhoods. During this transition time, they tend to be socially isolated from friends, peers, extended family, and potential service providers.

c) Native Americans who inject

[See page 18, Native American/American Indian.]

The general health status of Native Americans is lower in almost every national health indicator. Substance use, primarily alcohol use, accounts for most of the top ten causes of early death, either directly or indirectly.⁵⁹

d) Asian Americans/Pacific Islanders who inject

[See pages 18 – 19, Asian American/Pacific Islander] An Additional principle recommended when working with API injectors:

- Power imbalances and gender role ideology are particularly evident in some API cultures, particularly among recent immigrants.

⁵⁹ National Commission on AIDS. 1992. *The Challenge of HIV/AIDS in Communities of Color: The American Indian and Alaskan Native Community*, http://hivinsite.ucsf.edu/topics/native_americans/2098.2b78.html.

4. Barrier and suitability issues for rural residents

As shown in the epidemiologic profile, HIV infection due to injection drug use is on the rise among rural residents. Injection drug use takes place in all regions of the state.

The 1997 CIP included interviews with injectors in four rural Colorado counties: Weld, Larimer, La Plata, and Mesa.⁶⁹ Two of these sites, Fort Collins and Mesa county, involved sufficient numbers of injectors to have separately-reported results within the larger report. The generalizability of these findings to all rural areas cannot be assumed, but the findings do give insight to how rural injectors might differ from urban injectors.

The typical Fort Collins injector was found to be socio-economically different than the typical urban street user. Of the Fort Collins injectors interviewed, 29 percent reported full-time employment, and 14 percent reported regularly performing day labor as a living. Twenty-one percent of the interviewees reported selling or re-selling drugs as their primary source of income. Many of these interviewees lived in their own home or apartment (43%), although a significant number did report living on the street. All of these interviewees also reported that their last injection episode was in a private location (party, dealer's house, own home, friend's home).

Ninety-two percent of the Mesa County injectors interviewed were over 30 years of age, which is significantly older than the average age of the other interviewees in the study. There appeared to be very extensive connections among the injectors in this rural region; many of the interviewees claimed to know approximately 30 other injectors in their area, and some knew over 50. Injection tended to be in their own home (58%) more so than in a friend's home (25%). The rate of HIV testing for these interviewees was also very low. Only one of the twelve Mesa county interviewees had been tested; in comparison, more than 80 percent of the urban interviewees claimed to have been tested for HIV, and the vast majority of these interviewees reported testing multiple times.

The 1997 CIP also noted the extent to which urban residents travel to rural areas to purchase or inject drugs. For instance, when asked where else they have purchased and/or injected drugs, residents of metro Denver listed Alamosa,

Bailey, Breckenridge, Canon City, Carbondale, Central City, Deckers, Durango, Elizabeth, Fort Collins, Glenwood Springs, Grand Junction, Idaho Springs, La Junta, Pueblo, and Telluride.

In a general sense, many of the barriers listed above are also true for rural injectors, with additional complications:

- a) Rural areas have tended to lag behind urban areas in their movement from the Moral and Temperance Models to the more modern viewpoints concerning drug use and treatment.
- b) County sheriffs and rural police departments often have very large jurisdictions with few personnel. As a result, rural areas can be attractive to those who manufacture, distribute, and use injectable drugs, particularly methamphetamine.
- c) Availability of drug treatment is much more limited in rural areas, and often involves extensive travel.
- d) Methadone is only available in the Denver area, Boulder, and Colorado Springs.
- e) Concerns about IDU and AIDS stigma are heightened in rural areas, where anonymity cannot be taken for granted.
- f) Most of the HIV prevention models developed for injectors are designed to be implemented in inner city, street-level venues where injectors congregate. Such identifiable, accessible venues do not exist in the vast majority of rural areas, where users are more integrated into the wider community and are even more likely to be injecting in private homes.

Two issues concerning confidentiality can also impact the effectiveness of certain methods of intervention. First it tends to be a barrier to Group Level Interventions (GLI) in communities where it is unacceptable to identify with a group so stigmatized by the local population, and secondly it tends to be a barrier to GLI to discuss matters of personal risk in group settings where every one knows each other. In such cases, information obtained from interviews and focus groups in District four and eight has shown that potential clients prefer Individual Level Interventions (ILI).

Need for safer sex materials distribution/availability based on needs assessment results, low socio-economic status of rural communities and confidentiality issues.

Please see notice regarding need for safer sex materials in rural areas as described on [page 34](#).

5. Barrier and suitability issues for young injectors

The 1997 Colorado CIP involved extensive interviews of young injectors (defined as age 25 or younger for this study). Major findings are listed below.⁶⁹

Drug use starts out by providing youth with satisfaction, entertainment, and excitement; however, it can lead to chronic use where the majority of one's energies are focused upon getting the drug. For most of the youth, HIV was not listed as a top priority, particularly for the "street kids," for whom bigger concerns were: where will I stay tonight, who are my friends, where can I get some food, how can I get more drugs, does he like me, etc.

These youth reported that they are relatively unconscious or unaware of their injection practices, as long as "things flow along freely." As the report notes, "In order to bring syringes into focus a whole new interpretive frame needs to be developed around them that goes beyond AIDS. It needs to be more important and understandable to these clients."

