

# **MODULE FIVE**

## **Prevention Issues for the Mental Health Provider**

### **A. HIV Transmission, Risk Behaviors & Determinants of Risk**

#### **1. The Nature of HIV**

- HIV is a fluid-borne virus. It has been isolated in the body fluids and tissues of infected persons. It is not an airborne virus and cannot therefore be transmitted casually. HIV can be transmitted by the following body fluids which are listed in order of most viral concentration or Viral Load (VL) to least VL: blood, semen, vaginal secretions, and breast milk. Though present in other body fluids, the concentration of virus is so low that risk of transmission is negligible to non-existent.
- In order for transmission to occur, there must be a source of infected body fluid and there must be a sufficient quantity of the infected body fluid. The quantity of a particular fluid necessary for infection will differ depending on the amount of virus present in that fluid.
- The viral load present in any particular infected body fluid will vary according to many factors. Infected individuals may be hyper-infectious early in the disease process during the acute illness phase (before the body has had sufficient time to mount an antibody response and reduce VL) or late in the disease process when the immune system is failing and the body is unable to keep VL at reduced levels. VL in any particular body fluid is also dependent on treatment efficacy throughout the course of the disease.
- In order for transmission to occur, there must also be a portal of entry for infected body fluid (means/mode) to “get into” the body. In other words, there must be a way for viral absorption to take place. This happens by way of intact or lacerated mucous membranes, cuts or open sores. Sexually, this absorption may take place in the vagina, anus or mouth.
- HIV is NOT transmitted casually by objects like dishes, silverware, toilets, or doorknobs. Activities such sports, hugging, massage, kissing, sneezing pose no risk. It is impossible for other creatures like bugs, dogs, mice, cats to transmit HIV. HIV is a human-specific virus.

#### **2. Routes of Transmission**

- There are five modes of transmission for HIV: 1) sexual contact, 2) sharing needles or other drug injection paraphernalia (e.g. cooker, cotton, water, etc.), 3) infected mother to child (before or during birth), 4) breastfeeding, 5. transfusion of blood or blood products.

- Certain sexual behaviors have been associated with risk of HIV transmission. Seldom are these sexual behaviors associated with any one group of individuals. Assuming that only certain types or groups of individuals participates in a particular behavior may result in an inaccurate and therefore useless risk assessment and risk reduction plan.
- The majority of people infected with HIV acquired the virus sexually, by way of unprotected anal or vaginal intercourse with an infected partner. In the case of intercourse as a risk factor, one must consider the individual client's sexual role or roles. Assuming that there are no lesions present on either partner, an HIV-negative insertive partner is considered to be at lower risk of infection from an HIV-positive receptive partner. Conversely, an HIV-negative receptive partner is at considerably higher risk for infection during unprotected vaginal or anal intercourse with an HIV-infected insertive partner. The reasons for this are clear and related directly to the quantity of body fluid exchanged and the mucosal surface area of the vagina or anus versus the urethral opening of the penis (portal).
- Male clients who most often or always play the insertive role in intercourse may try to use this information to legitimize their own risk behavior. It is important to make clear that "potentially lower risk" is not the same as "no risk" and the fact that he has remained uninfected to date may have more to do with luck than anything else. Frequency or infrequency of unprotected intercourse with HIV-positive partners or partners of unknown serostatus is of little consequence. Infection is possible and odds are offer no protection.
- HIV may also be transmitted by sharing inserted sex toys if the object is transferred from one partner to another without washing thoroughly.
- Oral/genital contact poses some risk for HIV transmission depending on the specific behavior. Though HIV can and has been transmitted through oral/genital contact, it is seldom the only transmission factor identified by persons testing positive for HIV. A great deal of controversy remains about the likelihood of HIV transmission but current understanding of the virus indicates risk is present.
- Oral-genital HIV transmission is biologically plausible if HIV-infected semen or vaginal fluids contact the oral mucosal however given that there is a low concentration of virus in saliva and that certain enzymes in the saliva inactivate the virus, transmission risks have been considered low.
- Despite numerous studies which bear this assumption out, oral-penile contact remains very controversial. Regardless of previous findings, controversy has arisen from several studies where exposure of semen to the oral cavity was reported as the only risk behavior in a small number of cases. Lifson, et al. (1990) Samuel et al. (1993), Keet et al. (1992), Edwards and White (1995) and Schaker,

Collier, Hughes, Shea, & Corey (1996). These studies mention a total of 15 subjects who report oral-genital contact as their only possible source of infection.

