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## The Sex Issue

When AIDS was first named – Acquired Immune Deficiency *Syndrome* – its transmission routes, or even whether it involved a specific pathogen, were mysteries. We know now that it is an infectious disease caused by a virus most commonly transmitted through sex. The existence of a sexually transmitted, potentially deadly virus has affected the sexuality of everyone on the planet, and produced major upheavals in how societies and cultures perceive and talk about sex. Groups that rarely discussed sexual behavior were finally forced to address it.

After their diagnosis, most people with HIV eventually return to the sexual arena, and the fantasy that they will have sex only with other people with HIV remains just that. Only by acknowledging the sexual needs of people with HIV, and by viewing their sexuality as more than simply a vector of transmission, will we ever effectively address prevention issues.

On a personal note, this is my last issue as Editor-in-Chief of *ACRIA Update*. After eleven years, I've resigned my position as Executive Director of ACRIA. I'm extremely proud of this publication and I'd like to express my appreciation to all the writers who have contributed their expertise and their personal stories over the years.

ACRIA's programmatic activities, both research and treatment education, are as relevant today than at any other time in the agency's 14 year history, and are more far-reaching. I've realized the goal that I set out to achieve. I feel it's time to move on. The accomplishments and successes of ACRIA were possible only through the efforts of the most dedicated and caring staff an executive director is likely to find. With much gratitude, I say goodbye.

*J Daniel Stricker, Editor-in-Chief*

## Sex Workers and HIV

*by Luis Scaccabarozzi*

A smartly dressed couple check into a four-star city hotel armed with a bottle of champagne and condoms. In a building across the street, a couple who has just met is putting on a condom. In a parking lot of the local high school, in the back-seat of a car, two young people, high on dope, are removing one after finishing sex. Out in the suburbs, a man puts one on before he has sex with his regular partner at his home. In a bathroom of a public transportation system, another man is performing oral sex on his male partner.

No, these are not couples engaged in affairs. They are not people who have just met at a bar, nor teenagers after the school dance. They are certainly not long-time lovers. They are all people who are part of the sex industry – sex workers and their clients.

including HIV. But in many parts of the world the reality may be quite different. It is difficult to determine precisely the incidence of HIV infection among sex workers, or the prevalence of safer sex practices during commercial sex transactions. Like other marginalized populations, sex workers often receive scant attention from both public health officials and researchers. The stigma attached to sex work, and the criminal sanctions it can entail, make reliable data hard to come by. There is almost no information about male sex workers. Nevertheless, some limited studies have been done around the world in the more than two decades of the pandemic, and the results do not seem to bear out the premise that sex work by itself contributes disproportionately to the spread of the virus.

### Regional Differences

Outside of Africa, the incidence of HIV among sex workers is generally about the same as in the population as a whole. This is true even in

*(continued on page 3)*

### Are Sex Workers Spreading HIV?

Historically, sex workers have been blamed for transmitting sexually transmitted diseases,

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ACRIA is an independent, non-profit, community-based AIDS medical research and treatment education organization dedicated to rapidly improving the length and quality of life for people living with HIV/AIDS. Bulk copies of *ACRIA Update* are available free to agencies that provide services to people living with HIV/AIDS. For more information, call 212-924-3934 ext. 120.

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## **Pregabalin for Peripheral Neuropathy**

People with HIV who have peripheral neuropathy will take either pregabalin (Lyrica) or a placebo (dummy pill) for 3 months. Participants must be 18 or older and have had pain in their hands or feet for at least 3 months.

## **TH9507 for Lipodystrophy**

People who have excess abdominal fat and who are taking anti-HIV drugs will take either TH9507 (an experimental growth hormone releasing factor) or a placebo (dummy pill) for 26 weeks. Participants must be 18-65 years old, with a CD4 count over 100 and a viral load below 1,000.

## **TMC 114 for Treatment-Experienced Adults**

People who have taken anti-HIV drugs from three of the four classes of drugs (an NRTI, NNRTI and two PIs), and who have limited or no treatment options due to resistance or intolerance, will take TMC 114 (a new PI) along with other anti-HIV drugs. Participants must be 18 or older, have a CD4 count below 200 and must not be eligible for any other Tibotec-sponsored HIV trial.

## **UK-427,857 for Drug-Resistant HIV**

People who have taken anti-HIV drugs from three of the four classes of drugs will either take UK-427 (an experimental HIV CCR5 attachment inhibitor) with an optimized regimen of anti-HIV drugs, or take a placebo (dummy pill) with an optimized regimen, for 11 months. Participants must be 16 or older and have a viral load of at least 5,000.

**For the above trials, contact Dr. Douglas Mendez at 212-924-3934 ext. 126 or Dr. Yuriy Akulov at ext. 124.**

### **Editor's Notes**

- All material in *ACRIA Update* is presented for educational and informational purposes only, and is not intended as medical advice. All decisions regarding one's personal treatment and therapy choices should be made in consultation with a physician.
- *ACRIA Update* refers to most drugs by both their commercial and scientific names upon their first reference in an article. Thereafter in the article, they will be identified with the name by which we feel they are most commonly known, either commercial or scientific.

## Sex Workers and HIV *(continued from first page)*

developing countries, although the incidence does vary geographically.

In Europe, HIV incidence is low, including among sex workers. As with other populations, however, the incidence rises dramatically among those who use intravenous drugs. In Vienna, where sex workers are registered and regularly screened for various STDs, the few found to be HIV positive reported that they were IV drug users or had sexual partners who were. In Seville, Spain, sex workers who used intravenous drugs were eight times as likely to be HIV positive as were those who used non-intravenous drugs. In the Netherlands, where sex work is legal and regulated and where drug use is largely approached from a public health rather than a criminal point of view, both non-IV-drug-using female sex workers and their male clients were found to have an extremely low incidence of HIV, and that was concentrated among sex workers who had recently come from AIDS-endemic countries.

In a similar study to that mentioned above, non-IV-drug-using female sex workers in Amsterdam reported not only no HIV infection but consistent condom use. Conversely, a small group of transgender Dutch sex workers among whom there was a fairly high incidence of HIV reported not using condoms during receptive anal sex. In Glasgow, where HIV rates are low even among IV drug users and where almost 75% of female sex workers also inject drugs, all of the HIV-positive sex workers studied have been found to be IV drug users.

The story in Asia is complicated, and data are spotty. The only large-scale study of HIV among sex workers in Asia was done in the Philippines, evaluating 25,392 sex workers in 64 cities between 1987-89, before the pandemic had become widespread in the region. This study showed that the prevalence of HIV was 0.08%; however a study a year later showed 0.23%, suggesting an increase. In China, most women arrested for prostitution have been found to have active STDs, primarily gonorrhea, but no correlation has been found between HIV and sex work.

Interestingly, the Chinese government has suggested a link between HIV and sex work as part of its campaign to eliminate the sex trade, even as it denies that HIV is a public health problem within its borders. Thailand, on the other hand, has often been cited as a model for government regulation of sex work. Although prostitution is officially illegal, in the early 90s the Thai government began working with brothel owners to enforce 100% condom use. Free condoms were given to brothels, and sex workers were told to insist on condoms. Establishments that allowed unprotected sex were shut down. As a result, condom use increased from 14% in 1989 to over 90% by

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*“There are virtually no data on sex workers in the United States, possibly because of government refusal and private reluctance to recognize this population.”*

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1994. Over the same period, the number of new STI cases among men treated at government clinics plummeted by over 90%. HIV infection rates among military recruits fell from 4% in 1993 to below 1.5% in 1997.

In other geographical areas or populations where HIV has not been studied specifically, researchers often use other STDs with which the virus has been associated as surrogates to help them gauge the incidence of infection. In Tokyo, sex workers have been found to have high rates of hepatitis C and *Treponema pallidum*. At the very least, the data from Japan and China should serve as

a reminder that there are other things besides HIV to which sex workers and their customers may be vulnerable. This might indicate that concerns should not be focused on stigmatizing HIV with sex workers, but on implementing public health programs that will provide education and access to care and treatment for HIV and STDs for everyone who might be engaging in high-risk behaviors. We all know that high incidence rates of STDs are often linked to high HIV incidence rates.

There is limited information on HIV among sex workers in North and South America. The only large-scale study – of over 960 female Peruvian prostitutes over a three-year period – was conducted in the early 1990s and showed some HIV infection (0.3%) and a much larger incidence of HTLV-1, hepatitis B and C. 17.6% had HTLV-1 antibody, 59.8% had hepatitis B antibody, and 0.7% had antibody to hepatitis C. There are virtually no data on sex workers in the United States, possibly because of government refusal and private reluctance to recognize this population. One study of HIV-positive tuberculosis patients in Los Angeles found that nearly all had risk factors that included prostitute contact, multiple sex partners, and histories of STDs, leading public health officials there to recommend screening all TB patients for HIV.

Africa, of course, is the global epicenter of the pandemic. Once again, epidemiological research is scarce, especially with regard to individuals engaged in sex work. Some limited studies done in the early 1990s found high and increasing incidences of seropositivity among female sex workers in Cameroon. Early speculation, based on very small studies, that HIV might be confined to discrete areas of the continent evaporated in the late 1980s when the infection rate among sex workers in Djibouti exploded. In 1987 in Djibouti, only 2% of sex workers were HIV positive, much lower than the incidence rate for that reported in any Eastern African country. However, in a later study in the early 1990s, HIV infection rates were found to be 36% for street sex workers and 15.3% in sex workers working as bar hostesses.

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## Sex Workers and HIV *(continued from previous page)*

### **Is Prostitution a Risk Factor for HIV?**

A 1994 study of HIV prevalence in female drug injectors in the U.S. found a 12.9% HIV prevalence among those involved in prostitution and 14.4% among those not involved. The women not involved in prostitution were less likely to be in contact with drug treatment or helping agencies and were less likely to have been tested for HIV than those engaged in sex work. Respondents in contact with treatment agencies and those involved in prostitution were more likely to be aware of their HIV status, with 72% of the HIV-positive nonprostitutes unaware of their status. While these results take sex work itself off the hook, drug use among sex workers appears to be high. Of 85 sex workers in a Glasgow study, 81% were IV drug users, their most commonly used drugs being heroin and temazepam. While 98% indicated that they always used condoms during vaginal intercourse, this only applied to commercial sex; only 17% always used condoms with their regular sexual partners, who were frequently drug users.

### **Clients of Sex Workers Increase Risk of Contracting HIV**

While no clear behavioral pattern emerges for female sex workers, most are believed to have contracted HIV through heterosexual contact rather than through IV drug use. A study in Kingston, Jamaica, for example, tracing a sharp rise in seroprevalence, found that factors associated with infection in heterosexual men included history of other STDs, sex with prostitutes, and multiple sexual partners.

The story is complicated, however, by the presence of other risk behaviors among this population. In a London study, many HIV-positive men who used female sex workers also reported having sex with other men and using injected drugs; some also had had blood transfusions or gonorrhea, and a few said that they had also been paid for sex.

Past history of other STDs clearly correlates with HIV incidence. In a study of men who had other STDs and who used sex workers, every man who seroconverted

had a genital ulcer of some kind related to the STD. The authors concluded that men with other STDs have a very high risk of acquiring HIV from prostitutes. Transmission of HIV from male to female in unprotected sex appears to be high. A study in Thailand found that almost all HIV-positive men who were unaware of their HIV status until they donated blood had had sex with prostitutes, and almost half of their wives or sex partners were also infected. Risk factors for transmission from male to female were genital herpes, gonorrhea, or chlamydia infection. By contrast, regular use of condoms decreased transmission to one-tenth that of the larger group.

### **Sex Workers as a Prevention Resource**

Many who do HIV prevention work with sex workers find them to know a great deal about the human side of sex, including the behaviors and attitudes that go with it, making them an ideal source of knowledge about safer sex practices. Often, they have developed some expertise about the prevention of HIV and other STIs. Sex workers are aware of the implications of the spread of the disease, not only for their own lives and livelihoods, but also for their many sex partners, and in turn for the general population. As a result, many sex workers make it a practice to instruct their clients in safer sex practices before engaging in sexual contact with them.

There is now near-universal use of condoms by sex workers in industrialized countries. It is possible that this is having a far larger impact on the overall sexual culture than conversations that should be (but often aren't) happening in doctors' visits. It's difficult to prove, but probable, that sex workers have been more successful in safer sex education than all the television advertisements put together. After all, the best way for someone to learn something is to do it. Put in terms of positive reinforcement theories, the best way for a man to start to feel good about using condoms is to have someone put one on him and then proceed to give him a pleasurable experience. Yet sex workers are widely perceived to be a major reservoir of infec-

tion, the vectors for the transmission of HIV/AIDS into the general population. Some sex workers, of course, do have unsafe sex. Sometimes they are coerced into it by a threatening client, or they may simply be offered more money to dispense with the condom. Sometimes the workers themselves are affected by alcohol or drugs.

But often, even under these circumstances, many sex workers don't do anything unsafe. Why not? Because they have learned to take care of themselves; because they have self-esteem, because it has become a habit to carry condoms and use safer sex practices. Sometimes it's just that they want to keep on living so that they can continue using drugs. The key to stopping sexually transmitted diseases is control. The more control sex workers have over their lives, the more likely they are to develop self-esteem and the responsibility that comes with it. If they do not, they are more likely to be careless and risk being infected or infecting their partners with HIV. This doesn't mean that sex workers are not exposing themselves to HIV, but we need to stay aware that the issue is the risk behavior, whether through unprotected sex or IV drug use. Therefore it is important to provide public health policies that will allow sex workers to have just access to health care and prevention services.

### **Sex Work, Public Policy, and HIV**

In 1986, the First International Conference on Health Promotion stated that for "all people to achieve their fullest health potential" they need "a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices." In order to achieve such potential, the people need to "take control of those things which determine their health."

