BEHAVIORAL AND SOCIAL SCIENCE VOLUNTEER PROGRAM

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THE LINKAGE

NEWSLETTER OF THE BEHAVIORAL AND SOCIAL SCIENCE VOLUNTEER PROGRAM

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AMERICAN PSYCHOLOGICAL ASSOCIATION

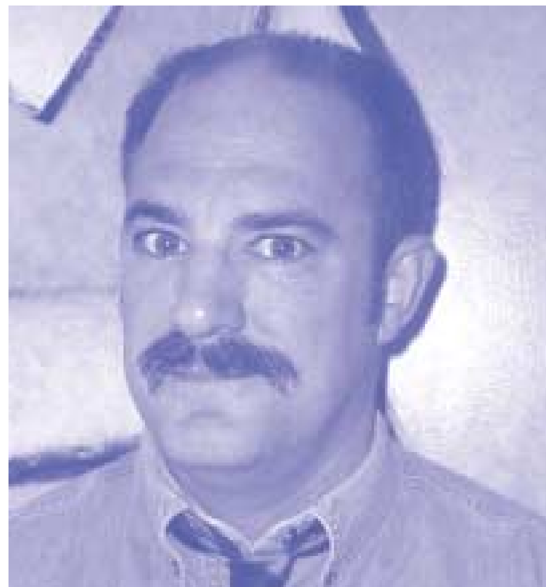
Factors Associated With High-Risk Sexual Behavior Among Men Who Have Sex With Men

Ron Stall, PhD, MPH

A series of recent publications from three continents have reported substantial rises in sexual risk taking among men who have sex with men (MSM). The data reporting rises in behavioral risk among MSM (see Wolitski, et al., 2001; Stall, et al., 2000 for reviews) mirrored consequent rises in STD rates and possibly even HIV infection itself. Thus, the behavioral literature on sexual risk taking among MSM has demonstrated valuable public health utility in two very different historical contexts. The first of these contexts was during the early and mid-1980s (in which rapid declines in sexual risk taking occurred in tandem with declines in STD and HIV transmission rates among MSM), and the second, during the current era of increasing sexual risk taking (in which rises in sexual risk taking reported in the behavioral literature predicted later STD outbreaks and possible rises in HIV infection itself).

Achieving an understanding of the variables associated with sexual risk taking is of critical importance to the design of effective interventions to stop the spread of HIV infection among MSM. Although knowing that the rate of high-risk sex within a given population of MSM has risen to (say) 32% is useful, that knowledge does little to help craft effective prevention design. An understanding of the variables associated with high-risk sex within a given population of MSM contributes to the design of interventions that are effective, culturally competent, and timely.

The goal of this short commentary is to describe many of the variables associated with high-risk sexual behavior among MSM identified in the public health literature from the United States. The phrase "men who have sex with men" is used here to describe not only gay-identified men, but also to include men who do not identify as gay or homosexual and/or men who have sex with men and women. Thus, the emphasis here is on men who are behaviorally homosexual, although it is likely that the majority of the men so described will identify themselves as gay or homosexual. This particular review will focus on "mainstream" communities of men who have sex with men who are found in most of America's large urban centers. In the United States, such men are often (but certainly not exclusively) of European



Ron Stall, PhD, MPH, Chief, Behavioral Interventions Research Branch, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention, Atlanta, GA

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From the Program Director's Desk

E. Duane Wilkerson, MPH

The BSSV Program has recently embarked on two new programs of technical assistance (TA) services. In response to requests from CDC, the program is now putting new and increased efforts into targeting community-based organizations (CBOs) that are indirectly funded by CDC. Indirectly funded means these CBOs have contracts to do HIV prevention with their state or local health departments.

In addition, the BSSV Program has been drafted into the larger CDC effort to disseminate HIV interventions that have proven effective and to conduct regional trainings across the country, training CBOs to implement them. BSSVs will be given the opportunity to attend the training with a local CBO, then to be a coach with the CBO as it begins implementing the intervention at home.

In June, we will conduct a pilot training for our advanced training. We have trained 139 volunteers since December 1998 in the basic training. We intend to offer one basic training and one advanced training each year. The advanced training will address in more detail the primary types of TA that our volunteers have encountered over the past 3 years and will focus on the new areas of TA need that will come from the CDC dissemination of intervention effort.

Robin Kelley, the Assistant Program Director, has evaluated 77 of the 82 linkages that have been completed since 1998. There is much data to consider in these 77 evaluations (63 of them have responses from both the volunteer and the agency). Ms. Kelley and Dr. John Anderson will be analyzing the data and sharing lessons learned during the coming year.

In my preliminary reading of the evaluation reports, especially those coming from the agencies, I am continually impressed and struck by a recurring theme. The majority of the agencies report that they (1) received outstanding TA from the volunteer, and (2) received much more than they asked for or expected from the volunteer.

E. Duane Wilkerson, MPH

There is little doubt that the increased awareness and respect for the BSSV Program at CDC is a direct reflection of this high quality of TA being provided by you, the volunteers, and the strong commitment to making agencies and CPGs more effective. My hat goes off to you!

For those who have not yet had the opportunity to be involved in a linkage with the program, let me quickly say three things: (1) We are working hard to increase the number of TA requests and give everyone an opportunity, (2) just "being there" and available in your geographical area gives us the freedom and flexibility to offer TA in ways we could not do otherwise, and (3) you don't have to wait for us to find a CBO or CPG that may need your services. We encourage you to reach out to your own community and see if there is a need.

We are very pleased to offer this edition of the *Linkage* to you. We think you will find the articles by Drs. Stall, Ayala, and Wheeler to be timely, informative, and thought provoking. We believe they offer a foundation and a point of departure for further discussion of what is needed for effective HIV prevention efforts for MSM. ▼

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descent, of middle class orientation and income although not uncommonly of high educational attainment. Two reviews that accompany this essay (by Drs. Wheeler and Ayala) focus on the special circumstances of MSM of color.