- Behaviors related to drug use include the injection drug user (IDU) sharing “works”: needle, syringe, cotton (filter), cooker, or water for cleaning as mentioned earlier. Sharing any of these tools may facilitate HIV transmission if one partner is infected.
- Drug use is associated with poor decision-making and or lowered inhibitions. Specific drugs are linked to hyper **or** diminished sexual behaviors. The culture of drug use may also involve survival sex: sex for money, drugs, food, shelter for self, children.
- Vertical transmission, or from mother to child can occur antepartum, intrapartum, postpartum (before, during, or after birth). 65-70% of transmission happens at or around time of delivery, the remainder occurs during pregnancy. New studies led the American College of Obstetricians and Gynecologists to recommend that HIV+ women consider cesarean delivery 2 weeks before the anticipated natural birth of their child. This can potentially reduce transmission to 2%!
- In the United States, approximately 1% of vertical transmission occurs through breastfeeding.
- Without intervention 25% of children born to infected mothers will be HIV+.
- Since ACTC 076 (AIDS Clinical Trials Group study) demonstrated the efficacy of AZT/ZDV (Zidovudine) therapy for reduction of perinatal transmission, this has become a widely accepted for reducing HIV transmission from mother to child.
- Simonds (1999) notes that the widespread use of ZDV during pregnancy had led to a decline in the number of perinatal HIV infections. Thus, the number of children with HIV infection is declining. However, long-term outcomes for those children born to mothers with HIV infection and exposed to ZDV therapy are not known.
- HIVNET 012 study findings from joint Uganda-US study that a single oral dose of the NNRTI Nevirapine can dramatically cut vertical transmission rates

Possible Topics for Discussion:

What transmission risk factors do your clients most often present?  
Which are causes of the most concern to you as a counselor?  
Do you ever find yourself debating degrees of risk with clients;  
who usually wins? Is this “boxing” or debate conducive to  
effective risk education? What do you think is behind the client’s  
wish to debate? How do you handle denial of risk without debate?

### 3. Biological Correlates of HIV Risk

- Certain biological correlates have been associated with increased HIV risk. The presence or a history sexually transmitted diseases (STD) is a strong independent predictor of HIV infection and a marker for unprotected sex.
- STDs may weaken or breach mucous membranes (ulcers) and ulcerative STDs provide gateway/source for infection. Nonulcerative STDs may form a discharge that contains infected cells. Treating STDs reduces risk of HIV transmission
- Lacerated tissue increases the risk of HIV transmission. Lacerations can occur for various reasons.
- Infectiousness is related to viral load (VL) which correlates with HIV transmission risk. VL is associated with disease stage as well as history and efficacy of HIV antiviral treatment.
- Virulogical susceptibility to anti-HIV treatments and strain of HIV are related to HIV risk. Transmission of drug resistant virus is a serious potential public health threat.

### 4. Psychological, Social, and Situational Correlates

- According to Kelly and Kalichman (2002), behavioral research over the past two decades has revealed a fairly consistent set of psychological, social, and situational factors associated with patterns of high-risk sexual or drug use behavioral practices. These include:
  - 1) *risk-related cognitive and attitude factors* (including incorrect beliefs about risk, negative attitudes toward condoms, weak intentions to change behavior, poor perceived self-efficacy for enacting behavior change, and negative outcome expectancies concerning safer sex);
  - 2) *poor risk reduction skills* (in areas such as correct condom use, sexual negotiation or assertiveness, and risk-reduction personal problem solving);
  - 3) *relationship factors* (with patterns for safer sex more likely in casual, transient, or “first time” partnerships than in affectionate, ongoing or primary relationships);
  - 4) *limited social and peer normative supports for risk-reduction behavior change*; and,
  - 5) *situational factors* that contribute to risk, such as concurrent substance-use problems (see reviews by Kalichman, 1998a; Kelly, 1995).