In May 2003 however, Congress passed the United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act (Global AIDS Act), and in December 2003 it passed the Trafficking Victims Protection Reauthorization Act (TVPRA). The Global AIDS Act bars the use of fed-

eral funds to “promote, support, or advocate the legalization or practice of prostitution.” This language has been used by the U.S. government to require that organizations receiving U.S. global HIV/AIDS funding must adopt specific positions opposing prostitution, making it virtually impossible to work with this population.

These restrictions were first applied to foreign nongovernmental organizations only, with the law specifically exempting the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization (WHO), the International AIDS Vaccine Initiative, and any “United Nations agency.” In June 2005, however, the U.S. Agency for International Development issued a directive requiring that funding for AIDS programs be given only to those organizations – both U.S. and foreign – with policies explicitly opposing prostitution and sex trafficking. Such funding restrictions parallel other similar, and increasing, efforts to force public health organizations to comply with ideologies that often run counter to both public health practice and human rights standards. It appears that sex workers are not included among “all people.”

Previously, funding had allowed the establishment of community drop-in centers, where sex workers gathered and received support from others and information relevant to their health. Condoms and other safe-sex accessories were also available. Outreach workers were able to share prevention messages and information not only about safer sex but about needle-exchange programs. The current low incidence of HIV/AIDS in the sex industry attests to the success of many of these programs. At some of these centers, medical clinics were set up to provide anonymous HIV testing for sex workers. Anyone who tested positive was followed up for care. At some clinics, sex workers participated in the interviewing process for hiring staff – a striking example of patient empowerment.

Some in the HIV community are biased toward programs run solely by sex workers, but the participation of health professionals in health programs is important. Healthcare providers, clinical and non-clinical, need to have empathy and to

appreciate that sex workers can be part of the solution, not part of the problem.

This is more difficult in countries where the economic or social situation of sex workers makes it difficult for them to use or to purchase condoms. Countries where AIDS has had significant impact on the sex industry are those in which there is little support for sex workers. In such countries, sex workers have had to organize and to educate themselves.

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*“There is little evidence that prohibitive legislation affects the amount of commercial sex available. But it does affect the health, welfare, and self-esteem of sex workers.”*

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In Brazil, for example, the sex workers’ organization in Rio de Janeiro is trying to teach its members about AIDS and safer sex. In Thailand the group Empower teaches sex workers to negotiate safer sex in English, the language most commonly used by tourists. In Nepal, a research project involving voluntary HIV testing of sex workers resulted in the promotion of condom use and its significant increase. Sex workers subsequently set up their own network of support and education groups – the first organization of its kind in Nepal.

In Africa, sex workers use condoms less frequently than their counterparts elsewhere, and the incidence of AIDS among sex workers has increased dramatically. But education of both clients and workers can make a difference. One campaign in central Africa, which combined education with the distribution of condoms, reported

that 75% of the sex workers involved began using them.

### **Implications**

According to WHO, “In order to achieve ...risk-reducing practices, it is essential to avoid discrimination against people engaged in prostitution, and to ensure their active participation in prevention and care efforts.” Most countries, however, deal with sex work by legislating against it. This forces sex workers to hide, which has the effect of cutting them off from society and keeping them from prevention and/or care services. There is little evidence that prohibitive legislation affects the amount of commercial sex available. But it does affect the health, welfare, and self-esteem of sex workers, which are in inverse proportion to the legal sanctions against them.

Prostitution law reform is good for health – and its beneficial effects could be considerably accelerated by giving sex workers the information, the international connections, the support, and the resources they need. Perhaps one day the word “prostitute” can become synonymous with “safer-sex educator.”

The results of international studies are fairly consistent and indicate that, outside of East Africa, the prevalence of HIV in sex workers is generally low, and not significantly different from the HIV incidence in the population as a whole. While prostitution per se is not a significant risk factor for acquiring HIV infection, IV drug use is, and a significant proportion of sex workers are also IV drug users. Men who use sex workers do have a higher risk of acquiring HIV, but only if they have other STDs or engage in other high-risk behaviors (e.g., anal sex without a condom).

The bottom line: if you use a condom correctly, your risk of contracting HIV from a sex worker is probably no greater than the risk from your girlfriend or boyfriend. But if you don’t use a condom, your risk increases greatly, especially if you also have an STI. As with all risk behavior, it’s what you do, not who you do it with, that matters.

*Luis Scaccabarozzi is Director of Treatment Education at ACRIA.*

## Personal Perspective: Discovering Myself

by Juana D.

I'm originally from Tehuaca, a small town in Mexico. I was raised to believe that I shouldn't have sexual feelings; that those were feelings only men have. I was taught that a woman's purpose in life was to serve her husband and her family. I lived a sheltered life, and left a home dominated by men to marry at 16 and enter a home dominated by another, much older, man. I was taught that I should take insults and mistreatment, and that a woman's role was to be a martyr. I believed that my role in life was to serve my husband.

Shortly after I married my husband 17 years ago, we moved to a small town north of Chicago, Illinois. It was difficult for me, being unable to speak the language, far from friends and family, without any emotional support. My husband was often away, not only at work but, as I later learned, meeting both men and women for sex, and using drugs and alcohol. He began getting in trouble and was in and out of jail.

I had four children by the time I was 21, seven by age 27. I had a total of nine pregnancies since I knew very little about birth control, and my husband wasn't willing to use condoms or let me use birth control pills. Two of my children were lost in early pregnancy, perhaps due to the many sexually transmitted diseases (STDs) that I had: syphilis, genital warts, gonorrhea, yeast infections, herpes and shingles (several times). But I was never told they were STDs. I thought I was being treated for problems related to my pregnancy. No one ever asked me to have an HIV test.

The language barrier was a large part of the problem in understanding my health, but part of it was fear: fear that there were problems in my relationship; fear that I wouldn't have financial support for myself and my children; fear about my immigration status; fear that my health problems were more serious, fear that I might have HIV (yes, I had heard about HIV, but thought that it only affected gay men); fear that I wouldn't be able to get the medical help needed if I was diagnosed with a serious disease; fear about asking the doctors the right questions.

I think the people involved in my care should have been more proactive about asking questions about my sexual history, my husband's sexual history or other risk behaviors. Maybe it would have pushed me to ask questions, to open my eyes quicker, to learn more about HIV and perhaps decide to get a test. It would have helped me to ask questions about sex, about what an orgasm was, about exploring my own sexual needs as a woman. Maybe all I needed was that push to change my entire life.

I needed to face the fear of discovering myself sexually and understanding my own sexual feelings. Because I was infected sexually, sex would have a much different meaning for me in the future. I needed to understand what sex was all about and what it meant to me. And I would need to change my entire view of the world – I had seen my role only as a person who existed to serve the needs of my husband and my family. In my culture, it was considered bad for women to even consider enjoying sex – my role was to lie down and allow my husband to do his business.

What have I learned about sex and sexuality? I've learned that I am a person who has needs – sexual needs – that need to be satisfied. So my next step was to learn how to accomplish this, since I had never been able to before. I attended support groups where I became knowledgeable and decisive about my health. I met other Latinos who had been living with this disease for many years – much longer than me. I learned that I was not dying and that I could lead a healthy life.

As I became healthier physically I also became healthier emotionally, becoming more trustful of people, including men. I was approached by single men at these support groups who wanted to get to know me better. But I was closed off from the world, and honestly felt no interest for any of these men who were also living with HIV. I began to ask myself if I should decide whom to date in this "microsociety" of Latino men in a small rural town in Illinois. But there are not many men who attend HIV-positive Latino support groups, for fear of being identified in the community as gay men or substance users. I later learned that some of them had engaged in risky activity such as IV drug use or unprotected sex with multiple partners (including other men)

but that they did not identify as IV drug users or gay men.

It was almost three years after my diagnosis that I met a man I was comfortable with, but he was HIV negative. Fear began to creep in about how I would tell him that I was HIV positive. I continuously rehearsed in my mind how I would bring it up to him and what I would say. I jokingly thought to myself, "How bad could this man be – he accepted the fact that I was a single woman with seven children. Why wouldn't he accept a 'tiny virus'?" It was a difficult but needed conversation where I let go many tears. He asked a few questions, also let go some tears, and left without letting me know if I would see him again. But he showed up at my doorstep a few days later to let me know that he didn't mind that "tiny virus." I know it was a very difficult decision for him to make. And for me, too – until then I had believed that because I was living with HIV, I needed to have a partner who also had HIV.

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***"I had syphilis,  
genital warts,  
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But I was never  
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It's been a year since we've met and, although we are not living together, we continue to see each other almost every day. We enjoy our sex life, and are very careful to engage in healthy and safe sex. We also keep up on any information that is available, and he attends some of the social activities for patients at the HIV clinic. He has been completely the opposite of what I believed men were like. He is aware of my needs – my sexual and emotional needs. I've learned that I didn't need to limit myself to those men that belonged to my support group – that love, sex, sexuality could all happen, and not necessarily in that order. I learned to move freely through what is seen by many as two different worlds, the one for those with HIV and the other for those without it. I learned that there were other couples where one was HIV positive and the other was HIV negative, and I learned that there was a term for those couples, "serodiscordant." I try not to label myself, the sex that I have, or the relationship that I have. All I know is that I feel well and am learning more about sex, sexuality and my own feelings about both.

I have learned that sex and sexuality come in many different forms, and that labels are not necessary. When my husband was engaging in sexual activity with men, women or whoever crossed in front of him, he put us both at risk for HIV and all the other STDs. It wasn't the gender of his partners but the sexual behavior that led to us getting HIV. I've learned that sex and sexuality are an important part of our healthy being. I never thought that sex should be enjoyable. I thought it was just a means of procreation and was done only to serve my partner's needs. At 32, with seven children and HIV, I can now say that I enjoy sex and have had an orgasm! I didn't know even that word existed before.

Because I am now more confident about sex and have freed myself of my cultural baggage, I can communicate better and am more independent. I have since been able to start my own business cooking and delivering meals to fieldworkers. Although I have not been able to learn English, I know that I can become part of the outside world and communicate with my limited English.

I don't feel like I have to serve my boyfriend but that we can satisfy each other mutually. My role is no longer to serve a man in all his needs; women have needs, too. Sex may not be the most important thing in life, but it's important enough that if done irresponsibly it can cause diseases or meaningless relationships, leaving you unable to enjoy a healthy relationship with a partner. It's been a process of learning and facing my own doubts, fears, and beliefs, but it was worth the journey.

I feel comfortable with myself now; in three years I have become another person. I can't say that it is all because of my attitude changes about sex and sexuality but that did play an important part of feeling comfortable as an HIV-positive Latina. I'm writing anonymously so that I don't place people's eyes on my children, since I still live in a community of mostly farm workers. Perhaps when they are grown I will be able to tell another story. In the meantime, this is the one that I need to tell now.

*Juana D. is living with HIV in a rural community north of Chicago, Illinois.*

*Translated by Luis Scaccabarozzi*

## Women: The Sex Factor

*by Lisa Frederick and Sarah Swofford*

- 22% of people living with AIDS in the U.S. are women: 88,815.
- In 2003, 27% of new HIV infections in the U.S. were in women.
- African-American women are 25 times more likely than white women and four times more likely than Latina women to have an AIDS diagnosis.
- 16- to 21-year-old African-American women are seven times more likely than white women and eight times more likely than Latina women of the same age to be HIV positive.
- In 2001, HIV/AIDS was the number one cause of death for African-American women aged 25-34 and among the top four causes of death for African American women ages 20-54.

*From "HIV/AIDS Among Women"  
Centers for Disease Control and Prevention*

In the U.S., HIV infection rates are rising fastest in women. Globally, women now account for half of people living with HIV. In the U.S., where 25% of all women are African-American or Latina, they account for 83% of all new HIV cases, with most of these infections occurring in African-American women. Other populations traditionally considered "at-risk," such as men who have sex with men (MSM) and IV drug users, have seen HIV infection rates drop in the 25 years since the epidemic began. Now, heterosexual African-American women have also become a significant risk group. Having a history of sexual abuse, poverty, violence, or limited educational and economic opportunities can also increase the risk.

Why is this happening? How does a woman's environment, culture, socioeconomic status, education, race or age affect her ability to express herself sexually and to negotiate safer sex? Do biological factors increase a woman's chance of infection? Are HIV prevention campaigns failing to provide prevention education that utilizes gender-sensitive and rights-based approaches? Is it due to a lack of female-controlled prevention methods? Are other factors at play, such as sexual and domestic violence?

Clearly, there are many issues contributing to these increasing infection rates. Socially defined gender roles and stereotypes limit a woman's social and economic power and her right to healthy relationships. Any discussion of HIV in the U.S. must consider the role that gender plays in women's lives and sexuality.

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## Women: The Sex Factor *(continued from previous page)*

### **Dynamics of Women's Sexual Practices**

The overwhelming HIV risk factor for women today is heterosexual sex, which accounts for 79% of HIV infections in women in the U.S. Has this changed women's sexual practices and relationships? To find an answer, one must examine a variety of racial, cultural and social factors. In a study on relationship dynamics, ethnicity and condom use among low-income women conducted by The Center for the Study of Population at Florida State University, African-American and Latina women reported higher levels of consistent condom use than white women. In the same study, women who made monetary decisions independently were more likely to be consistent condom users than women who didn't participate in financial decisions. Even women who *shared* in financial decisions were less likely to use condoms than women who were financially independent. These findings suggest that race and culture alone aren't the determining factors for African-American and Latina women's disproportionate HIV infection rates. Socioeconomic independence may be more important.

In a large study of 56,000 adult men and women, only half of women question potential partners about STDs, with African-American women more likely to have such conversations than white or Latina women. Unfortunately, such questioning can lead to a false sense of security and lower rates of condom use. The study also found that 66% of study participants have had unprotected sex while under the influence of alcohol. Alcohol and drugs were the biggest risk factors for unprotected sex among both men and women in every demographic subgroup.