A note regarding causation is probably necessary here. The identification of associations of high-risk sexual behavior and/or HIV infections is not meant to imply that there is a causal relationship between a given association and an HIV-related dependent variable. In view of the substantial difficulties of conducting randomized trials to test the causal power of the associations, there may never be strong empirical data to support causal assertions about any of the associations described in this review. For the time being, it is probably most useful to think of most of the variables described here as mediators of high-risk sexual behaviors; mediators which themselves are useful foci in the design of effective interventions. For example, one can design and field an effective intervention to reduce HIV risk among young African American MSM without assuming that either youth, African American race, or being gay is causally related to HIV risk.

This review has been organized to describe (1) associations that have been the focus of intervention inquiry throughout the history of public health response to AIDS among MSM, (2) associations that may have emerged as important since the development of HAART medications to treat HIV infection, and (3) a set of associations that may be important, but which probably still remain underemphasized. The essay will end with a short set of comments about the most effective way to move the prevention field forward during the third decade of the American response to AIDS among MSM.

Associations Long Recognized To Be Associated With High-Risk Sex Among MSM

Individual-Level Associations

A series of individual-level demographic variables have been found in numerous studies to be associated with high-risk sexual behavior and/or HIV infection among MSM. Perhaps the most striking of these is race, in that some ethnic minority men (and especially African American and Latino MSM) are typically found to have much higher HIV infection rates than do MSM of European American descent (Valleroy, et al., 2000; Catania, et al., 2001). Relative youth is also a strong marker for HIV risk.

Epidemiological surveillance among MSM as young as 15-20 years of age often yields high rates of new HIV infections. Less well studied in the American literature is the effect of socioeconomic status on sexual HIV risk, although at least one population-based study found a strong association between HIV seroprevalence and low educational attainment among MSM (Catania, et al., 2001). Finally, HIV status itself can be conceptualized as a demographic variable among MSM, and many studies have detected a strong association between HIV seropositivity and greater sexual risk among MSM.

Not all sexual acts between men convey an equal risk for HIV infection; it therefore stands to reason that men who have eroticized the most risky sexual practices (for example, unprotected receptive anal intercourse) are at the greatest risk for HIV transmission. Similarly, many different epidemiological studies have found that men with greater numbers of sexual partners, and especially greater numbers of high-risk sexual partners, are more likely to be HIV seropositive. Thus, there is a strong relationship between the divergent strategies that MSM adopt to achieve sexual pleasure and HIV risk with men who have adopted the strategy of engaging in the highest risk acts with greater numbers of different partners at greatest risk of HIV transmission.

One means of mitigating the risk of high-risk sexual acts conducted with multiple partners is, of course, to use condoms, and/or to attempt partner-based strategies to prevent HIV transmission (see the discussion on partner-based strategies, below). Men who can demonstrate greater skills at using condoms, who have ready access to condoms and lubricants, and who report a greater sense of self-efficacy at being able to use condoms consistently also

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HIV/AIDS and Latinos

The rate of AIDS cases among Latinos in the United States is almost 4 times the rate among Whites, and HIV remains a leading cause of death for Latinos ages 25 to 44. This briefing, "Latinos and HIV/AIDS in the United States," cosponsored by the Kaiser Family Foundation and the Congressional Hispanic Caucus Institute, offers a perspective on these numbers. Congressman Ciro Rodriguez; Claude Allen, deputy secretary, Department of Health and Human Services; Ingrid M. Duran, president and CEO, Congressional Hispanic Caucus Institute; Jennifer Kates, senior program officer, Kaiser Family Foundation; and others discuss the effect the HIV/AIDS epidemic has had on Latinos in the United States. Also find the transcript, fact sheets, surveys, and other related resources.

Where:
http://www.kaisernetwork.org/healthcast/kff/07mar2002

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typically report lower rates of sexual risk taking.

Finally, there is also some evidence that psychological variables, such as depression, may influence the ability of MSM to stay sexually safe over time. Other variables that hold strong clinical implications—such as the experience of childhood sexual abuse and/or problematic substance abuse profiles—are typically found to be associated with a high-risk sexual profile.

Variables at the Level of the Sexual Partnership

It has become commonplace to note that high-risk sex requires (at least) two partners—a fact that suggests that partner-based strategies to promote sexual safety might be useful. Certainly, the status of partnerships (whether steady or casual) has often been found to be associated with whether unprotected anal sex occurs between men, with men in steady partnerships more likely to report that behavior. However, these measures typically do not take into account knowledge of the primary partners' HIV status and/or agreements about levels of risk allowed with secondary partners. Were such partner-level variables taken into account, rates of "risk" in such partnerships might well be found to be lower. This point illustrates the importance of communication skills to managing risk within relationships. The ability by partners to discuss accurately HIV status, sexual risks taken with other sex partners, and how these may change over time is surely essential to the success of partner-based strategies. In addition, relationship skills (the ability by partners to negotiate a partner-based sexual safety strategy and—perhaps more importantly—the ability to discuss lapses in that strategy) must also be a crucial component to the success of partner-based strategies.

Contextual-Level Variables

Sex between men also occurs in a physical, emotional, and sociocultural context, and these variables are also understood to influence whether high-risk sex occurs. Of the contextual levels variables, perhaps the best studied is that of sex under the influence of alcohol and/or drugs (see Stall and Purcell, 2000 for a review). Although the behavioral data concerning the associations between alcohol and/or drugs during sexual activity are still far from uniform, both seroprevalence and seroincidence data strongly support the argument that MSM who also use drugs are a vulnerable population for HIV infection. Other mood states (transitory depression, use of sex as a coping strategy, emotional attraction between partners, the desire to engage in "time out" behavior, and the trait of "sensation seeking") have also been identified as important emotional contextual components to high-risk sexual events.

Considerable attention has been devoted to the question of whether sex that occurs in bathhouses is higher risk than sex that occurs in other contexts. To date, little evidence has emerged to show that bathhouse attendance per se causes increased participation in unprotected anal intercourse, although it is also fair to question whether this simple measure of risk is the most appropriate to the bathhouse setting. Interestingly, less work has been done to address the far more common phenomena of the effect of housing setting on sexual risk, that is, whether being the guest or host during a sexual encounter has an effect on the type of sex that is practiced during that encounter.