- Additionally, studies with college students, adolescents, MSM, and women demonstrate a clear association between sensation seeking and high-risk behavior. Sensation seeking is associated with clusters of high-risk behaviors, not only sexual. Sensation seeking is also associated with stress reduction. Zukerman's Experience-Seeking Scale (1971) was designed specifically to tap sexual sensation seeking. Kalichman, Heckman, and Kelly (1996) reported a path-analysis that showed sensation seeking significantly predicted unprotected intercourse even after accounting for substance use.
- Sexual adventurism is similar conceptually to sensation seeking. It is comprised of the following in relation to sexual activity: poor impulse control, risk seeking, and attraction to dangerousness. DiFrancesco, Ostrow, and Chmiel (1996) found that the MSM in their study who seroconverted had greater sexual adventurism scores early in the study than compared to non-seroconverting, seronegative controls.
- Threats of living in the "inner city" include: violent crime, drug prevalence and abuse as well as discrimination and have been linked to increased frequency of HIV risk behavior (Kalichman, Somlai, Adair, & Weir, 1996). Unsafe sexual practices and more sexual partners, alcohol and other drugs are cited as mechanisms to relieve tension.
- Psychopathology and psychological disturbances are known to increase sexual risk-taking. Mania can encompass hypersexuality and lack of sexual impulse control can lead to aberrant sexual acting out with multiple partners. Excessive sexual-erotic ideation and sexual compulsivity may cause individuals to continue unsafe behaviors regardless of risk of infection for self or others.

Possible Topics for Discussion:

How do **you** discuss the biological correlates for HIV risk with clients? Are clients in general receptive to a discussion which may include discussion of genital self-exams and other personal topics beyond risk behavior? Who are your clients and where do they fall with regard to the 4 factors associated with psychological correlates of risk? Which clients pose the greatest challenge to you as a counselor and educator, as an individual? How do you handle those clients, and importantly, your personal response?

## **B. Empirically-Based HIV Prevention Interventions**

### **1. Overview of Research Findings**

The following section is excerpted from *Kelly, J.A. & Kalichman, S.C. (2002). Behavioral Research in HIV/AIDS Primary and Secondary Prevention: Recent*

- Because of the need for effective face-to-face interventions, a good deal of research has sought to identify HIV risk-reduction approaches that can be undertaken with individuals, couples, or small groups. Most of the interventions studied in these research trials have combined together a number of components, including risk-reduction education, exercises to encourage the development of positive attitudes, beliefs, and intentions concerning behavior change, activities to strengthen risk-reduction behavior skills, such as by practicing correct condom use and role playing sexual communication or assertiveness skills, risk-behavior self-management strategies, problem solving about the application of risk-reduction strategies in one's own relationships, and reinforcement of support for behavior-change efforts.
- The behavioral objectives of these interventions have usually included reductions in rates of unprotected sexual intercourse and increased condom use, or the adoption of other safer sexual practices. In research with adolescents, the impact of intervention on abstinence and delay of sexual activity onset have sometimes also been examined.
- Although the populations studied in small-group HIV prevention interventions are diverse, the procedures used in most of these interventions have a good deal in common. All of the interventions have involved substantial amounts of contact time with participants, always more than 4 hours and sometimes including as many as twenty 90 min group meetings.
- Usually drawing on constructs of social-cognitive and reasoned-action theories, the interventions studied in these trials have attempted to increase participants' knowledge about HIV prevention steps, strengthen behavior-change motivations, teach risk-reduction skills, and encourage behavior-change goal setting. Because risk-producing behaviors, situations, relationships, and social contexts vary greatly for persons of different genders, sexual orientations, ages, and cultures, all of these successful interventions have been tailored to address the needs of the client groups involved.
- Intensive, small-group risk-reduction interventions of this type have generally been shown to produce moderate to large effect sizes on behavioral outcomes, such as rates of unprotected sex and levels of condom use (Kalichman, Carey, & Johnson, 1996).
- Strengths of intensive, small-group HIV prevention interventions include their transportability to many kinds of service delivery settings, the existence of well-defined protocols that can guide program implementation by service providers, and use of an intervention approach with enough intensity to allow clients to receive substantial assistance for making change in what may be longstanding

and complex risk behaviors. A limitation of these approaches is that, except in clinic-based or institutional settings where clients attend the group program as a part of their usual service routines, it may be very difficult to engage community members to seek out intensive multiple-session programs that require great motivation and time commitments.