We interviewed ten young African-American single women, asking them if HIV had for this article, the question "Has HIV changed the sexual practices of your peers. The answer was a resounding, "No!" While one of the ten women interviewed had moved away from penetrative sex (even using condoms during foreplay), the others stated that none of their sexual activities had changed. One young woman claimed that her peers were using dental dams for oral sex (though she did not); the

older women had never used them. There was clearly more concern about condom use during anal sex as opposed to vaginal sex. The one activity that had changed was group sex; those who had been engaging in it were less likely to do so after seeing the rise in numbers in infection rates for African-American women. All ten women knew they were HIV negative, but not if their partners were. Only two of the women knew about the window period (the three-month period between HIV infection and a positive HIV antibody test), and most were misinformed about basic HIV information they thought they knew.

### **The "Down Low"**

One recent topic of much discussion has been men who have sex with men outside of their relationships with women, known in certain circles as being "on the down low." There are those who attribute the high infection rates in African-American women largely to "down low" activities, to the extent that there are now guides on how to know if your partner is "on the down low." A recent Chicago study of 5,000 HIV-positive MSM found that African-American men reported high rates of sex with women, regardless of whether they identified as gay, bisexual or straight. And a recent review article in the *Journal of the National Medical Association* concluded that "non-gay-identified men of other races...also engage in in homosexual sex and do not disclose their homosexual behavior to female partners, [but] the high background prevalence of HIV and the greater odds of bisexual activity among black men" make this a "pressing issue." So, although this behavior is not limited to the black community, African-Americans have been the hardest hit by this activity.

Other studies have found that, even when many African-American women are aware of their partners' sexual practices with other men, they still engage in unprotected sex. What are the reasons that African-American women would knowingly put themselves at increased risk for HIV infection? One of the findings supported by this research says the lack of African-American male partners influences black women's sexual choices.

The study supports the proposition that bisexual activity among African-American men places heterosexual African-American women at risk for HIV infection.

### **Assumed Monogamy**

Women who are married or in what they presume to be monogamous relationships are not exempt from HIV infection. Worldwide, over 80% of new infections in women occur among those who are married or in long-term relationships. In low-income areas of New York City, women are more than twice as likely to be infected by husbands or steady boyfriends than by casual sex partners.

Often a woman doesn't learn her partner's status until after his death, leaving her with grief combined with resentment and feelings of betrayal, especially upon discovering that their partner knew his status and never revealed it while continuing their sexual relationship. Many married women think their marital status keeps them safe from HIV infection. Single women, especially those with one partner, put themselves at risk by assuming their partner is being faithful while having unprotected sex. Women often believe that as long as their partners aren't bisexual or IV drug users, they are safe, yet it is clear that assuming one is in a monogamous relationship can be high-risk.

### **Women Who Have Sex With Women**

When talking about the dynamics of women's sexual practices we must include women who have sex with women (WSW), although data on HIV and WSW is very limited. Female-to-female transmission is far less likely than male-to-female transmission. The most current data from the CDC show that through December 1998, 2% of women with AIDS reported having sex with women. These 2,200 women also reported other risk factors, like IV drug use and sex with high-risk men. 347 women reported having sex only with women, but they also reported other risk factors, IV drug use being the main one.

The perception that women cannot infect other women with HIV can actually put WSW at risk. Although data are limited, it

appears that in the few cases where female-to-female sexual transmission has been thought to occur, contributing factors like sharing sex toys, the presence of blood during sex, and former heterosexual sex by at least one female partner was reported. Yes, the HIV infection rate among this group is low, but it cannot be discounted. More data that adequately represent all women are needed so that women can have access to the information needed to protect themselves.

### Young Women

One out of four AIDS cases in women are among young women aged 29 or younger. This is a higher proportion overall than for young men (one out of six). Young women today have known sexual experiences only in the era of HIV/AIDS, and the majority of HIV-positive women ages 13-24 were infected through sexual relationships with HIV-positive men. Has growing up knowing about HIV shaped the way young women make sexual choices?

Surprisingly, it seems that knowing about HIV has little or no influence over young women's sexual behavior. Rather, most sexual protection decisions seem to be based on pregnancy prevention. A 1999 New York study of African-American and Latina adolescents found that condom use among women who used some type of hormonal contraception was low. Instead, adolescent girls who used either oral contraceptives or long-acting agents such as Depo-Provera were less likely to use condoms than other sexually active teen girls. In another study, African-American female adolescents reported that not using a condom was a sign of intimacy and trust.

Yet, due to a variety of factors, young women are at increased risk for contracting HIV and other STDs. Biologically, young women are more physically vulnerable to contracting HIV during sex. Additionally, sexually active young women often have male partners who are older, and as the age difference increases, so does the probability that sex is unprotected. Young women often have inaccurate beliefs about protecting themselves from HIV infection. Many believe that being in a sexually exclusive relationship is adequate protection, even if they live in an area with high HIV infection rates.

Knowing how to prevent HIV infection may not always be enough to protect young women. Rather, it seems that often they feel they do not have the right to make sexual decisions. A Texas study of 904 sexually active young women between the ages of 14 and 26 found that almost 20% believed they never have the right to refuse sex, ask their partner his STD status, or say if their partner is being too rough. Clearly, sexual coercion and adherence to harmful gender roles is a

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reality for many young women who do not feel they have the power to choose when and how to have sex. Young women who have suffered sexual abuse or coercion are also more likely to have earlier sexual experiences with multiple partners, putting them in at higher risk for contracting HIV and other STDs.

In the context of HIV prevention education for young people, programs that solely teach abstinence until marriage are an unfortunate reality. While education about abstinence is important, “abstinence only” programs that censor information about contraception disempower young women. Numerous studies have shown that sex education that includes information on both abstinence and contraception is the only effective way to lower teen pregnancy and STDs. The current administration's doubling of

funding for “abstinence only” education, is increasing young women's vulnerability to HIV. Funding priorities should be given to comprehensive sexual education programs that have proven effective at delaying the onset of sexual activity, reducing the frequency of sexual activity, reducing the number of sexual partners, and increasing condom and contraceptive use among young people.

### Sexual Violence

The links between gender-based violence and HIV infection are undeniable. The physical, sexual, and psychological abuse of women and girls crosses all cultural and socioeconomic boundaries and is usually perpetrated by family or intimate partners. Gender-based violence is the most common form of violence that women face, yet it is estimated that more than 50% of sexual assaults go unreported. Still, based on reported numbers, in the U.S., one in six women is a survivor of rape or attempted rape and girls ages 16 to 19 are four times more likely than the general population to be sexually assaulted.

A 2002 UCLA and Drew University study of 490 women in Los Angeles found that a history of childhood sexual abuse was a primary risk factor for HIV infection. Other studies have shown that survivors of physical and sexual abuse were more likely to be abused in the future as well. Women who had suffered chronic childhood sexual abuse or had been raped as adults were not only much more likely to engage in unprotected sex as adults but were more likely to be in abusive relationships. A World Health Organization study on domestic violence also found that women in physically or sexually abusive relationships have an increased risk of contracting HIV. These women also reported more frequently than others that their partners had multiple sex partners and refused to wear condoms.

Fear of violence plays a large role in the way women access and act on information related to HIV, limiting their ability to negotiate condom use during sex. Women who fear or suffer domestic violence are less likely than others to suggest condom use, seek out HIV/AIDS information, be tested, disclose their HIV status, or obtain

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## Women: The Sex Factor *(continued from previous page)*

services for the prevention of mother-to-child HIV transmission during pregnancy.

### Prevention

The HIV epidemic has different implications for women than for men. During heterosexual intercourse, women are more vulnerable to HIV and other STDs than their partners, due to larger mucous membranes that are exposed during sex, greater transfer of fluids from men to women, and microscopic tears to the vagina that occur during intercourse. In addition, untreated STDs, which are more frequent in women, increase the chance of HIV infection.

Current HIV/AIDS prevention options are limited, and none are woman-controlled. Often, women lack the social or economic power to demand the use of condoms. The female condom is currently the only form of protection that is woman-initiated. Yet, since the female condom is a visible barrier, male consent is necessary for it to be used. Therefore, while providing an alternate form of protection, it is not protection that a woman solely controls.

Microbicides are the only prevention method that could be applied without a partner's knowledge. A range of microbicides are in development (see article on page 18) that would provide protection from HIV and other STDs, and in some cases pregnancy. In the form of gels, foams, creams, suppositories, films, rings, or sponges applied vaginally and in some cases anally, microbicide use will be dictated solely by the person applying it. Unfortunately, development has been slow and approval remains years away, highlighting the fact that research on woman-controlled prevention methods is often not a high priority and resources for it are scant.

Since microbicide development may not be in the economic self-interest of pharmaceutical companies, funding must come from the public sector, and unfortunately has not been rapidly forthcoming. In addition, many HIV/AIDS advocates worry that, once approved, high prices will make microbicides unaffordable for poor women. This is especially a concern

for women in developing countries – the very countries most in need of such life-saving technologies. Once proven safe and effective, microbicides must be accessible and affordable for all if they are to have a significant impact on reducing HIV infection rates.

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*“Our need for sexual and emotional connection must not outweigh our better judgments to protect ourselves.”*

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### Final Thoughts

There are so many issues surrounding the HIV/AIDS epidemic and the ways it pertains to women's sexuality. For this article, we focused primarily on the complexity of the issues women today face in order to have intimate and sexual relationships in the context of HIV/AIDS.

Through our research we found that even words used to describe women's sexual behaviors, such as “negotiating,” seem better reflective of a business transaction than of what for many women is an intimate and emotional experience. Yet the actions we must take to protect ourselves in our sex lives often mirror just that.

Unfortunately, we found that women seem to not be “negotiating” sexual protection effectively. Many of the reasons for this have to do with prevailing societal norms that perpetuate the idea that women do not have the right to control their bodies and sexual encounters. Gender roles and stereotypes such as these lead to unequal power dynamics in

relationships and economic dependence. Other factors such as violence against women and lack of education, female-controlled prevention technology, and adequate research and funding on women only serve to exacerbate an unequal status quo that puts women at risk.

Yet, our findings also showed that women engage in dangerous risk-taking in the name of emotional and physical connections. It seems we often equate intimacy and trust with not verifying a potential partner's HIV and STD status before having sex, trusting in supposed fidelity, and engaging in condomless sex. And young women are learning this from us. Our need for sexual and emotional connection must not outweigh our better judgments to protect ourselves.

Clearly, the more empowered we are in our relationships, the better able we are to protect ourselves, not only from HIV infection but from other harm as well. So, what makes women feel powerful? The lack of research on women on this subject unfortunately leaves us no alternative but to rely on smaller studies and to look into our own lives for answers. These are: having goals for ourselves, knowing what we want, and having the ability to achieve it; intrinsically valuing what we have to offer; having the resources to provide for our families; and feeling physically attractive and sexually independent. When we buy into societal norms and expectations that limit our abilities to make informed choices we are limiting our power in our sexual lives.

To be successful, HIV initiatives must address obstacles to women's healthy sexual behaviors. Public policy initiatives should prioritize programs that enable women to overcome these obstacles and fund adequate research on women. Finally, only when we are truly honest with ourselves about issues and situations that are harmful to us and finding ways to deal with them will we really see infection rates in women drop.

*Lisa Frederick and Sarah Swofford are treatment educators at ACRIA.*

## Personal Perspective: **Sex Is What We Do**

by *Dana Diamond*

Having made the journey from being diagnosed with HIV and hepatitis C, coming out of jail, entering a therapeutic community, and detoxing from methadone, it is truly a blessing to address a topic dear to my heart: helping women with HIV find a healthy, satisfying sex life.

I currently run programs for women with HIV at Exponents in New York City, and many participants come to our programs with a history of sexual abuse and domestic violence. There is a strong association between childhood sexual abuse and HIV-related sexual risk behavior, and we work hard to help participants feel safe enough to disclose this information. This may be the first time many individuals reveal their sexual abuse history, and therefore we have to be prepared to make appropriate referrals for medical and/or social support.

In addition, many women who attend our programs have a history of domestic violence or are currently in abusive relationships. In these relationships, it is the man who decides whether to use safer sex methods. If a woman suggests it, she runs the risk of physical abuse. We deal with delicate negotiation strategies daily. Individuals can't always "just say no" or ask for a condom, so we need to work with individuals over time. Their attitudes and behaviors took years to form, and women in abusive relationships cannot simply walk away. To help them make behavioral changes we need to work on what they tell us they need, not what we think they need.

One of the first things we teach is that sex is what we do; sexuality is who we are. HIV-positive women are entitled to free expression of both, just like anyone else. There are many people who believe that HIV-positive individuals should not have sex anymore. But this is not real. If we don't acknowledge that we are sexual beings like all others we increase the likelihood of falling into unsafe sex practices. We need to be able to speak out in a safe atmosphere, where we can brainstorm and share ideas about how we can enjoy safer sex.

Everything about HIV affects your sex drive. How can you

feel sexy when you feel so nauseated that you are on the brink of tossing your cookies? Or if you come to bed looking like the Hunchback of Notre Dame? Let's face it—there is nothing sexy about that, especially when we are so image-conscious to begin with.

If you are in a serodiscordant relationship, fear of transmission always manages to work its way in, even though you are doing everything possible short of jumping into a latex sack to protect your partner.

Then we have the dreaded world-shattering prospect of DISCLOSURE. I can't tell you how many women just stop having sex because they are afraid to disclose. So we discuss how we can assess whether we are ready to disclose, how to disclose if we have chosen to, and how to assess the benefits and consequences of disclosure. Much of the time we dread an outcome that may turn out to be positive. And many women feel that if they meet someone who doesn't want to get to know them better because they're positive then, oh well, that's unfortunate for that person, but they're going to move on.