Culture is widely assumed to have an effect on sexual practice, although relatively little research has been done to describe the specific ways in which culture functions to shape sexual practice in diverse MSM subcultures. It is widely assumed that among men who do not identify as gay and among whom fear of disclosure and/or violence is high, that discussions about sex in general and safe sex in particular are attenuated. Some MSM cultural contexts may operate under a system of gender-based rules (rules based on understandings of male and female behaviors rather than rules based on understandings about sexual preference), contexts that may encourage some men to have receptive anal intercourse and perhaps allow them less power to negotiate condom use. Perceived peer norms, which reflect community assumptions about whether anal sex should (or should not) involve condoms, have been shown in numerous studies to be associated with sexual risk among MSM.

It is widely assumed that among men who do not identify as gay and among whom fear of disclosure and/or violence is high, that discussions about sex in general and safe sex in particular are attenuated.

Variables That Have Emerged During the "Protease Era"

The emergence of combination "cocktail" drugs (also known as HAART medications) to fight HIV infection are said to have profoundly changed the calculations that MSM use to gauge sexual risks. Such claims certainly

seem sensible: The development of reasonably effective treatments for a fatal disease, however toxic, time-limited, or demanding, should logically lower the sense of danger for that disease, sometimes leading to an inappropriate sense of "treatment optimism." Treatment optimism would be enhanced if widespread use of the HAART regimen is accompanied by a dramatic decline in deaths attributed to AIDS, a return to health among men who had previously been very sick is widely observed, side-effects of HAART are not as easily observed, and widespread media/advertising coverage is devoted to the positive effects of HAART. Each of these phenomena has occurred within gay communities of the United States. Thus, it should not be surprising that several researchers have found associations between a sense of HIV treatment optimism and increased high-risk sexual behaviors. Elford, Bolding, and Sherr (2001) nonetheless offer a thoughtful critique of this literature to argue that a sense of treatment optimism alone could not explain the rapid increases in sexual risk that have been observed in several Western societies.

A concept related to that of treatment optimism is that of "AIDS burnout." It should be remembered that the gay male community did not adopt safe sex regimens as a lifelong strategy—rather safe sex was initially conceived as an adaptation to a terrifying, but temporary, health crisis. In fact, some have argued that no group of men can be expected to adopt condoms as a permanent and universal sexual strategy, and that the gay community has now reached the limit of the "condom code." In the historical context of the protease era, some MSM are reporting the use of sexual strategies that go beyond the initial safe sex recommendations. In particular, many MSM seem to be testing strategies that include the strategic abandonment of condoms as a safe sex tool, a strategy that appears to be very common in at least some gay male communities (Ekstrand, et al., 1999).

The men who have adopted these strategies are using their own bodies as tests of the epidemiological hypotheses…

Many strategies that include strategic abandonment of condoms during sex have emerged among MSM, only some of which have been well described. The strategy of "negotiated safety" in which seronegative partners negotiate anal sex without condoms in that relationship in connection to a joint schedule of HIV testing is one such strategy. Related to this strategy is unprotected positive-on-positive sex, a form of sexual expression that assumes that no further harm could result from HIV transmission between men already infected with HIV. Finally, "positional" strategies have also been described, strategies based on the assumption that negative insertive partners are unlikely to be infected by positive receptive partners.

It should be noted here that little or no data exist to measure the utility of these strategies in preventing HIV transmission. The men who have adopted these strategies are using their own bodies as tests of the epidemiological hypotheses listed in the previous paragraph. Certainly these strategies can be expected to offer little protection against STDs other than HIV, and it may be that the observed rise in rates of STD transmission among MSM in the United States is related to the use of these strategies. However, it should also be noted that these men are challenging the notion of "use a condom every time" as an unworkable long-term strategy and are gambling with very high stakes indeed to define a set of effective "harm reduction" strategies. Whether these strategies work to contain ongoing HIV infection among MSM is a question of great interest to many individuals interested in the health of MSM.

Associations Understudied to Date

One of the very few characteristics that all of the American subpopulations characterized by high vulnerability to HIV infection share is that they are subject to simultaneous epidemics that appear to interact in ways to fuel the AIDS epidemic. These interacting epidemics, in the case of gay men, include (at least) substance abuse, depression, violence, other STDs, and childhood sexual abuse. However, public health approaches to each of these health problems have been more or less monolithic—as if the health problem addressed by a particular agency were the only health problem MSM face. Thus, the potential for collaboration across health movements to create and understand the effects of a conjoined gay men's health movement designed to respond to these problems as interacting phenomena remains understudied. In addition, the effects of structural interventions that change the place of MSM in American society (such as the recent legal changes granting greater recognition of homosexual partnerships in Vermont and California) also remain unstudied.

Another area that remains understudied is that of HIV prevention trial research itself. The Prevention

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Conference Call With DR. RON STALL

Scheduled for April 19, 2002

Take part in a conference call with ***Dr. Ron Stall***, PhD, MPH, Chief, Behavioral Interventions Research Branch, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention, Atlanta, GA.

Host Name: BSSV Program
Date: April 19, 2002
Time: 1:00-2:00 p.m. (EST)
Conference Code: 648489
Federal participants, call: 404-639-3277
Nonfederal participants, call: 1-800-311-3437

If you are calling from area code 404, 770, or 678, please do not use the 800 number.

For security and confidentially purposes, participants will not be connected to a conference call without a valid conference code.

If you have a problem during your conference, you may press *0 at anytime to signal the attendant. If you have questions about the technical operations of the teleconference equipment please call 404-639-7550.

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Research Synthesis review conducted at the CDC identified 98 relevant and rigorous prevention trials conducted through 1998 in the United States. Of these 98 randomized trials designed to measure the effects of different approaches to HIV prevention, only 10 were conducted among MSM populations (Johnson, et al., in press). The 10% of the relevant and rigorous prevention trials conducted among MSM stands at considerable contrast to the proportion of Americans who have died of AIDS who were MSM (approximately 50%).