For these young injectors, violence and personal safety were major concerns, overshadowing HIV. In particular, violence from older homeless men, sex partners, and police were noted. Abuse was a common occurrence, often related to sex and drug use, but the youth felt uncomfortable reporting this abuse to service agencies. Young MSM were particularly hesitant to report abuse at the hands of a male sex partner.

Many of the street youth expressed a strong need for social and psychological support. Some of these youth used pets (dogs, rats, snakes, etc.) as psychologically significant sources of support and companionship; however, non-acceptance of pets was cited as a barrier in seeking services from agencies and outreach workers. These youth also complained about a lack of agency support for their desires for intimacy or community, which their drug use partially provides in their lives. The street youth made a sharp distinction between "genuine" and "wannabe" street youth. The needs of the two groups are quite different, though the risk

behaviors may be the same.

For these young injectors, HIV programs run the danger of becoming overly identified with the systems that they went into the streets to avoid. When this identification occurs, the programs lose their credibility. Some homeless shelters check the youth for outstanding warrants, for instance. This has resulted in some youth avoiding the programs or refusing to share any information that might "get them into trouble."

In summary, the report notes that "kids must be convinced they are entitled to better or different lives. Repeated and consistent consciousness raising activities on drug use and sexual activity are needed. Few service agencies were reported to have helped to make them feel better about themselves. Instead, what happens is they usually feel they have failed."

6. Men who have sex with men who are also injectors

[See page 17, *Injectors*.]

7. Transgender and gender variant people

[See page 19 – 20, *Transgender and Gender Variant People*.]

8. Disabled people who are injectors

[See page 20 – 23, *People with Disabilities*.] In addition, too many service providers patronizingly believe that people with disabilities could never have a substance use problem. Conversely, many people with disabilities live in situations where power imbalances are almost insurmountable, and thus limited ability to leave situations where drug use has become uncontrolled. These choices are particularly difficult when they involve caregivers.

9. Barrier and suitability issues for injectors living with HIV

As noted in Chapter Seven of the Comprehensive Plan, if infectiousness is related to the amount of virus in the blood, IDUs on HAART may be less likely to transmit HIV to their injecting partners. However, this potential prevention benefit will never be realized if injectors are not provided the same access to state-of-the-art care as non-injectors. The following excerpt from Canada's *National Action Plan for Injection Drug Use* summarizes Colorado needs, as well: "Addressing the multiple difficulties in seeking appropriate, accessible treatment for a substance use problem

can be overwhelming, as it can also be for HIV infection. Attempting to do this when both conditions are present, and particularly if other issues such as mental illness are also present, can seem insurmountable. Individuals with these conditions may have to confront discriminatory and/or uninformed attitudes on the part of treatment providers, and availability of appropriate treatment spots is frequently limited. Decision-making regarding the best treatment approach is often taken out of the hands of the individual for fear, on the part of the health care providers, that an injection drug user will not comply with treatment regimes. Pain may not be well-managed by physicians unwilling to prescribe adequate medication to someone with a history of substance use, fearing the risk of overdose. It must be recognized that injection drug users living with HIV are individuals, suffering in a myriad of ways, and in need of the best possible interventions, tailored to their unique situations. They retain all the rights of every other citizen, and must therefore be given equal access to a continuum of services, as well as the dignity of making their own decisions. If lack of compliance with a drug treatment is feared, then the patient must be supported to ensure adherence to the treatment regime, just as any other individual is, whether diagnosed with diabetes, epilepsy or another condition. Bias against treating IDUs is unjustified and unacceptable.”⁶⁰

As discussed at length above, injectors must cope with significant bias. If HIV prevention adds to the bias against injectors living with HIV, our HIV prevention efforts will be harmed. Therefore, it is particularly important that efforts for injectors living with HIV adhere to the principles of Harm Reduction mentioned above. Particularly important are principles relating to giving users a real voice in programs, focusing on quality of life, taking a non-judgmental and non-coercive approach to services, and deepening our understanding of other social inequalities related to vulnerability (poverty, class, racism, social isolation, past trauma, sex-based discrimination, etc.)

For injectors living with HIV, improving the availability, effectiveness, and client-centeredness of methadone and substance abuse treatment programs serves both a humanitarian purpose and a public health purpose.

Injectors living with HIV are also a largely untapped resource for HIV prevention. Who better to reach out to people at risk through sharing of needles than a current or former injector living with HIV who is also well-trained in HIV prevention interventions? Employing injectors living with HIV could also be a tremendous source of empowerment, as the benefits of HAART make them well enough to re-enter the work force. Our HIV prevention system could channel all that they have learned toward the noble purpose of preventing future infections, when other potential employers would hold their drug use history against them.

⁶⁰ Canadian National Task Force on HIV, AIDS, and Injection Drug Use. 1997. *HIV/AIDS and Injection Drug Use: A National Action Plan*. Ottawa, Canada: Canadian Centre on Substance Abuse, Canadian Public Health Association, and Health Canada, <http://fox.nstn.ca/~eoscapel/cfdp/hiv aids.html>.