Most of the time, though, I do not find that type of reaction. It generally has to do with how we communicate this information. If I feel good about myself and positive while delivering the information, most of the time that's how it will be accepted. I will not apologize to anyone for being HIV positive. It is important that I forgive myself for my past destructive behaviors and that I be responsible for my current and future actions. I may be an HIV-positive woman, mother, sister, coworker, educator, but above all I am a human being and I intend to enjoy my life to the fullest each and every day. I don't have time for negativity. It is such a huge waste of energy. So, as I go through life with that attitude, and the support of some very dear friends, I feel good about myself and am therefore able to help provide a safe atmosphere for others to explore their sexuality.

Tell me, what's sexier than that?

*Dana Diamond is longtime survivor of HIV and Assistant Director of Prevention at Exponents, Inc., in New York City.*

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***“How can you  
feel sexy  
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# No Turning Back: HIV and Gay Male Sexuality

by Nicola Di Pietro,

A recent documentary film, *Gay Sex in the 70s*, covers “the sexually explosive 12-year period (1969-1981) between Stonewall and the onset of AIDS” and leads to two related questions: How has gay male sexuality changed as a result of the HIV epidemic? And what are the implications of those changes for HIV prevention efforts?

It would appear that much has changed in the past two decades, but not exclusively because of the disease. New social settings have been used by gay men to express their sexuality, and social and cultural elements have influenced the way their sexuality is expressed. Understanding how these changes have influenced sexuality is crucial to any discussion of HIV prevention. The many options for sexual expression that exist today further complicate the already difficult task of HIV prevention.

## Changes due to AIDS

Gay sexuality in the 1970s was characterized by the often open sexual practices that sometimes occurred in public locations: bars, bathhouses, outdoor cruising areas like parks or Manhattan’s abandoned piers, sex clubs, etc. Much of this is gone, due partly to responsible choices made by the gay community and partly to intense city government campaigns that outlawed adult entertainments and policed sexual behaviors in public places. Even the terminology has changed: the neutral term “MSM” (men who have sex with men) was borrowed from epidemiologists to replace gay or homosexual, terms considered too limiting for men who do not identify as gay, or too charged with stigma and political connotations.

In the early years of the epidemic, there were between 8,000 and 10,000 deaths annually in New York City, almost exclusively among gay men. Fear gripped the gay community, and many responded by embracing safer sex or abstaining from sex altogether, approaches still practiced today. Others turned to the relative safety of relationships, and the new century has seen the growth of a vibrant movement claiming the right to marriage. But sex with occasional multiple partners remains a significant element of gay male sexuality. In response to the government shutdown of commercial sex establishments, there has been an explosion of private sex parties, and a new venue for sex with multiple partners has been introduced and embraced: the Internet. And as in the 70s, there remains a core group of highly visible individuals who embrace the use of illegal recreational drugs to enhance sexual activity.

In the 1980s, gay men widely adopted safer sex practices, but the number of new AIDS cases among MSM did not begin to decline until the advent of HAART (highly active antiretroviral therapy) in 1996. Today, new HIV/AIDS cases are actually increasing among MSM – a 9% increase from 2001 to 2004, with the largest increase occurring in 2004. And this year, a five-city CDC study of 1,767 MSM with a median age of 32 found high rates of infection: 25% tested HIV-positive. Alarming, 46% of African-American MSM tested positive, and 67% of those who did were unaware of their status.

A report from the Guttmacher Institute cites “prevention fatigue” (difficulty maintaining safer sex habits) and disinhibition (underestimating the consequences of HIV infection) as key barriers to control of the epidemic. Maintaining prevention can be difficult. Deciding to follow safer sex practices requires information, motivation, and time. Sticking to the decision requires constant reinforcement that safer sex itself does not provide. Behavioral modification does not generate visible results: time goes by uneventfully, a person tests negative for HIV, and the perception builds that the precautions may not be needed. Eventually the person may slip into episodes of unsafe behavior. Paradoxically, negative tests can reinforce the idea that safer sex is not needed.

Disinhibition is even more insidious. The success of anti-HIV medications in reducing progression to AIDS, prolonging life, and restoring quality of life for people with HIV has reduced fear of the virus. A common perception is that treatment will take care of an infection that does occur, and many people are unaware that progression to AIDS and development of HIV resistance still occur and that treatment comes with significant side effects and demands strict adherence. Viral load testing is also partially to blame for the more relaxed attitude toward HIV. “Undetectable” levels of HIV are taken as a license to have unprotected sex based on the assumption that when undetectable, there is a very low risk of the virus being transmitted. Efforts to counter this misinformation have achieved varying levels of success, and scare tactics do not work well in practice, especially for skeptical individuals.

Over all, it appears that as one group adopts safe sex practices, another comes along and engages in risky behaviors. This changing framework constitutes a challenge for HIV prevention, but targeted prevention programs have demonstrated some effectiveness. In the 1980s, white gay men were the focus of prevention efforts, and HIV incidence in that population declined. Over the last decade, ethnic minorities and young adults have been the focus of prevention efforts. While new cases in adolescent and younger adults are still growing, 12% fewer new HIV cases among those aged 25-44, the generation exposed to prevention measures in the last decade, were reported in 2004, compared to 2001. A similar drop occurred among African-Americans. The current focus of CDC prevention efforts is “prevention for positives” – encouraging people with HIV to practice safer sex. The emphasis is now on HIV testing, since the CDC has found that the majority of new sexually transmitted infections involve people unaware of their HIV status.

## Sexual Settings

To be effective, prevention efforts require us to monitor the pulse of the epidemic – in particular the pulse of the risk behaviors in various populations. We need to look in detail at the aspects of MSM sexuality today. Specifically, we must examine the settings for socialization and sexual expression.

Abstinence is a controversial concept with different definitions. For some, it means the total absence of any sexual activity; for

others, it refers only to avoiding penetrative sex. The adoption of some form of abstinence may seem a direct response to the HIV epidemic, but in fact the practice has always been one of the many ways in which men attracted to men dealt with sexual desire. Many gay men do not feel at ease in the gay scene, which generally caters to young, healthy-looking, attractive men. Some may have difficulty finding partners, and may eventually stop looking choosing to live as single, independent men. Abstinence is quite prevalent in older men, as it is in people with chronic diseases or disabilities; 31% of people living with HIV report they are abstinent. But abstinence is not an irreversible choice. Significant relationships can unexpectedly develop, and abstinence may be broken in anonymous settings.

In an article in *Social Work* magazine, Harvey Gochros, a support group facilitator who worked for years with HIV-positive people, describes the physical, social, and psychological factors that complicate the sexual activities of MSM living with HIV and that make abstinence an attractive option. Absence of willing sex partners is an important factor – potential partners may refrain from getting involved with a person in precarious health, both to avoid the risk of infection and out of reluctance to assume the burden of caregiving. Economic factors can force people into living arrangements without a private space in which to engage in sexual activities, and physical ailments and side effects of medications can reduce sexual desire.

These obstacles are exacerbated by the negative societal attitude toward homosexuality, and in particular toward the sexuality of HIV-positive people, seen by some as inappropriate, irresponsible, or even criminal. These physical and social factors in turn influence psychological factors: people living with HIV may perceive themselves as unattractive and may experience guilt in connection with their status. Sexual experience can therefore be distressing, leading to abstinence or alternative sexual behaviors such as masturbation and viewing pornography – ways to keep sexually active while avoiding rejection and post-sex guilt.

Stable couple relationships are an important and often underestimated form of sexuality for MSM. The 2000 census counted 300,000 same-sex male households in the U.S.; this figure underestimates the number of stable homosexual relationships, since many gay couples maintain separate residences. The rising number of gay male couples and the campaign for same-sex marriage may be visible signs of a reaction to the HIV epidemic. Fear of infection may play a role, but increased acceptance of a gay identity may be more important. Of course, intimate relationships, whether between same-sex or mixed-sex couples, do not simply

offer a means for sexual partnering but also offer shared identity and personal growth.

As there is no normative structure for same-sex relationships, gay men continually reinvent what it means to be together and renegotiate the rules for sexual conduct. One option is to form couples based on HIV status. This serosorting allows people living with HIV to find understanding in HIV-positive partners and spares them the need to coach HIV-negative potential partners to accept and respect their status. The other advantage for seroconcordant couples, whether HIV positive or negative, is that they can engage in unprotected sex with limited risk provided they practice mutual monogamy or have only safer sex with outside partners. Superinfection (infection with a second strain of HIV)

has been reported, but rarely in people who have had HIV for over one year. Seroconcordant HIV-positive couples must decide for themselves if the risk of superinfection outweighs their desire for condomless sex.

Unfortunately, even monogamous couples can expose each other HIV. In one study, a third of couples interviewed had engaged in unprotected anal intercourse before they knew each other's serostatus or had had unprotected sex prior to the monogamous commitment but too recently to be detected by current HIV tests. On the other hand, serodiscordant couples must maintain safer sex practices even if committed to monogamy. According to a 2003 study published in *AIDS Care*, such couples experience higher distress than other couples, similar to couples coping with other chronic illnesses. This distress is the same for both the positive and the negative partner, showing that they face the challenge of HIV as one unit. The same study found that a high level of sexual satisfaction reduces the level of distress in serodiscordant couples, indicating how important sexuality is for the couples' overall well-being.

According to a 2003 study, more than half of the men in primary same-sex relationships also have non-primary sexual partners, but this does not automatically translate into unsafe sex. The HIV epidemic introduced the concept of safer sex negotiation, detailed discussions of sexual activities before the occasion arises. For HIV-negative couples the promise of monogamy is now also a commitment to protect the partner from infection and has its ritual of testing together for HIV and disclosing each other's HIV status. Slipping from a monogamous commitment cannot be overlooked, but requires responsible acknowledgment. Open couples need to define specifically the level of risk acceptable to both and the need to reveal to each other the details of their sexual experiences outside the relationship.

*(continued on page 15)*

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*“Maintaining prevention can be difficult... Paradoxically, negative HIV tests can reinforce the idea that safer sex is not needed.”*

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## Risky Business

by Spencer Cox

When it comes to HIV, gay men literally wrote the book on how to prevent the disease. During the 1980s and early 1990s, new infections among gay men dropped by historic proportions. Today, when most health experts talk about prevention for gay men, they focus on groups that have traditionally been hard to reach with safer-sex information: young gay men and gay men of color.

However, recent statistics suggest dramatic increases in risky sex (and other kinds of risky behavior) among older, white, and relatively affluent gay men in major cities – traditionally the group for whom prevention efforts were most effective. Aided by the epidemic of crystal methamphetamine that has swept through the gay community, this new wave of infections poses troubling challenges for HIV prevention efforts.

It has always been hard to get a clear picture of where the epidemic is headed. The long asymptomatic period after infection and spotty surveillance efforts have usually meant that data reflect the epidemic of five to ten years ago. However, a variety of “secondary” markers suggest a resurgence of high-risk behavior.

For instance, because syphilis is transmitted in much the same way as HIV, we’ve often looked at rates of that disease to show us who is having unprotected sex. Among urban gay men, syphilis rates have more than tripled since 2000. In New York City, the rise in syphilis rates among gay men has been associated with increased average income, diagnosis in a private doctor’s office (as opposed to a public clinic), increased age, and residence in one of the “gay ghettos” along the west side of Manhattan. The syphilis epidemics in other major cities, including Los Angeles, Chicago, San Francisco and Washington, DC, followed a similar pattern.

Measuring new HIV infections directly is harder, although a number of cities have reported increases in new HIV infections among gay men. However, looking at newly reported

HIV cases, we can get some idea of where the epidemic is moving. One-third of newly reported HIV cases among gay men in New York City are in men over 40; 44% are in men in their 30s. The epidemic in gay men under age 30 largely affects men of color; over age 30, the disease affects a far greater percentage of white men.

Much of this resurgence may be related to the use of crystal methamphetamine, a highly addictive form of speed that has swept through the gay community. About 20% of gay men in San Francisco report some meth use, as do about 15% of gay men in New York. In Chicago, nearly one in five gay men who reported using meth said they took the drug weekly. Rates of use among whites were about three times that of African-Americans.

Use of meth is strongly associated with risky sexual behavior, and with HIV infection. Meth users have many more casual sex partners, and more episodes of unprotected receptive anal intercourse. In a recent study from the Los Angeles Gay & Lesbian Center, which offers HIV testing, nearly one-third of recent positive tests in gay men were associated with meth use.

Another key contributor to the spread of HIV in this population is depression. Gay men have much higher rates of depression than the overall population of men – about 20% of gay men show some signs of depression, as compared to about 7% of all men. Depression has been strongly linked with unsafe sex in HIV-negative men. However, interestingly, the risk is concentrated not among men with the

most serious kinds of depression, but among men with “dysthymia,” or mild, chronic depression.

Traditionally, our HIV prevention programs (and, indeed, most kinds of health promotion campaigns) are based on giving people information, such as instructions on having “safer sex.” However, if the epidemic is indeed experiencing a resurgence among relatively affluent, middle-aged white gay men, this presents us with some vexing questions; this population, it is safe to say, does not lack for

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***“The rise in syphilis rates among gay men has been associated with increased average income, diagnosis in a private doctor’s office, increased age, and residence in one of NYC’s “gay ghettos.”***

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information about how best to prevent HIV transmission. How, then, should health departments and AIDS organizations go about preventing the disease from spreading further?

One obvious answer is to develop programs to prevent meth use, and to treat meth addiction. Another is to concentrate on the development of meaningful mental health services.

However, more fundamentally, it is time for gay men to think about our communal behaviors and institutions.