Finally, although some work has been done to study the effects of homophobia on gay men's health (and on sexual risk taking in particular), the health consequences of homophobia remain understudied. Since empirical data to describe these connections still remain scarce, I will take the liberty of describing the experiences of a classmate of mine from my junior high school years so that the potential ways that homophobia might affect health are illustrated.

"Ricky" was a somewhat effeminate teenage boy who had the great misfortune to be identified early in his seventh-grade year as the class faggot. As such, he became fair game for males in the class to publicly beat up, while subjecting him to humiliating verbal abuse at the same time. I still carry a mental picture of Ricky moving from one class to another while running a gauntlet of blows from his male classmates. In time he stopped trying to defend himself from the strikes that came his way, even declining to put up an arm to protect himself. Even though this abuse occurred in full view of our teachers, I never once saw a teacher intervene to protect Ricky. I note that it is unlikely that Ricky had become sexually active with other boys by age 13—he had only committed the crime of being identified as someone who wanted to have sex with other boys, a perception that may even have been false.

Ricky's horrifying school experiences raise some unanswered questions about the potential health effects of homophobia. How could someone who experienced ongoing attacks of this kind during his early teenage years grow to become a man who believes that he is a worthwhile human being, with a right to health and happiness? If Ricky did mature into being a gay male adult, how would he learn how to fall in love and have sex in ways that were healthy for him? Did his refusal to protect himself against the blows of his classmates predict an inability to protect himself from sexual risks in later life? Did he interpret the lack of protection offered by his teachers to mean that he deserved to be beaten up and publicly humiliated? And how did the audience of other homosexual kids in that school—paralyzed by fear of being identified as queers themselves—interpret Ricky's fate? And what would Ricky's teenage years have been like had he been African American, and so forced to cope with the effects of racist as well as homophobic attacks?

Discussion

The achievement of an understanding of the associations of high-risk sex among MSM demands an understanding of psychological and sociocultural variables and how their interplay changes over historical time. To date, some of the associations with high-risk sex have been used to inform the design of effective AIDS intervention programs, although many other possible associations remain untapped. In addition, the earliest theory used to guide the design of intervention programs to help MSM avoid HIV infection was heavily weighted toward psychological/cognitive and demographic variables. The incorpo-

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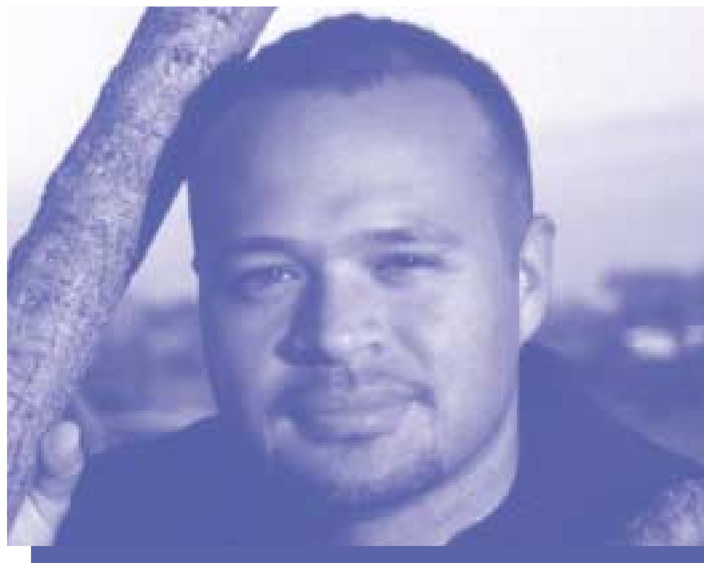
Sex, Culture, and Gay Men of Color: Re-Casting HIV/AIDS Prevention

George Ayala, PsyD



George Ayala, PsyD, Researcher, Center for Community Health, University of California, Los Angeles

It is painfully evident that Latino and African American gay and bisexual men and other men of color who enjoy sex with men continue to be disproportionately affected by HIV/AIDS, showing some of the highest HIV seroprevalence rates, incidence rates, and rates of unprotected sex (U.S. Department of Health and Human Services, 2000; Coates, T., Faigle, M., Koijane, J., & Stall, R., 1995); OTA Report, 1995; Lemp et al., 1994; Osmond, D., Page, K., & Wiley, J., 1994). The social and sexual lives of many men of color who have sex with men have been affected by at least three social oppressive forces—poverty, racism, and homophobia—that together tend to produce heightened risk for HIV infection by increasing social isolation, alienation, and personal shame (Diaz, Ayala, & Bein, 2001). Although many men have responded to the oppression with creative acts of personal agency, ranging from committed social activism to acts of personal heroism, others have been deeply troubled by financial hardship, family rejection, and discriminatory practices that prevent their fair and full participation in professional life and in the mainstream gay community. In light of these realities, it is therefore, not surprising that Latino gay men constitute one of the most vulnerable groups in the nation for the transmission of HIV.

By June 1999, a total of 51,681 AIDS cases had been diagnosed among Hispanic/Latino men who have sex with men (MSM); Latino MSM thus constitute about one-half (49%) of all reported Latino male AIDS cases in the nation (Centers for Disease Control and Prevention (CDC), 1999). However, CDC statistics on the "exposure category" among Latinos in the United States should be seen as conservative estimates of MSM cases. About one-fourth (22%) of all U.S. Latino AIDS cases diagnosed in 1998-1999 did not report risk exposure category (CDC, 1999); most likely, a large proportion of those undetermined cases occurred among MSM, but were not reported as such because of severe stigmatization of homosexuality in the Latino culture (Diaz, 1998).

Because we lack a systematic plan for counting new HIV infections in the nation, estimates of HIV seroprevalence are difficult to obtain for Latino gay/bisexual men, as well as for any other particular group in the nation. However, this limitation can be overcome somewhat by estimating HIV prevalence in probability samples of different populations at risk. Probability samples not only yield a representative group of the given population, but also—because the probability of being selected is directly measured—the observed data can be weighted/corrected to estimate the true prevalence of a given variable within a measurable margin of error. Fortunately, we now have two large studies that involve probability samples of Latino gay/bisexual men that include self-reported data on HIV testing and serostatus.

In a recent household probability sample (N = 2,881) of geographic areas with high concentration of MSM in four different U.S. cities (San Francisco, Los Angeles, Chicago, and New York), a substantial number of Latinos (n = 246, or 10% of the sample) were included. In this study, 19% of the Latino sample reported an HIV-positive status (Catania, 2000). In a second study, a probability sample (N = 912) of Latino gay/bisexual men who attend Latino gay venues in the cities of Los Angeles, Miami, and New York yielded a similar prevalence of 22% (Diaz, Ayala, & Bein, 2000). From these two studies, and taking into account the limitations of self-reporting a stigmatized status, it can be said with great confidence, and conservatively, that about one out of five Latino gay/bisexual men in large U.S. urban centers are infected with HIV.

Rates of sexual risk behavior among Latino gay men are disproportionately high. In five different studies of gay/bisexual men in the United States, Latinos have

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HIV/AIDS Prevention Targeting Black and African American MSM: A Commentary

Darrell P. Wheeler, PhD, MPH

The scientific community has concluded that the HIV/AIDS epidemic is disproportionately affecting communities of color. Most notably African American and Hispanic/Latino communities. Among these broad and diverse groupings, the data reveal significant and identifiable pockets of even higher rates of HIV/AIDS infections. As Valleroy (2001) points out, the rate of infection among African American men who have sex with men (MSM) is as high as 33% in some areas. Since 1995 we have seen a greater increase in annual incidence of HIV and AIDS among Black/African Americans compared to rates for non-Hispanic Whites in the same period. While Black men comprise less than 6% of the overall population, their rate of new HIV infections is more than double the rate for White gay men. The incidence of new AIDS cases and AIDS related deaths is also higher for Blacks than for Whites (CDC, 2000; CDC, 1999; CDC 1998).

Incidence and prevalence statistics clearly underscore a failure to stem the epidemic's growth within this population. Further, these data suggest, if not a failure, a lack of efficacy in meeting the prevention and intervention needs of Black and African American gay men. As the number of new cases of HIV/AIDS among Black/African American gay men increases, we will need to develop more culturally specific and effective service and treatment models (Institute of Medicine, 2001; Peterson, 1995; Peterson, Coates, Catania, Hauck, Acree, Daigle, Hilliard, Middleton, & Hearst, 1996).

Much public and private discussion has been generated by these reports. While the severity of HIV/AIDS is a significant part of this dialogue, homosexuality, homoeroticism, and heterosexism fuel much of the heated debate on the issue. On the one hand we want to apply sound public health and scientific intervention and investigative methods. On the other hand, there is still a push to classify and categorize men based solely on their sexual practices. In a recent study, I found that many men shun such essentializing. They see themselves as not gay, not bisexual, and certainly not confused. Some of these men characterize themselves as heterosexual, even though their behaviors would suggest, to the categorical thinker, something else. The end result is that the interventions targeting Black gay and bisexual men miss a significant segment of the Black male "at-risk" population because they are alienating to their understanding and construction of who they are (Wheeler, 2001).

Darrell P. Wheeler, PhD, MPH, Henry and Lucy Moses Fellow, Hunter College School of Social Work, Hunter College, New York, NY

A comprehensive examination of the literature on homosexuality, gay, bisexual, down-low, and other euphemisms to identify Black men who have sex with men is well beyond the scope of this commentary. I would, however, highlight that racial, ethnic, and cultural backgrounds influence and shape early developmental experiences, life scripts, worldviews, and interpersonal interactions. These factors also influence the ways in which Black men interpret, perceive, maneuver in, and interact with their world, including behaviors associated with HIV/AIDS infection and transmission (Icard, 1995; Peterson, 1996; Marin, 1995).

While these statements may not seem groundbreaking to regular readers of the *Linkage*, many interventions fail to include these factors in their program designs and/or implementation. While these factors may be noted in the background and justification of needs, they are frequently understated or omitted in the program component. The net result is that much of the service provider's time and intervention effort is spent addressing these systemic and "background" forces for which they receive little or no funding.

I have found that service providers have a lot to say about the work they do and what really works. All too often they do not have the time or resources to say it. Because the literature in this area is so sparse, I believe one goal of

the consultant should be to assist service providers in having their voices heard.

In the remainder of this commentary I would like to present a few of my observations on HIV/AIDS prevention work with this population and offer guideposts (not resolutions) for future prevention interventions.

One of the first things that strikes me about many HIV/AIDS prevention efforts for Black and African American MSM is their decontextualized orientation. By this I mean interventions that narrowly focus on men as being either vectors for, recipients of, or at risk for becoming infected with, HIV/AIDS (period); the entirety of the man being summarized in and around an HIV/AIDS prevention and/or intervention agenda. This narrow orientation to services flies in the face of a daily onslaught of personal and socially denigrating experiences; experiences that may exacerbate the man's engagement in HIV/AIDS risk behaviors. Further, it is interesting to note that with the heightened media attention on the HIV/AIDS epidemic among Black and African American MSM, the focus is almost exclusively on the pathologies of sexuality and/or substance use. These factors are undoubtedly examined for their documented association with HIV sero-conversion. However, these variables are treated as immutable elements of the Black MSMs' existence, not as the consequences or correlates of structural, institutional, or social forces. This is not to ignore the individual's role in risk-taking behaviors, but rather to round out our understanding of the forces that lead to the behavior(s).

For some time now there has been a cry among providers of services to Black and African American MSM to stop the rhetoric and get "real" about HIV/AIDS prevention services to Black and African American MSM. Getting "real," for the uninitiated, means actually putting resources into motion and achieving results. For some providers, developing interventions with the men and not just having them receive services has been a critical pathway to success. Another important and seemingly useful element has been to include, as part of the intervention, an agenda of social and political change and activism. These are powerful adjuncts to behaviorally orientated condom self-efficacy interventions.