Drug use, for example, has become highly normalized within the gay community. A 2001 study found that almost one in four urban gay men had recently used a stimulant drug, such as ecstasy, cocaine or methamphetamine, and almost one in five reported “multiple drug use.” About 20% said that they had “frequent use” of these drugs. Are these levels too high? Given the strong association of methamphetamine with negative outcomes, should we single out this drug for prevention efforts? Or should we conduct more general programs that are designed to lower the overall rate of drug use? Is there some middle ground between complete prohibition and an “anything goes” attitude towards high levels of drug use? Are our institutions, such as nightclubs, websites and circuit parties encouraging addiction and HIV infection? This is a conversation that is urgently needed, and one that should not be shut down by our discomfort.

Finally, it is worth noting that many AIDS organizations have simply ceased to provide meaningful prevention services for gay men. The success of HIV prevention in the 1980s led prevention experts to focus on higher-risk populations. However, these data prove once again that HIV prevention requires more than a one-time intervention. To be effectively sustained, behavioral changes must receive ongoing support that is adapted to current challenges. At present, however, gay men are not receiving that support. If we want prevention efforts that meet our needs, we will need to vote loudly, with our voices and with our checkbooks. We too deserve lives without HIV.

*Spencer Cox is the Founder and Executive Director of The Medius Institute for Gay Men's Health.*

## No Turning Back *(continued from page 13)*

Sex with occasional outside partners and serial dating is common among MSM. Societal rejection of same-sex relationships can make it difficult to start and maintain a relationship, and there are ample opportunities for MSM to find casual sex partners, especially in large cities. A U.S. study of public sex environments (PSEs) – parks, beaches, public bathrooms, truck stops, etc. – and commercial sex environments (CSEs) – bars, bathhouses, sex clubs, etc. – found that half of the HIV-positive MSM surveyed had visited a PSE (50%) or a CSE (41%) in the previous three months, with 24% going to both. Interestingly, MSM who visited PSEs did not engage in more unprotected sexual activities than did those who did not visit PSEs, while visitors to CSEs had significantly more unprotected sex than non-visitors.

A European study found that between a quarter and a half of MSM use PSEs or CSEs and that the majority of users of both PSEs and CSEs are gay identified. The most common sexual activities in PSEs are mutual masturbation and oral sex, and less than 10% report unprotected anal intercourse. The type of activity varies according to situational constraints. HIV prevalence is twice as high among users of PSEs as in the entire gay population.

Most of the empirical evidence suggests that MSM tend not to disclose their HIV status to casual partners or negotiate safe sex in public and commercial sex environments. These are spaces where very little conversation occurs, and talking about HIV is considered a spoiler for the budding sexual adventure. The burden of initiating the conversation about disclosure is put on the HIV negative partner, and based exclusively on the perceived risk of the sexual activity engaged upon. Eventually, high-risk behaviors occur even when HIV status is disclosed and the partners are serodiscordant, but this behavior is not all about irrepressible sexual urges.

According to a 1999 study published in *Sexualities*, there are four powerful nonsexual factors that drive the engagement in sexual activities by gay men, including risky sexual practices: “(1) the need to validate one’s sense of physical attractiveness; (2) the need to restore a wounded sense of masculinity; (3) the need to alleviate painful experiences of loneliness and social isolation; and (4) the need to get away, find relief or escape, at least temporarily, from difficult situations brought about by poverty, racism, interpersonal rejection, and AIDS.” Thus the contextual elements of setting and motivation need to be considered when planning any prevention strategy.

### **Social and cultural determinants**

Ethnicity and age are two other factors influencing sexual behavior in the time of AIDS. According to an article by Vickie Mays in the *Journal of Black Psychology*, MSM belonging to visible racial and ethnic minorities experience prejudice and discrimination both within the predominantly white gay community and within their often macho ethnic communities. MSM in these com-

*(continued on next page)*

## No Turning Back *(continued from previous page)*

munities have adopted strategies summarized by terms like “homothugz,” or “being on the down low.” The tough image of the “hip-hop” and “posse” culture they adopt offers protection against a discrimination too often expressed through physical violence. Many ethnic communities have very strong support networks, but these are often centered on institutions that are intolerant of sexual diversity. Organized religion, for example, is very important in African-American and Latino communities, but the churches are a major source of discrimination against black and Latino MSM. Social rejection from their community makes self-acceptance more difficult, and being closeted can be psychologically unhealthy.

There is a sharp divide between the pre-AIDS gay generation and their younger counterparts. The former share a profound experience of grief for the loss of countless loved ones and friends, nostalgia for a paradise lost, and resignation to the constraints of safer sex. Younger gay men entered the sex scene in an age when condoms, HIV testing, serostatus disclosure, and sex negotiation were part of the package; while they may feel cheated of the golden era of free sex, they nevertheless grew up on the concept of safer sex, since condoms, HIV testing, serostatus disclosure and sex negotiation were part of their entrance into the sex scene.

But the generation coming of age today, after the introduction of HAART, has had little exposure to the ugly realities of the epidemic, and may therefore be at greater risk of developing unsafe sexual habits. The success of HAART has, ironically, increased the danger that these young people will lapse into dangerous sexual practices.

### Conclusion

Our sexuality is a large part of who we are as human beings. It is also a basic right and an essential part of our quality of life. Sexuality is also fluid; contextual factors like ethnicity, socioeconomic status, and age, as well as settings of sexual activities all contribute to the sexual choices that we make. Their role is becoming more apparent as studies discover new settings and new modalities for sexual encounters.

Epidemiologic evidence and behavioral research have discovered wide variety in the ways MSM have responded to the challenges of the HIV epidemic and various prevention messages. Successful prevention requires open, accurate communication that acknowledges the right to sexuality in all individuals, at all ages, and in the presence of any medical condition. Every social, ethnic, and cultural group can be receptive to prevention messages that validate them by responding to their unique needs as well as to overall public health needs.

*Nicola Di Pietro, MD is a Public Health and Social Science Researcher.*

As a gay man coming of age in the 70s, sex clubs and public sex spaces were an important part of my sexuality. But I maintained a difficult love/hate relationship with these spaces. While they provided near-instant gratification at almost any time of the day or night, they certainly did not provide what I was really looking for: a life partner. Like many gay men I met, I had many partners but, in my case, little satisfaction. And when AIDS appeared I found another reason to dislike these spaces: not only did they not fill my emotional needs, but now they were dangerous to my health, too.

All these concerns became moot in 1994 when the Giuliani administration began a serious crackdown on sex spaces, triggered by an undercover TV news report on the sex clubs – videotaped at my favorite club! Highly sensational, it led to real fears that all sex clubs (which had actually been banned in New York State by legislation passed in 1985 but had continued to operate) would really be closed down this time.

I wasn't that surprised by the report, since I had seen behavior at sex clubs that seriously disturbed me. I saw guys screwing without a condom right beneath a “Safe Sex is Good Sex” poster. I saw orgies packed into tiny rooms where condom use was virtually impossible. And the worst case that I saw (an image burned into my mind to this day): a very young man on his back with his feet in stirrups, drugged out of his mind, being entered without condoms by one guy after another while about 20 guys watched. To me, this sent a powerful message, one much more potent than any safer sex poster or brochure: My peers see this behavior and approve. How would we ever get a handle on HIV transmission if the message being sent out by guys in our group sex establishments was that unsafe sex was cool?

So in early 1995, I decided to take on the issue. I thought that we had a chance to kill two birds with one stone: prevent the sex clubs from being closed down and do something about all the unsafe sex that was happening there. I contacted the owner of every commercial sex space in New York City, gay or straight – not an easy task, since these are not people who seek the limelight. But eventually we convened a meeting with about 30 owners, all of whom were very concerned about the future of their establishments. I proposed that we take a proactive stance: tell the city that sex clubs should stay open, but that unsafe sex would not be allowed. How could that be done, you ask? The idea was to make common something that was then being done at only a few clubs: using monitors.

This was actually not a new concept. The New York Jacks, a club that celebrated mutual masturbation long before the AIDS epidemic, held regular sex parties in which only masturbation was allowed. A sign was posted at the door: NO LIPS BELOW THE HIPS, and anyone found having oral or anal sex was promptly told to leave. Since no one wanted to be thrown out, the rule was rarely broken. I had also seen monitoring work in other ways: I knew of one backroom in which the very sexy monitor stopped anal sex, but also joined in the fun on occasion!

This led to my idea: the community would find and train “lifeguards” – sexy guys who would wear lifeguard tank tops and patrol the sex clubs. If they found anyone having unprotected anal sex, they would say, “Here, use this condom or take it home.” (Since oral sex presented a low risk of HIV transmission, it seemed best to focus efforts on unprotected anal sex only.)

## *Personal Perspective: How I Joined the Sex Police* by Mark Milano

Using lifeguards would, of course, require that all the sex in the clubs happen out in the open: no booths with doors or private rooms. But the owners were okay with that. Anything that would get Giuliani off their backs was fine with them. I envisioned a real community effort: GMHC would train the lifeguards, the owners would hire them, and ACT UP would endorse the idea of promoting safer sex in the clubs.

Boy, was I wrong! I brought the idea to the floor of ACT UP and was crucified. Not only did people hate the idea of “Sex Police,” they hated me for even proposing it. Member after member got up and called me a fascist, neo-con, or self-hating gay, and people who had worked with me for years screamed at me or stopped speaking to me altogether. Activists were adamant that anyone had a right to be infected if they chose to, and that we had no right to tell anyone how to have sex.

And I agreed – to a point. Certainly, anyone should be able to do whatever they wanted in the privacy of their home. But I felt commercial sex establishments were different. These places were making tons of money by providing a space that I felt facilitated unsafe sex with multiple partners. If AIDS activists really wanted to promote the idea that safer sex was important, I thought the message should be, “If you want to be unsafe, that’s your right, but not in our sex spaces.”

So without the support of ACT UP, the sex club owners met with the city. As the meeting was about to start, I stood up and said, “We’re happy that the city has agreed to meet with those of us who have been working on this...” Mark Barnes from the NYC Department of Health interrupted me, saying, “I’m in charge of this meeting – I’ll take it from here.” He proceeded to negate any work we had done, saying only, “We will be sending undercover police into your clubs and if we see any anal or oral sex, we’ll shut you down.” Period. No discussion, no request for input, no community involvement, nothing. The meeting was over. I was furious. And I felt like a fool for thinking the Giuliani administration would ever listen to us.

So we continued to promote the idea of safer sex clubs on our own (GMHC also refused to get involved), and the debate raged on. I got hate mail from all corners: straights calling me a sick faggot promoting the spread of disease, gays calling me an embarrassment for promoting gay promiscuity, and activists calling me self-hating for promoting the idea of sex police.

We met with the New York State AIDS Advisory Council for their recommendations, and they agreed that the clubs should be regulated, not closed. Likening multi-partner sex to other “vices” that society controls but does not ban, like drinking and smoking, the Council recommended that the city work with the owners and the community to forge a mutually acceptable solution.

But the community and city would not budge. The activists said simply, “Hands off our sex spaces!” The city said, “Anal, oral or vaginal sex, with or without a condom, in a commercial sex establishment is illegal.” Clubs tried to work around the law – one sex club claimed it was an art gallery and had patrons make partial payments on paint-

ings instead of charging admission – but the city knew how to close the clubs. One by one, they were shut down.

One of the funniest moments came when the West Side Club went to court to stop its closure, saying it was not a sex club. The judge asked, “If you aren’t a sex club, what are you? You have no license to be a gym or a sauna.” “We’re a conference center,” their lawyers replied. “For who?” “Professionals: lawyers, doctors, ministers.” “Why do you have all those tiny rooms with beds in them?” “For people to rest in between meetings.”

But the West Side Club had one tactic the city couldn’t beat: hide all the sex. The clubs that remained open moved all the sex into booths or rooms. The police couldn’t see it, so as long as the club had some other reason for existence (showing movies, etc.), they weren’t a sex club. Of course, this also meant they could no longer provide condoms, since that would mean admitting patrons were having sex. So now we had clubs where people had sex behind closed doors with no condoms, unless they had the forethought to bring their own.

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**“How would we ever get a handle on HIV transmission if the message being sent out by guys in sex clubs was that unsafe sex was cool?”**

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The community broke into two factions. One group, the AIDS Prevention Action League (APAL), formed to fight any closings or monitoring. Another, the Gay and Lesbian HIV Prevention Activists (GALPHA), formed “to end HIV transmission in commercial sex establishments.” I attended meetings of both groups. APAL had a lot of discussions about finding new, creative ways to promote safer sex in the clubs, but in the end all it did was make yet one more poster, visit a sex club (I’m not sure what members did there other than to have sex), and hold a safer sex party. GALPHA had similarly unproductive meetings and then a few members arranged to meet, without me, with city officials about the unsafe sex occurring in the clubs. This was viewed as a real betrayal by many in the community and hardened the two stances even further.

The end result was that sex spaces moved underground. They are still there, but they are harder to find. One notoriously unsafe party was held for years by a well-known “elder” of the gay community. They got around the undercover cops by requiring people to get naked or to play with their dicks before entry – something that is apparently too traumatic for straight undercover cops to do.

And, I’m sorry to say, the unsafe sex continues. Gay men have now adopted the fantasy of “serosorting.” Many online ads request partners who are “disease-free,” as though asking a stranger his HIV status offers any useful information. If I tell guys I’m negative, the option of unsafe sex often appears. What a disaster! If guys think that condoms can be avoided simply by asking your partner if he’s “clean,” they’ll have an unpleasant surprise the next time they have an HIV test.

I believe that we missed a golden opportunity. We had the chance to create vibrant sex clubs that sent a clear message: we value safer sex and refuse to stand by and watch guys get infected. Instead, the steady drumbeat of new infections continues behind closed doors.