There are at least three notable programs in New York City that work with Black and African American MSM populations. In each of these programs there is an intervention component that includes work on the man's involvement in social, political, and economic self-determination. The undergirding philosophy for each program varies, but the common theme seems to be that being at the tables of (political and economic) decision making is essential if Black and African American MSM are to have access to the same resources available to White MSM. This access to the resources is essential for developing and implementing not just HIV/AIDS prevention efforts, but also for contributing to the men's sense of empowerment and self-determination.

Unless these issues are included as part of the arsenal of HIV/AIDS prevention efforts targeting Black/African American MSM, I cannot imagine eradication of this disease in the foreseeable future. Further, as Dr. Ayala points out, there is also a need to incorporate and highlight the positive and pleasurable aspects of the MSM experience in our prevention efforts.

Implications for Practice

In consulting to HIV/AIDS service providers, a few agenda items seem to consistently surface: Detailing the work actually done, need for greater accountability, and need to package and market their services to funders.

As noted earlier, HIV/AIDS work with Black and African American men who have sex with men is more often than not a complex process. Locating the populations, establishing rapport, creating and sustaining relationships, and (then) delivering meaningful HIV/AIDS prevention and intervention services is not a quick intervention. Frequently, because of funding mandates, the emphasis is on the provision of HIV/AIDS specific services. However, in practice, service providers expend significant time forming relationships and establishing trust with the target audience. Once these rela-

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Health Disparities and African Americans (Audio Web cast)

"Health Disparities for African Americans, From Insurance to Disease: Planning on a Healthier Checkup for the Future," a briefing from the Emerging Leaders Series sponsored by the Congressional Black Caucus Foundation. Congressman Donald Payne; Dr. Marsha Martin, executive director, AIDS Action Network; Dr. Lorraine Cole, president and CEO, National Black Women's Health Project; and others discuss health disparities and the effect of HIV/AIDS on the African American population.

Where: http://www.kaisernetwork.org/healthcast/cbcf/05mar2002

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reported the highest rates of unprotected anal intercourse (UAI), even when compared to men from other ethnic minority groups (Doll, S, Byers, R., Bolan, G., Douglas, J., Moss, P., Weller, P., Joy, D., Bartholow, B., & Harrison, J., 1991; Fairbank & Maullin, 1991; Lemp, 1994). In San Francisco, where research has documented significant reductions of risky sexual behavior among gay/bisexual men (Coates et al., 1995), rates of unprotected anal intercourse among Latino men have remained relatively high. In a survey of knowledge, attitudes, and behavior conducted in the summer of 1990 in San Francisco's American-Indian, Filipino, and Latino gay/bisexual male communities, 35% of Latinos reported unprotected anal intercourse during the last 30 days, as compared to 25% of Filipinos and 12% of American-Indians (Fairbank & Maullin, 1991). In the Lemp et al. (1993) study of young gay men in the San Francisco Bay Area, 40% of Latinos reported unprotected anal intercourse during the last 6 months, as compared to 38% of African Americans and 28% of non-Latino Whites.

In the venue-based probability sample of Latino gay men in the three U.S. cities mentioned above, rates of unprotected anal intercourse were 28% (estimated by sexual activity in the last 2 months) and 37% (estimated by sexual activity with the last two sexual partners within a 12-month period). Interestingly, the more recent data on rates of recent risk behavior (UAI with non-monogamous partners) and the data on HIV prevalence converge at about 20%.

The incidence of STDs within the population provides the best surrogate marker for unprotected sexual activity. Research also clearly indicates that persons infected with other STDs have a "twofold to fivefold increased risk for HIV infection" (MMWR, 1998). The rates of chlamydia are more than 4 times greater in Latinos (321.9 per 100,000 population) than in Whites (70.4 per 100,000 population).

While this research describes the epidemiological realities facing Latino men who have sex with men and individuals working diligently to prevent the spread of HIV, it offers us little insight for understanding how best to help men avoid transmitting HIV, because this research is deeply entrenched in individualistic notions of "risk" (Fisher and Fisher, 2000) that problematize and stigmatize anal sex between men (latex barriers present or not) (Guzman, 2001). Moreover, we as researchers and preventionists have largely failed to understand the chance for transmitting HIV in the context of important social and cultural forces that are constantly at play in the sexual exchanges between men (see Ayala & Diaz, 2001; Diaz & Ayala, 2001; Farmer 1999; and Singer, 1992 for important exceptions). We have also been conspicuously silent about what men think and feel when having sex. This silence in AIDS prevention research and practice has retarded our conversations about HIV and AIDS by excluding examinations of pleasure and desire (Reid-Pharr, 2001; Plummer, 1994; Williams, 1996).

Epidemiologists and behavioral scientists are fond of sex counting—enumerating the times anal sex was performed with how many sex partners of what gender in what position within a given succession of months. We have neatly calculated rates of unprotected sex—how often condoms were not used during anal sex with those sex partners of that gender in those positions in that window of time. This way of studying HIV transmission assumes that sexual behavior is the result of some rational decision-making process stripped of emotions, alienated from pleasure, and divorced from desire. We have so trivialized sex between men that we overlook the importance of understanding the decisions men make about their actions, their social networks, their sex, and their group affiliations in their social and cultural context. In the end, we learn little about pleasure, desire, sex, the place each occupies in the lives of men, the meaning that men bring to each, and what men feel or think when we have sex.

Robert F. Reid-Pharr, in "Black Gay Man: Essays," grapples with identity politics and critiques queer theory for often being aloof and obtuse, removed from the day-to-day lives of our respective communities, and having done little to advance an understanding of how to affect oppressive economic and social structures. Reid-Pharr challenges us for being willing to let stand the most "tired and hackneyed notions of what our sex actually means": ideas about sex taken out of context and viewed as devoid of the influences of larger social and cultural forces. He writes:

"If there is one thing that marks us as queer, a category that is somehow different, if not altogether distinct, from

As a result, AIDS prevention research and practice has suffered, and gay men of color are left to shoulder a disproportionate burden of the HIV/AIDS epidemic.

the heterosexual, then it is undoubtedly our relationships to the body, particularly the expansive ways we utilize and combine vaginas, penises, breasts, buttocks, hands, arms, feet, stomachs, mouths, and tongues in our expressions of not only intimacy, love, and lust but also and importantly shame, contempt, despair, and hate. Because it is impossible to forget that we hold a tangential relationship to what Michael Warner calls heteronormativity, we often are forced to become relatively self-aware about what we are doing when we [have sex], suck, go down, go in, get on, go under. Even and especially when that tricking happens in the blank, barely penetrable atmosphere of the dark room, I am aware of the immense contradictions at play, the pleasure and danger located at the end of his cock, pleasure and danger that are intimately linked and that work together to produce the electricity of the encounter (Reid-Pharr, 2001, pp. 85-86).

Anyone who understands Reid-Pharr's challenge should be surprised that AIDS prevention research and practice have devoted so little theorizing to how "we inhabit our bodies," especially how we have sex, or rather what we think and how we feel when we have sex. As a result, AIDS prevention research and practice have suffered, and gay men of color are left to shoulder a disproportionate burden of the HIV/AIDS epidemic.

It is time to seek the counsel of gay men of color like Robert Reid-Pharr if we are to begin addressing the chokehold HIV/AIDS currently has on gay men of color. We must pay closer attention to the works of my mentors, brothers, and comrades who have and continue to write about "queerness" and "coloredness," not as problems to be solved, but as fertile ground upon which to launch more sophisticated and nuanced explorations of desire, pleasure, culture, and the challenges of living with multiplicity (Guzman, 2001; Hebert, 2001; Reid-Pharr, 2001; Cortez, 1999; Bracho, 1999; Bracho, 1997; and Spieldenner, 1996). These individuals are not epidemiologists or research scientists, but students of "queer coloredness," poets, cultural workers, artists, and scholars whose irreverent use of humor, poetry, images, and criticism poignantly teach us about the experiences of gay men of color, in all of their glorious complexity, contradictions, messiness, and potential to upset the status quo. As cultural critics, visionaries, feminists, and progressives, Reid-Pharr, Cortez, Hebert, Bracho, Guzman, and Spieldenner actively de-construct and re-construct notions of identity and in doing so challenge the social institutions of racism, classism, sexism, and homophobia.

What makes the work of these men so instructive in the context of HIV/AIDS prevention is that while they continue to critique essentialist understandings of what it means to be "gay men of color," they acknowledge the political importance and potency of claiming that label. Claiming identity (gay man of color)—or not—is at once a purposefully political and deeply personal act because it makes explicit social location, highlights individual agency, and signals cultural defiance. As gay men of color, our sexual exchanges are therefore deeply implicated in the social and cultural structures (race, class, and gender) within which our sex happens. HIV/AIDS prevention research and practice would do well to take heed and follow suit.

For preventionists and behavioral and social scientists this means being willing not to privilege HIV-related epidemiological research data over the cultural criticism and artistic work of gay men of color. We must keep sex, pleasure, and desire at the forefront of our own work and resist the impulse to decontextualize, essentialize, or homogenize the sexual exchanges between men. Practically speaking, we must partner with local poets, cultural workers, artists, and scholars who are weaving important insights about the multiple meanings gay and bisexual men of color ascribe to their sexual exchanges into their own work. We must use this work to inform our own assessment and intervention design and implementation activities. And if in the end, we are still left scratching our heads about stubbornly persistent HIV infection rates among gay men of color, we must ask ourselves, "Are we really listening?"

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Call for Proposals

The APA Society for the Psychology of Women (Division 35) Section on the Psychology of Black Women is soliciting proposals for the:

2002 HIV/AIDS Prevention Small Grant

For Prevention/ Intervention Research or Curriculum Materials Designed To Prevent or Reduce HIV Infection Among Black Women and Female Teenagers

Division 35 Section on the Psychology of Black Women seeks to assist in reducing or eliminating HIV infection and cases of AIDS among Black women and female teenagers by supporting curriculum development and prevention/intervention research that is culturally relevant, gender-specific, and age appropriate.

The Section hopes to encourage researchers who work with these populations to design, promote, or enhance innovative, creative, and effective prevention and health promotion curriculum materials that can aid in the reduction of HIV-related sexual behaviors that may incur exposure to HIV infection.

Three grants will be awarded this year: Two individual grants of $2,000 each and one $2,150 grant to a project focused on Black female teenagers.

Submission Deadline:

June 7, 2002

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tionships are established, then HIV/AIDS related work can occur. As a consultant one of my tasks is to assist the service provider in fleshing out the conceptual model of his/her intervention. The benefit of doing this is not just in documenting the details, but it also assists in resource allocation, task assignments, and strategic planning. Detailing the intervention also provides the basis for greater accountability and specificity in the evaluation process. With a more detailed characterization of the services provided, packaging and marketing the intervention is, if not simpler, more concise. Clearly this is not a comprehensive list. It does however, underscore what really seems to me a bottom line: Effective HIV/AIDS prevention efforts targeting Black and African American MSM are needed now. As a consultant it is not my role (or desire) to impress the recipients of services with my talents, but to assure that the good work recipients do is enhanced through our collaboration and supports the goal of reducing HIV morbidity and mortality among Black and African American MSM.

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ANNOUNCEMENT

The InterAmerican Journal of Psychology has published a special issue titled "HIV/AIDS: Challenges for Research and Action," edited by Dr. José Toro-Alfonso, past chair of the Committee of Psychology and AIDS of the APA. The dual language (English and Spanish) publication has articles by renowned figures of the Americas and was financed by the University of Puerto Rico, NIAID, and NMAC. Authors are from Mexico, the United States, Puerto Rico, and Costa Rica. Díaz Loving gives an overview of prevention efforts in the Americas. Kalichman and colleagues speak to single session approaches to risk reduction, and Ayala and Díaz write about race, class, and HIV risk among gay Latino men. Moscoso et al. speak about adolescents, and DeLeûn does an excellent analysis of the status of HIV/AIDS policy related to Latinas. Public policy in various Latin American countries is also the subject of a Toro & Varas' article. Schifter presents data relative to HIV/AIDS in incarcerated populations in Costa Rica, and Parker analyzes the evolution of HIV/AIDS prevention, intervention, and strategies in the last decade.