*Mark Milano is a longtime AIDS activist and an educator at ACRIA.*

# The Future of HIV Prevention: New Tools, New Hope

by *Betsy M. Finley and Carolyn J. Plescia*

Approximately 40 million people are currently living with HIV worldwide, almost 5 million of whom were infected in 2005. In addition to expanding the availability of antiretroviral (ARV) treatment in developing countries, the scale of the epidemic requires the continued promotion of available prevention tools and the exploration of a range of novel technologies. Research and development are ongoing for several promising new prevention strategies, including male circumcision, microbicides, pre-exposure prophylaxis, and preventive HIV vaccines. Efforts also continue to promote known strategies, including prevention of sexually transmitted infections (STIs). In many cases, the methods in development are initially expected to have partial efficacy and are intended to be used in conjunction with male condoms. In addition, no one method can meet the needs of all individuals; therefore, a range of complementary prevention tools will be needed to stem the epidemic.

## **Sexually Transmitted Infections**

The spread of HIV is thought to be accelerated by the relationship between HIV and STIs. The presence of an STI may increase the infectiousness of an HIV-positive individual as well as enhance susceptibility to HIV infection among those who are HIV-negative.

Ulcerative STIs – chancroid, herpes, and syphilis – can increase viral shedding of HIV, generally from the ulcer itself. Ulcers may also bleed during intercourse, which in turn can increase HIV transmission. Susceptibility to HIV can be intensified in the presence of an ulcerative STI, either through mucosal disruption or through an increase in the presence or activation of cells susceptible to HIV. Susceptibility may be further increased by interactions between viral STIs and HIV.

Inflammatory STIs – chlamydia, gonorrhea, and trichomoniasis – can also enhance HIV infectiousness by increasing viral shedding. Susceptibility to HIV can

be increased among HIV-negative women by proliferation of HIV-susceptible cells resulting from infection from non-ulcerative STIs. HIV replication may also be facilitated through an interaction between chlamydia and selected white blood cells.

The relationship between HIV and sexually-transmitted types of human papillomavirus (HPV) is complex. Coinfection with HPV and HIV is frequent, an occurrence that is likely a result of common risk factors as well as an increase in susceptibility to HPV among HIV-positive individuals. The converse may also be true: the risk of acquiring HIV may be increased by HPV infection. Additional research is needed to further define the association between HPV and HIV and the potential impact of HPV infection on HIV transmission.

Condoms can reduce the risk of contracting many STIs. Studies have shown decreased rates of gonorrhea, chlamydia, herpes simplex virus type 2, and syphilis among those who use condoms consistently. The reduction in STIs that would result from increased condom use could reduce HIV incidence.

## **Bacterial Vaginosis**

Bacterial vaginosis (BV), sometimes referred to by the general term “vaginosis,” is one of the most common infections of the female reproductive tract and may play a role in increasing the susceptibility of women to HIV infection. BV, which occurs in up to 25% of women, refers to a drop in the levels of lactobacilli (bacteria that help to protect the vagina). BV, unlike many other STIs, is common among women having sex with women.

BV and STIs commonly occur together, but researchers are unsure as to why. One theory is that acquiring an STI is linked to low levels of lactobacilli. Some data support the use of condoms in preventing BV, but due to the uncertainty of its cause and its high prevalence in areas where the risk of HIV infection is also high, further

research is needed to consider if interventions to control BV can be useful as an HIV prevention method in women worldwide.

## **Male Circumcision**

It is possible that male circumcision could play a significant role in reducing the spread of HIV infection in hard-hit areas such as sub-Saharan Africa. In 1986, the first report that suggested that circumcision may offer a degree of protection from HIV infection was published. In the years following, numerous observational studies and meta-analyses were conducted, with the former suggesting that areas with the highest HIV prevalence – namely Eastern and Southern Africa – were also areas where most men are not circumcised. A meta-analysis revealed an association between circumcision and lowered HIV risk among men in sub-Saharan Africa – 21 of the 27 studies reviewed demonstrated a reduction in HIV risk among circumcised men. But due to the lack of experimental data, a causal relationship between circumcision and HIV prevention could not be established. It was also unclear, based on the observational studies, whether HIV infection rates were greater in high prevalence areas due to low rates of circumcision or because of behavioral differences between the circumcised and the uncircumcised groups.

In the first randomized clinical trial assessing whether circumcision can reduce the risk of HIV infection, researchers found circumcision to have a 60% protective effect. Of more than 3,000 men who were followed for an average of a year and a half, 20 members of the intervention group and 49 of the control group acquired HIV during the trial. This means that the intervention (circumcision at the beginning of the trial) prevented six out of ten HIV infections during the study, suggesting that men who have been circumcised have less of a likelihood of acquiring HIV when having sex with HIV-positive female partners. The data from this first clinical trial seem to indicate that in regions with high

HIV prevalence, circumcision could reduce men's risk of becoming infected. Different cultures have various views about circumcision, and implementing this potential HIV prevention method on a large scale could be difficult. Since data from the first trial seem to indicate that circumcision is partially protective, circumcised men will still need to use condoms. Programs that promote circumcision for HIV prevention will need to include a condom education component.

### Microbicides

Microbicides are substances intended to reduce sexual transmission of HIV or STIs when applied topically to the vagina. A number are currently in development. A microbicide could be formulated as a gel or cream; film; suppository; pre-loaded diaphragm or cervical cap; or slow-release sponge or vaginal ring. Some formulations would be applied prior to each act of intercourse, while others might be worn by the woman continuously to provide protection for a longer period of time. Some microbicides might be contraceptive; others would allow women to become pregnant while simultaneously offering protection from HIV. An ideal microbicide would also be acceptable to a variety of men and women in different cultures.

Microbicides would provide a much-needed woman-controlled method of HIV prevention. As the HIV epidemic progresses, women and girls are increasingly affected. Between 2003 and 2005, the number of women living with HIV increased by 1 million to a total of 17.5 million worldwide. In sub-Saharan Africa, 57% of HIV-positive adults are women. Moreover, women – particularly young women – are biologically more susceptible to HIV and STIs than men. When combined with the persistence of gender inequality, economic disparities, and violence, this increased biological risk further reduces women's ability to protect themselves from HIV. Microbicides, which could be used with or without a partner's knowledge, would provide a prevention option for women that they could control.

Microbicides could prevent transmission of HIV through several mechanisms of

action. Membrane disruptive agents (surfactants) kill or inactivate viruses or bacteria by disrupting their outer membranes. Vaginal defense enhancers boost vaginal immunity and maintain the protective acidic pH of the vagina. Entry/fusion inhibitors disrupt the process of attachment, binding, and fusion between HIV and host cells – by targeting either the viral envelope or host cell receptors and co-receptors. Replication inhibitors prevent the virus from spreading to other cells and/or interrupt the viral replication process by inhibiting reverse transcription.

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Microbicides may also reduce susceptibility to HIV by providing a physical barrier to infection and supplying lubrication during intercourse to reduce the risk of epithelial disruption. As microbicides with a single active ingredient or mechanism of action are unlikely to offer complete protection, combination microbicides are being explored as a means of increasing efficacy.

There are currently 14 microbicide candidate products in preclinical development and 15 in clinical development. Ten of the products in clinical development are in early-stage trials (Phase 1, 1/2, or 2) and five products are in more advanced trials (Phase 2/2B or 3). These late-stage trials, spanning 12 countries, will enroll nearly 30,000 participants. One of the five prod-

ucts in late-stage trials is a membrane disruptive agent (Savvy), one is a vaginal defense enhancer (BufferGel), and three are entry/fusion inhibitors (Carraguard, cellulose sulfate, and PRO 2000). Replication inhibitors are in early-stage trials, (Tenofovir/MPMA gel, TMC120, and UC-781). Each of the microbicides in late-stage trials is expected to have partial efficacy, which means they should be used with condoms. A 60% efficacious microbicide could avert 2.5 million HIV infections over 3 years if used in 73 lower-income countries.

The development of rectal microbicides is at a much earlier stage than vaginal microbicides, partly because the environments of the rectum and vagina are markedly different. Early research is being conducted to find markers that could be used to study the safety of rectal microbicides. Studies are also being done to determine the acceptability, when used rectally, of different volumes of a gel that is similar to potential microbicides. Given the differences in the tissues and structures of the vagina and rectum, more research is needed to assess the potential of microbicides for rectal use.

### Preventive HIV Vaccines

An increasing number of organizations have become involved in vaccine research and development, and the number of vaccines in clinical testing has grown substantially over the past five years. This growth, however, has occurred in the context of significant challenges.

Early vaccine candidates sought to elicit a humoral immune response, aiming to produce neutralizing antibodies, leading to viral clearance after exposure. For a variety of reasons, induction of this type of immunity has proven difficult. VaxGen's candidate vaccine AIDSVAX, which employs recombinant gp120 proteins to induce an antibody-mediated immune response, was shown to be ineffective in Phase 3 trials conducted in the United States and Thailand.

Recent research has focused increasingly on cell-mediated immunity. There are currently more than 30 products in early-stage trials taking place in 19 countries, the majority of which aim to elicit a cel-

*(continued on page 26)*

# Taking Sexual Histories: The Whys and Hows

by Luis Scaccabarozzi

It is important to tread carefully when taking a sexual history, not only because the answers are important but also because your client or patient will want to know why you need all that personal information. Since people can be uncomfortable when asked about their sexual history, providers must remain mindful of why each question is asked and what action will follow from the answers given.

Providers may need to obtain information for data collection purposes as required by funders, but they must first consider what the process means to clients. They should feel comfortable enough asking intimate questions to be able to help clients discuss risk behaviors and harm-reduction strategies, and to provide information. Whether collecting basic sexual history data or conducting in-depth research, they should be able to explain why they are collecting the information and how it will be used.

Taking a sexual history is an essential first step when providing contraceptive, reproductive, and HIV/STD counseling. It can screen for high-risk sexual behaviors, can identify sexual problems, and is an opportunity to provide information and support to clients. Statistics bear out that having sex is not rare for adolescent and young adult patients, or for any other patient who feels healthy enough. In a 2004 study of high school students, nearly 47% reported having had sexual intercourse. Between 800,000 and 900,000 females under the age of 19 become pregnant every year. Sexually transmitted diseases are also a major concern: chlamydia and gonorrhea incidence is highest among females aged 15-19 years old and males 20-24 years old.

Sex-related problems can lead to disease, illness, and even death; sexual abuse can cause sexual dysfunction and potentially contribute to substance abuse and mental illness; homosexual and transgender patients are at heightened risk for suicide and depression; and an estimated 50% of all pregnancies are unintended, leading to less prenatal care and a higher incidence of low birth weight, infant mortality, and other medical problems. Thus, understanding our clients' sex and sexuality is important in helping to decrease medical concerns linked to sexual behavior and sexual orientation.

## Whom Should We Screen?

Many high-risk-taking behaviors begin in adolescence. In fact, 7.4% of teens have had sex before the age of 13, according to a 2004 study. Despite this, research has shown that clinicians are less likely to question younger adolescents than older adolescents about their sexual behaviors.

At the other end of the life cycle, some care providers assume that older adults are no longer sexually active and fail to assess their sexual health. But older adults who remain sexually active also remain at risk for sexually transmitted diseases (STDs), and they may be less forthcoming about any sexual problems they may be experiencing. In a study of sexual activity among older adults, 31% of men and 43% of women reported sexual dysfunction. In the 1989 Massachusetts Male Aging study, 52% of men aged 40-70 reported erectile dysfunction.

Unfortunately, studies show low rates of sexual health assessment of older adults by physicians and other clinicians. Time constraints, underestimation of patient risk, and embarrassment prevent some clinicians from conducting such assessments. Others may not believe that a sexual history is medically relevant to the purpose of a particular visit, while still others are unfamiliar with some sexual practices and avoid the topic entirely.

In the case of adolescent patients, many clinicians fear that if teens disclose sexual activity it will initiate a cascade of questions about pregnancy and STD risk.

This may both lengthen the clinical visit and raise issues of confidentiality, parental involvement, and risk reduction. With older patients, some young physicians are uncomfortable asking questions about sexual dysfunction or satisfaction of people who may be their parents' or grandparents' age.

## Do Patients Want To Be Asked About Sex?

Patients who do not discuss their sexual health with clinicians or health service providers often wish they had, and that the discussion had been part of a routine exam or intake process. A 1999 study assessed adolescents' views regarding sexual history taking and found that a majority of adolescents believe it is important to discuss sexual intercourse, contraception, pregnancy, unwanted sexual activity, and STDs with their doctor.

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*“With older patients, some young physicians are uncomfortable asking questions about sexual dysfunction or satisfaction of people who may be their parents’ or grandparents’ age.”*

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## Are Clinical and Nonclinical Service Providers Trained To Obtain Thorough Sexual Histories?

Many graduating clinicians, including physicians, psychologists, and social workers, do not feel adequately prepared to evaluate sexual health problems. For example, studies have found that older physicians report they received less training on STD assessment than younger physicians. The situation is similar with non-clinical service providers.

Training in sexual history assessment may be increasing in medical school education, however, and students who have had sexuality/sexual health instruction report increased confidence in addressing this topic with patients. The American Medical Association has instituted efforts to increase physician comfort and sensitivity when assessing sexual history. A 2002 study reported that physicians who conduct sexual histories are also more likely to test patients for STDs, including HIV. Physicians and other healthcare providers are often the first point of contact for patients with sexual health concerns, and they can greatly affect sexual health and behavior in patients.

## When Should a Sexual History Be Taken?

Often a sexual history is obtained when a patient or client presents with a specific symptom or complaint, such as vaginal discharge. But providers should also take advantage of routine check-ups, well visits, and preventive health visits, not only at STD or HIV testing sites. A sexual history may be obtained during the general medical history or during the taking of personal and social history. The *Guidelines for Adolescent Preventive Services* (GAPS) screening tool (available at [ama-assn.org](http://ama-assn.org)) assesses several risk factors, including sexual activity, and can be given to adolescent patients as a survey to be completed before the physician enters the room. Likewise, other assessment tools can be developed to assess the sexual histories of all patients or clients who might also be putting themselves at risk for HIV, HIV superinfection, or other STDs.

## Elements in a Sexual History

The following is a list of elements that are essential to taking a good sexual history. There are many other sources of detailed examples of sexual risk assessment questions. This is meant solely as a summary of questions needed when gathering a sexual history:

- Confidentiality: Establish a safe and comfortable environment in which to discuss personal health issues.
- Patient concerns: Ask open-ended questions. This may help begin the discussion, but you may also have to ask about specific sexual problems. Many patients want to ask questions but won't unless given the opportunity.
- Sexual orientation and preferences: It is important not to assume heterosexuality when obtaining a sexual history. This discussion can be prefaced by stating, "I ask these questions of all of my patients. Are you interested in men, women, or both? Are you having sex with men, women, or both?"

- Age of "sexarche" (the onset of sexual activity): Younger adolescents who are in relationships with older partners know less about pregnancy prevention, HIV, and STDs, and are at greater risk of being coerced into unprotected sexual activity than those with same-age partners.
- Types of sexual practice (oral, anal, vaginal): Elicit information about sexual behavior and types of sexual practice.
- Date of last sexual intercourse: Important for pregnancy and contraceptive counseling, STD treatment and prevention, as well as knowing when to test for HIV.
- Sexual partner assessment: The number of lifetime partners, number of partners within the preceding six months, the nature of the relationship (serial monogamy versus one-time events), and domestic violence screening.
- Pregnancy: It is important to understand the patient's desires regarding pregnancy, so that counseling is consistent with his or her goals and information and advice is appropriate.
- History of prior pregnancies: Again, this is helpful in contraceptive and reproductive counseling to identify risk and needs.
- STD/HIV prevention practices: Inquire about condom usage (consistency, correct use, access), regular STD testing, number of partners, and reduction of risk behaviors.
- STD symptoms: Recognize that patients may be asymptomatic, and use the assessment to provide education regarding HIV/STDs.
- History of prior STDs: Eliciting this history provides an opportunity to discuss how to prevent future STDs and potential infertility and to assess HIV/STD risk. Assess the sex practices of those living with HIV as well as those who are HIV negative. Some clinical and nonclinical service providers assume that a person who is HIV positive is not engaging in unprotected sex, when STD and HIV statistics have shown the opposite.
- Problems related to sexual intercourse.
- History of sexual abuse: "Have you ever felt that you were forced to have unwanted sex?"

Asking all these questions at the initial visit might be overwhelming, depending on the reason for the visit; some of them may be reserved for subsequent visits. If patients or clients realize that a sexual history is part of a routine exam, they may be more comfortable raising questions or concerns in the future. Also, if patients see that their clinical and nonclinical service providers are sensitive and are comfortable asking these questions, they may view them as a resource for future sexual health information and discussions.

*Luis Scaccabarozzi is Director of Treatment Education at ACRIA.*

# Sexuality in Men of Color: The Impact of Culture

by Moctezuma Garcia, MS

The HIV/AIDS epidemic continues to have a disproportionate impact on Black and Latino populations. The Centers for Disease Control and Prevention reported that in 2004 among the 35 states that report confidential name-based HIV infections, 65% of people living with HIV are Black and Latino. Men who have Sex with Men (MSM) continues to be the predominant group of HIV transmission reported among men. HIV/AIDS interventions focused on behavior and education have been successful in reducing HIV prevalence rates among White MSM, but failed to reduce transmission rates among communities of color.

The epidemic among Black and Latino MSM has led researchers to use a psychocultural approach which includes psychological, social, cultural and behavioral factors, in developing more effective services for people affected with HIV/AIDS. In a 1998 book, *Latino Gay Men and HIV: Culture, Sexuality, and Risk Behavior*, Rafael Diaz examines the disassociations between men's intended behavior and actual behavior. His work emphasizes that sociocultural factors become internalized and affect the way an individual interacts with the community. Self-regulation, key to an individual's ability to practice safer sex, is dependent on one's intentions and interpersonal support.

But one's ability to practice safer sex can be affected by personal stress and social stressors. While Diaz focuses on gay Latino men, the model can be generalized to people of color and marginalized populations, since the same social stressors (racism, unemployment, homophobia, etc.) affect the ability to continue safer sex practices. Therefore, it is important to explore race, ethnicity, sexuality, masculinity, and religion in order to address the HIV/AIDS epidemic and empower people of color and marginalized populations.

## Defining Racial and Ethnic Identity

Racial identity is defined as an individ-

ual's identification with a group based on the perception of a common racial heritage. Jean Phinney defines ethnic identity as identification with a group based on common ancestry and one or more of the following: "...culture phenotype, religion, language, kinship, or place of origin," and emphasizes that ethnic identity is not set. Rather, it is dependent on an individual's understanding of the self and ethnic characteristics. Racial identity generalizes populations based on race, and ethnic identity is an attempt to categorize populations within a race.

In an article in *Medical Anthropology Quarterly*, Nina Schiller states that one of the major problems hindering HIV/AIDS initiatives is the practice of creating generalized risk groups (e.g., Hispanic, Black) that fails to explore how oppression affects people of color and marginalized populations. Oppression hinders the ability of people of color to access resources such as employment, education, healthcare, and housing. Since the drive to meet basic needs overcomes concerns of exposing oneself to HIV, consideration must be given to the psychological and social factors that affect behavior among people of color based on ethnicity.

As Phinney indicates, ethnicity is composed of various factors that are not captured in nationality alone. Marginalized populations such as MSM, injection drug users, sex workers, and immigrants exist in every nationality. But HIV prevention efforts target populations that are categorized as broad groups. These efforts focus on the most accessible members of the population, offering services to only a limited section of the community while failing to acknowledge its ethnic diversity.

For example, the Mexican population in the U.S. is comprised of a myriad of ethnicities: Mexican, Mexican-American, Chicano, people born in the U.S. of Mexican descent that identify as American, and other Indian civilizations.

HIV interventions targeting a Chicano population may need a political focus, while those intended for Mexican migrant workers may need to address housing, food, and employment. HIV service providers must develop a greater understanding of the ethnic characteristics of the population that they serve if they are to provide culturally empowering services for people affected by HIV/AIDS.

## Sexual Identity

Sexual identity is another important characteristic to consider in understanding ethnicity. Sexual and ethnic identity has resulted in a dual identity process, which affects gay, lesbian, and bisexual (GLB) people of color in struggling to define themselves within such social networks as family, work, and friends. GLB people of color must also take into account how their sexual identity will affect their economic security, safety, and social status. Researchers Eric Dubé and Ritch Savin-Williams write that traditional GLB sexual identity models are composed of the following age cohorts: awareness of homosexual attractions, ages 8-11; homosexual sexual behaviors, 12-15; gay or lesbian identification, 15-18; disclosure to others, such as heterosexual and homosexual friends, siblings, and parents, 17-19; and development of homosexual romantic relationships, 18-20.

Research on sexual identity among GLB youth has found significant differences among various ethnic groups. A 1999 study of gay men found that Latinos were the first to be aware of their homosexual attraction at the mean age of 8, compared to 10 years of age for White, Black, Latino and Asian male youth. GLB Asian men reported having sex with a male for the first time at the mean age of 18, compared to 15 years of age for all gay males. Approximately half of the same sample of young men had a romantic relationship with a female, with a significantly lower rate among Asians. Black men were also significantly more likely to have had sex with a male before sexual identification

and were the least likely to disclose their sexuality.

A 2004 study of both men and women also found that Black youth were least likely to disclose their sexuality to others, but found no difference in sexual identity, sexual attraction, and sexual behavior between Blacks, Latinos and Whites. Research in both studies corroborates the milestones specified by Dubé and Savin-Williams, providing greater understanding of the sexual identity development process among various populations.

Oppressive factors such as homophobia, discrimination, and lack of resources may cause people of color to have homosexual encounters prior to the development of their sexual identity. Dubé and Savin-Williams indicate that men experiencing this reported difficulties in adjusting to their sexual identity, more homosexual encounters, and more heterosexual encounters. Sexual identity disclosure to others is associated with one's adjustment to his sexual identity and men of color were found to be more susceptible to internalize homophobia and poor mental health. Future research is encouraged to explore the identity processes GLB youth experience to strengthen initiatives in developing services for the community and assist youth to navigate through the dual identity process.

### **Masculinity**

Masculinity among Latino and Black men has been stigmatized as self-destructive and research has failed to acknowledge its positive traits. Special consideration must be given to the historical context (slavery, colonialism, etc.) as well as existing oppressive structures such as racism, discrimination, and homophobia when discussing development of masculinity among Black and Latino men.

"Machismo" has stigmatized Latino men as individuals who like to prey on the weaknesses of others and has played up its relation to domestic violence, substance abuse, and tyranny in the home. But studies have also identified positive traits related to machismo, such as a strong work ethic and commitment to

roles as family provider and protector. One must take into consideration that the definition of masculinity is influenced by beliefs and values within a historical, social, psychological, and racial context. Research has also found that gender roles can transfer to homosexual encounters and relationships – the active (insertive) male taking the masculine role and the passive (receiver) male taking the feminine role. Status among MSM in Latin America is granted to the active male who never gets penetrated – he may be perceived as heterosexual in the Latino community, regardless of whether he has ever had a sexual encounter with a female.

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*“Homophobia, discrimination, and lack of resources may cause people of color to have homosexual encounters prior to the development of their sexual identity.”*

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A 2005 study identified four unique components in identifying masculinity among Black men: 1) manhood is interconnected with the self, God, family, community and others; 2) manhood is a fluid process; 3) manhood is a process for redeeming oneself within one's family or community, and 4) manhood is a constant process of maintaining one's independence and productiveness.

Masculinity exists among all racial and ethnic populations and it is essential to emphasize its positive characteristics as well as its negative. HIV interventions

need to be culturally sensitive and careful not to reinforce oppressive structures among the populations served. Service providers must increase their emphasis on empowering communities and dispelling the stigmas and stereotypes imposed on men of color.

### **Religion**

One must always consider religion when discussing characteristics of ethnic identity. Religion and spirituality continue to have a strong influence among Latino and Black communities. A national survey found that over 76% of Americans identified as Christian. Among Latinos, 57% identified as Catholic, 22% as Protestant, 5% as another religion, and 12% as having no religion. Another survey indicated that Blacks in the U.S. reported being raised in the following religious denominations: 80% Protestant, 11.6% Catholic, 1.2% Christian, .9% Muslim/Islam, .7% other, and 5.6% not religious.

A 2004 study found that organized religion played a significant role in the lives of Black and Latino MSM. Latino MSM expressed internal conflict between their homosexual desires and religious rhetoric that reinforces heterosexuality, leading to increased risk behavior. Additionally, a 1998 study indicated that Black MSM identified the church as a source of community and an important outlet for coping with racial oppression and discrimination. The men also stated that church is a good way to divert the community's attention from their sexuality while providing an opportunity for them to meet other men. At the same time, Black MSM report significant levels of homophobia in the church.

A 2002 study found that religious Black men had greater homophobia toward gay men than they did toward lesbians, in comparison to religious Black women. Frequent church attendance was also associated with homophobic attitudes in the Black community. Among sexually marginalized populations such as Black and Latino MSM, exposure to homophobic attitudes was associated with internalized homophobia, low self-esteem, psychological stress, and HIV risk behavior. As the literature demonstrates, religion

*(continued on page 26)*

## *Personal Perspective: Rediscovering Life*

by Victor R. Pond

It was the summer of 1982 and I was watching the evening news at a friend's home in the Bronx. The anchorman, with some alarm in his voice, walked us through some disturbing images of intravenous drug users and gay white men who were believed to be the primary carriers of some new disease. There was no shortage of "expert" opinions from men in lab coats trying hard to disguise their lack of real understanding of what all this meant. We then witnessed a resurgence of every sexphobic and homophobic belief that permeates this post-Victorian culture.

At the same time, HIV/AIDS was promoted, perhaps for public health purposes, as a standard medical condition when in reality it is anything but. From my vantage point it's more akin to a modern-day oddity: a disease for which there is no known cure being treated as a thesis on sexual morality (or is it immorality?). The end result is "scientific" dogma competing with genuine scientific inquiry, and a pharmaceutical industry gone amok with greed, co-existing with institutionalized cultural blindness, especially towards minorities.

As a bicultural and bilingual Latino from Panama, of West Indian and African descent, I found myself detached from this crisis since I was neither an intravenous drug user nor a White male homosexual. But I instinctively knew I needed to be equipped with cultural weaponry that would help me navigate what was ahead. I had never felt welcome in Latino communities, although I did have Latino friends. People always seemed surprised that I spoke Spanish fluently or that I identified as Black first. And there was an assumption of unquestioning cultural allegiance because of a shared language. I was not prepared to make that concession. I simply grew weary of negotiating identity politics.

My reality is that, at the end of the day, I'm judged by the color of my skin and not the content of my character. I'm guilty until proven innocent. I'm a walking crime waiting to happen. HIV/AIDS facilitated this soul-searching for me. In a society where skin color is the primary standard by which character is judged, I offered no apologies for seeking refuge within the African-American community that, while not devoid of biases, at least provided me with a safer space for my psychosocial, cultural and spiritual integration. It seemed less tiring than trying to find a space within the larger Latino culture that to this day struggles to recognize the contributions of African-Americans to the life and history of this continent. The

African-American LGBT community was wide and diverse enough for me to find my niche. It was critical at this time to have my African ancestry affirmed, particularly when racism morphed into a less ugly monster, but an even deadlier one.