If you are interested in obtaining this issue, contact the journal manager, Ms. Josephine Resto, at revinter@rrpac.upr.clu.edu.; (787)764-0000, ext. 7883 (Phone); or (787) 764-2615 (fax). Copies are $20 each, and $15 if you buy five or more.

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WEB SITE RESOURCES

www.hivaidsta.org
The AED-NASTAD Web site is specifically designed for community-planning folks, with listserv, peer materials, and publications: http://www.hivaidsta.org/ta_materials/index.htm. This has an index of TA materials for community planning folks.

http://www3.utsouthwestern.edu/preventiontoolbox/This Web site provides information in Spanish as well as English. It is a resource for program supervisors and staff who engage in outreach, education, and HIV prevention counseling and testing.

http://thebody.com/features/women/
"Women & HIV," is a new area of the Body Web site. This comprehensive, in-depth look at HIV/AIDS among U.S. women includes interviews with top AIDS specialists treating women, important resources for women, and an online museum featuring the artworks of Visual AIDS' female members.

http://chipts.ucla.edu/Assessment_Instruments/asmntframe.html
This Web site offers a variety of assessment tools and tips related to HIV, HIV adherence, substance use, coping, etc. It describes methodology, including sample size and power determinations, as well as techniques for data collection, including focus group tips. Assessment instruments that are not copyrighted are available here as downloadable PDF files accessible through Adobe Acrobat Reader. Information only is provided on copyrighted instruments.

http://www.omhrc.gov/OMH/aids/impact/fall2001.pdfOMHRC produces HIV Impact, a quarterly newsletter that focuses on HIV/AIDS in communities of color. You won't want to miss the best practice approaches, current data, new research, legislative updates, and funding opportunities.

http://www.aidschannel.org/resources/AIDSchannel.org
This is a multimedia Web portal on issues related to HIV/AIDS. Its mission is to foster understanding and knowledge and to emphasize that the disease is not only a health, but a development, social, economic, and human rights issue. The site brings together information and resources from civil society and organizations, governments, research institutions, media and other stakeholders working in the field.

http://www.usmbha.org
The United States Mexican Border Health Association (USMBHA), a Centers for Disease Control and Prevention (CDC) funded provider of technical assistance, has just launched its Web page. In an effort to improve health conditions along the U.S.-Mexico border, the USMBHA sponsors a number of activities targeting different health aspects. Please take note of the projects, news, publications, search, and other options available through this site.

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[1] *Although Asian Pacific Islander and Native American men represent a smaller proportion of HIV and AIDS cases overall, there is growing concern over rising infection rates and rates of unprotected sex in these communities. Often overlooked in discussions about gay men of color, Asian Pacific Islander and Native American gay and bisexual men have and continue to be deeply affected by the HIV/AIDS epidemic, requiring nothing less than our complete attention and vigilance.*

Presenting Research Findings: Helpful Tips

"Presenting Research Findings: Helpful Tips" was developed for community-based organizations (CBOs) who had spent 3 years collaborating with the UCSF Center for AIDS Prevention Services (CAPS) scientists on CBO-generated research questions. At the end of the project, each CBO did a community presentation on their work. This was a guideline developed by CAPS to help CBOs plan their presentations.

To DO!

- At the beginning of your presentation, clearly describe your population, especially how and why they are at risk for HIV.
- Also at the beginning, clearly state your research question(s), your methodologies, and what you will be covering in this presentation.
- Interpret the data and highlight key points for your listeners.
- Include photos, examples, quotations, or other representations of clients.
- Make summary statements about what you have presented.
- Reinforce the key take home messages in a clear, decisive way. Sometimes it is effective to state your conclusions at the beginning.
- Describe the limitations of the study (e.g., how representative is your sample?).
- Reinforce the purpose of your research throughout the presentation. Why is answering this research question important?
- Talk about the implications of your findings for program implementation; talk about future research questions you have.
- Rehearse your text and technology.
- Leave time for questions and answers.

To AVOID!

- Don't flood your audience with data; be selective. Select the data that illustrates your conclusions and is closest to your purpose for this presentation.
- Don't read raw data without interpreting it for the audience.
- Don't present complicated tables; keep overheads simple, using high contrast color. Mark significant findings.
- Don't talk about the research question, methods, key findings, or results without clear overheads reinforcing your points. ▼

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ration of other associations—drawn from the sociocultural and structural levels—can be anticipated to add to the efficacy of interventions designed to stop the spread of HIV infection among American MSM.

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Conference Updates

May 2, 2002

The Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention (DHAP), and the Academy for Educational Development (AED), Center for Community Based Health Strategies will be sponsoring a satellite broadcast on effective behavioral interventions for minority communities. Additional information will be provided as it becomes available.

May 4-7, 2002

"Voices 2002: The National Conference on HIV/AIDS for Children, Youth, and Families," Washington, DC. Sponsored by the AIDS Alliance for Children, Youth and Families. For information, visit the Web site at http://www.aids-alliance.org or contact Omar Perez at (202) 785-3564 or operez@aids-alliance.org.

May 23, 2002

"Effective Behavioral Interventions for HIV/STD Prevention." A live satellite broadcast by the CDC's National Center for HIV, STD, and TB Prevention, Division of HIV/AIDS Prevention Capacity Building Branch. For information, call (800) 462-9521 or go to www.phppo.cdc.gov/PHTN//calendar.asp.

May 30-June 2, 2002

"HIV/AIDS 2002: The Social Work Response," New Orleans, LA. Sponsored by the Boston College Graduate School of Social Work. For information, contact Dr. Vincent J. Lunch at (617) 552-4038.

July 7-12, 2002

"XIV International AIDS Conference," Barcelona Spain. The theme for this conference is "Knowledge and Commitment for Action." For information, visit http://www.aids2002.com.

September 19-22, 2002

"2002 United States Conference on AIDS," Anaheim, CA. For information, visit http://www.nmac.org/usca2002.

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