Like many same-sex-loving African Americans, I found refuge in the assurance that HIV would never come knocking at our doors. But it eventually did. HIV and AIDS swept through our communities like hurricane Katrina, leaving a trail of drowned hopes, shattered lives, and homeless dreams. Single-handedly, AIDS forced us to ask questions that for the most part remained securely hidden in the dungeons and attics of our minds. Were we being punished because of our sexual immorality? Was it time to consider "changing"? Was AIDS a modern-day divine retribution a la Sodom and Gomorrah?

That wasn't the time of air-brushed glossy photos of happy models climbing mountains peddling wonder drugs. Death paraded around like a paralyzing nightmare. I lived through that dreadful decade witnessing what was euphemistically described as "the look": the sunken eyes, the emaciated face, the swollen lymph nodes, the wasting, the AZT-induced hair thinning. We mourned our dead before they died. We learned to normalize the pain. We accepted the loss as irremediable. We taught ourselves to grieve to the beat of really loud house music and mind-fogging drugs. We even ritualized burials, making them less about a loss and more about celebrating a life. Many of us continued having the same kind of sex we'd always had, aware that according to public health officials we could be putting the nails in our own coffins. We were force-fed fear-based messages that were designed to police our bodies and our sex.

What many failed to acknowledge was that HIV/AIDS simply didn't have the power to suddenly redirect the natural flow of human sexuality that had been in place since the beginning of time. Neither could the "pathologizing" of sex or the notion of dying because of AIDS adequately substitute for the biological mandate of procreation. It was a knee-jerk reaction to the newness of publicly talking about sex as opposed to talking around it. To this day, HIV prevention messages targeted to "minority" men fail to differentiate between behavior and identity. No matter how well intentioned, messages targeting behavior will always be experienced as personal assaults, thus reinforcing resistance and psychological numbing.

While I am not HIV positive, I've always said that HIV chose me. I've been working in this field for at least 15 years, despite witnessing the AIDS-related deaths of friends, co-workers, patients and acquaintances. It's helped me appreciate my own humanity and that of others. I find myself battling judgmental attitudes and challenging myself to be more authentic, particularly when it comes to my Christian faith, which requires me to love even my enemies.

I've dated and had sex with several men who were living with HIV. But it was my first experience that really helped me mature emotionally and socially. I found out he was living with HIV after discovering a bottle of AZT in his medicine cabinet. I panicked and ran away. Only after the fact did I understand his struggle with disclosing this to me and why he avoided sex. I felt embarrassed and ashamed, particularly since I was employed by the NYC Department of Health as a Senior Public Health Educator. It was a very dear friend who was living with HIV that helped me sort through my feelings of anger and betrayal. It finally hit me why anyone would fear making this type of self-disclosure. The risks are high, and to have to live with yet another rejection is too great a burden for people who may be on the verge of emotional collapse

That experience helped me to rethink my attitude toward HIV and those living with it. I made a decision that I would not allow fear to control my decisions or determine whom I would be intimate with. I would not collude with popular culture that would have us believe that people living with HIV were to be segregated, pitied or treated with any less dignity. I would not compartmentalize my loving and deprive myself of connecting with another human being because of some artificial and cruel bias.

My rebellion and self-examination were greatly fueled by the advent of the so-called "moral majority" – a religious-political movement that would institute "ethnic cleansing" of all homosexuals if that were possible. Politicians, clergy, and scientists alike, forming an abhorrent coalition, cried

out for quarantine, and tried to legislate abstinence and other behavior change methodologies in the hopes that AIDS would go away, and with it authentic discussions about sex and sexuality. We could then return confidently to the hypocrisy of exploitation that under the guise of "free speech" has effectively polluted mainstream marketing. Our society would never have to confront the inherited and recurring dysfunction that has blocked real efforts to embrace sex and sexuality as wonderfully embedded traits of our humanity.

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***“AIDS has placed a magnifying glass to society, revealing the hypocrisy of moralists whose mission in life appears to be creating a world ruled by monolithic, monochromatic thinking.”***

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The greatest “contribution” of AIDS has been to place a magnifying glass to society, revealing the hypocrisy of moralists whose mission in life appears to be creating a world ruled by monolithic, monochromatic thinking. AIDS has given us enough evidence to take these enemies of humanity and diversity to the high courts of heaven where they will have to give an account for the many lives they’ve ruined. They will have to explain how eliminating homosexuals would solve world hunger, end domestic violence, end the abuse and neglect of children, save heterosexual marriages, bring world peace, eliminate race wars and institute social justice for all.

Finally, AIDS has encouraged a different and more significant examination of our lives. We’re rediscovering the principles of self-determination and of transparent collaborations. While not all will see this as relevant,

there’s a hunger for alternatives to simply reducing our lives to serial orgasms. For those who choose, there’s an intellectual arsenal rich in information that will help inform paradigm shifts and the sowing of seeds that are guaranteed to yield healthy fruit. We have to love each other through the pain, and experience each other’s touch as reinforcement of a bond that not even HIV/AIDS can sever.

*Victor Pond is Development Director of the South Side Help Center in Chicago, Illinois.*

## The Future of HIV Prevention *(continued from page 19)*

lular immune response. The products in development employ a range of strategies, including vector-based vaccines, lipopeptide vaccines, DNA vaccines, and recombinant protein vaccines. A large-scale trial of Aventis Pasteur's candidate vaccine ALVAC vCP1521, which uses a canarypox vector, was recently begun in Thailand and should produce results within five years. AIDSVAX is being used as a booster in this trial.

Despite the promising growth of vaccines in the pipeline, significant challenges persist, and cell-mediated immunity – on which the vast majority of current candidates rely – is unlikely to confer complete protection, but rather will lower transmission risk or slow disease progression by controlling viral replication. To speed the development of an effective vaccine, the pipeline may need to be evaluated and diversified. The differences in HIV types, or clades, around the world adds complexity, since a vaccine that is effective in producing an immune response to one clade may not have the same efficacy against another clade. These factors, and others, pose substantial challenges to the development of an effective HIV vaccine.

### Barrier Methods

The female condom has been shown in laboratory studies to be impermeable to STIs, including HIV. Epidemiological studies have demonstrated that the effectiveness of female condoms in preventing STIs is most likely comparable to that

offered by male condoms. While the cost of a female condom is significantly higher than the cost of a male condom, female condoms are available and have been found to be acceptable to both men and women in diverse settings. As a woman-initiated method of protection, the female condom provides another option for women at risk for HIV infection.

While all studies to date have been observational, evidence suggests that diaphragms are protective against STIs. Randomized controlled trials examining the effectiveness of diaphragms for prevention of HIV and non-HIV STIs are currently being conducted. Since the cervix is a principal entry site for STIs, including HIV, other cervical barriers including cervical caps may offer additional prevention options. To increase effectiveness, physical barrier methods could be used in combination with chemical barriers, such as microbicides.

### Pre-exposure Prophylaxis

Pre-exposure prophylaxis (PREP) involves the provision of antiretrovirals to high-risk individuals prior to HIV exposure in order to reduce the risk of becoming infected. PREP is distinct from post-exposure prophylaxis, which refers to the provision of ARVs to lower the risk of infection after a possible exposure. PREP – if found to be safe and effective – would provide a convenient method of HIV prevention for high-risk individuals in situations where they are unable or unlikely to

use other methods. A desirable formulation would be potent and non-toxic, would not bring about resistance, and could be given as a once-daily formulation.

Clinical trials have begun to determine whether tenofovir (TDF), when used as PREP, is a safe and effective method of prevention, but some trials have met with resistance. TDF trials in Cambodia, Cameroon, Malawi, and Nigeria were stopped after activists and community members raised a variety of concerns. Additional trials are planned or currently underway in Botswana, Ghana, Peru, Thailand, and the United States. But the controversy emphasized that clinical trials of new prevention methods will need to strike a careful balance between the urgent need to find new tools, and the ethical need to protect participants. Such trials will need to include the community in the earliest planning stages if they are to be successful.

### Conclusion

While no technology is anticipated to be the “silver bullet” of HIV prevention, the variety of methods in development has the potential to affect the HIV epidemic in a comprehensive manner. As partial effectiveness is likely to remain a concern even beyond the success of any prevention technology currently in development, employing methods such as condoms remains important.

*Betsy Finley and Carolyn Plescia are Writer/Research Associates at the Alliance for Microbicide Development.*

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## Sexuality in Men of Color *(continued from page 23)*

has both positive and negative influences among Black and Latino MSM. Providers are encouraged to establish relationships with religious congregations in an attempt to address homophobia in the community and strengthen services for people affected with HIV/AIDS.

### Discussion

Societal oppression affects every aspect of the lives of Black and Latino MSM. HIV services addressing the needs of people of

color are challenged to develop culturally empowering programs. Providers must identify and reinforce the positive factors in each community, acknowledge the heterogeneity of the target population, and involve members from the community when developing programs. Providers can assist gay, lesbian, and bisexual communities of color with services to address the personal conflicts associated with race, religion and sexuality. Masculinity among Black and Latino MSM is not nec-

essarily self-destructive and providers can develop programs for men to embrace their masculinity and sexuality. Finally, religion plays a significant role in the lives of Black and Latino MSM, and providers are encouraged to collaborate with religious institutions in addressing homophobia in the community and providing services for communities affected by HIV.

*Moctezuma Garcia is a PhD candidate at the CUNY Graduate Center.*

## **Banco Popular DreamMakers' Award**

At a ceremony at Banco Popular's Rockefeller Center branch in early December, ACRIA sealed a new partnership aimed at expanding and enhancing HIV healthcare and treatment education within New York's Hispanic and Latino communities. Our new partners are the DreamMakers, a community service volunteer program of Fundación Banco Popular, and the program involves both financial support and active participation.

The monetary support came in the form of a check to ACRIA for \$25,000 to support our treatment education efforts in Spanish-language-dominant communities. The participation will take place over the coming year and will be a two-way process. ACRIA will conduct a series of luncheon workshops for Banco Popular employees — DreamMakers — aimed at teaching them about HIV and AIDS and some of the issues of particular importance in Latino and Hispanic communities. The DreamMakers in turn will take the message back to their communities, assisting in both education and outreach. The DreamMakers will also act as advisors to ACRIA's Treatment Education Department, reviewing and contributing to written materials and curriculum development to help ensure that ACRIA's efforts in Spanish-language communities are culturally and linguistically appropriate and accessible.

In addition, Banco Popular will provide meeting spaces in their facilities for our workshops and trainings and our intensive technical assistance program.

The new partnership is the result of a collaboration between ACRIA's Treatment Education Director Luis Scaccabarozzi and DreamMaker Edward Castro Gomez of Banco Popular's Financial Operations division.

## **ACRIA Presents at NATAF**

Treatment Educator Lisa Frederick traveled to Oaxaca, Mexico, in November to represent ACRIA at the 2005 North American AIDS Treatment Action Forum (NATAF). Together with representatives of agencies from Canada and Mexico, Frederick cofacilitated a workshop on "Methods and Strategies for Educating About HIV Treatment," part of the conference's Care and Treatment Track. The workshop stressed the perspective and experience of the education providers while highlighting the central goals of treatment education programs. The presentation used interactive activities to review the basic skills required to conduct training, for example by presenting case studies followed by discussion on how to engage adult audiences and other aspects of adult learning. Approximately 85 people attended the workshop.

## **Researchers Present Data on Aging**

ACRIA researchers presented findings from their behavioral studies of older adults with HIV at two conferences held back to back in Orlando, Florida, this November.

The first was a "CE Pre-Conference" on Aging and HIV held in conjunction with the annual meeting of the Association of Nurses in AIDS Care (ANAC), cosponsored by ACRIA and ANAC and focused on the special needs of the growing numbers of HIV-positive individuals aged 50 and older. Dr. Stephen Karpiak, ACRIA's Associate Director for Research, gave the opening keynote address. He, with Research Associate R. Andrew Shippy, presented preliminary data from ROAH (Research on Older Adults with HIV), ACRIA's 1,000-person cohort study just concluded. In addition, ANAC's Research Committee was presented with the results of an Internet-based study of stigma among nursing professionals, conducted jointly by ACRIA, ANAC, and Indiana University.

Mr. Shippy also attended the annual conference of the Gerontological Society of America — relocated to Orlando from New Orleans—and reported on ACRIA's research on stigma among employees of community-based and AIDS service organizations. In addition, he presented data from ACRIA's earlier study of depression and cognitive impairment in older adults with HIV.

## **Volunteer Opportunities**

In an effort to attract and retain a corps of committed and well-rounded volunteers, ACRIA has overhauled its volunteer recruitment, screening, training, and utilization procedures. Our goal is to offer individuals the opportunity to observe and become a real part of the agency and its programs — to get a sense of what we do, why we do it, and how a not-for-profit organization works.

We have redesigned our volunteer application form and polled our staff about volunteer opportunities in their programs or departments. If you are interested in working with us, call Jack Denelsbeck at (212) 924-3934, ext. 120. Jack will schedule an interview to explore how you can put your own unique talents to work at ACRIA and become an important part of our team.

## **Resistance Forum**

On Friday, January 27, ACRIA will present a Community Forum on Resistance and Cross-Resistance, co-sponsored by the International Association of Physicians in AIDS Care. The forum will be held from 2:00 to 4:00 p.m. at Exponents, 151 West 26th Street, on the third floor. Attendance is free, and no registration is required.

If you would like more information, call Luis Scaccabarozzi at ACRIA, (212) 924-3934, ext. 111, or Jorge Rivero at Exponents, (212) 243-3434, ext. 101.

# generous contributions

The following persons, corporations and organizations made major donations between October 1, 2005 and January 10, 2006 to support ACRIA's research and education efforts:

Thoughtful donations were made in memory of the following individuals:

Cliff Adams	Ben Fishner	Jeffrey L. Mitchell
Barry Binkowitz, MD	Mark Gomez	Stephen Montgomery
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David A. Eklund	Ezra David Litwak	Ken Walter
Michael Faerman	John Menaker	

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