## **2. Project RESPECT**

- Project RESPECT is the largest trial of an HIV risk-reduction intervention directed toward individual clients seen in one-on-one counseling (Kamb et al., 1998). Project RESPECT was a multicenter randomized trial evaluating the efficacy of HIV prevention counseling in changing behavior and reducing new STDs. The Enhanced Counseling Intervention was one of two counseling models tested in the study.
- The Enhanced Counseling Intervention is based on theories of behavior change, particularly social cognitive theory and the theory of reasoned action. The four-session intervention was conducted by a trained HIV counselor, with all sessions conducted by the same counselor. Each session involved a client-centered, interactive approach, with Session 1 lasting 15 to 20 minutes, and Sessions 2, 3, and 4 lasting 60 minutes each. Session 1 was given during the enrollment visit, and the remaining sessions were conducted during the following three to four weeks. The HIV test results were given during Session 3.
- Each intervention session built on materials discussed during the previous session. Session 1 focused on a personalized assessment of risk. Session 2 focused on changing condom use self-efficacy, Session 3 on condom use attitudes, and Session 4 on perceptions of norms regarding condom use. Each session ended with a goal setting exercise. Whenever feasible or applicable, a condom use goal was encouraged.
- Project RESPECT enhanced intervention manual may be found, downloaded and shared at <http://www.cdc.gov/hiv/projects/respect/ecim.pdf>. It is a public document.

## **C. Risk Assessment**

### **1. General Orientation to Risk Assessment**

- Risk assessment is much more than a series of questions directed at an individual. Risk assessment is an exploration of behaviors and situations present or result in risk to the individual. Moreover, while some useful information may be gathered initially, risk assessment becomes an *ongoing* dialogue with the client about his or her behaviors and attempt to reduce risk.

- No one's health or sexual risks remain static over time. Monogamous, married men and women divorce or are widowed. Single or married individuals who have chosen, or are forced by situations to abstain from sex may at some point in time become sexually active. Perhaps most important is that a label should not automatically imply specific behaviors. Straight people have anal sex. Individuals who self identify as gay or straight may be totally abstinent or be having sexual relationships with members of the opposite or same gender, respectively.
- It is important to provide the client with an understanding of the purpose of risk assessment. Clients must be prepared by explaining that the same questions are asked of everyone and that asking a question does not imply that the counselor believes anything about the client or is making any judgement at all.
- Use of carefully worded open-ended questions is a skill of great importance in doing a comprehensive risk assessment. Rather than ask an individual, "Are you gay?", one ought ask "Do you have sex with men, with women, or sometimes with men and sometimes with women?" A closed question, such as "Do you use drugs?" is self-limiting. If the individual replies that he or she does not use drugs, further questioning in that area implies that you believe the person is lying. A better way to ask that question is, "What kinds of drugs have you used?" This kind of question normalizes the behavior provides permission for the client to give the counselor information.
- Counselors often make the mistake of assuming that the goal for behavior change should be risk elimination. Admirable though that goal may be, it may not be appropriate for some clients – many in fact. Short term, achievable risk reduction goals are more likely to achieve results than attempts at risk behavior elimination.

## 2. Risk Assessment Questions

- What do you do to put yourself at risk for this infection?
- How do you think you may have been exposed to HIV?
- How would you describe your own risk of being infected?
- How often do you do drugs, specifically drugs that you shoot?
- How often do you use condoms with your steady partner?
- How often do you use condoms with partners whom you do not know very well?
- How have your behaviors that we have discussed put you at risk for HIV?
- What are you presently doing to protect yourself?
- What would you like to do to reduce your risk of HIV?
- Who have you talked to about your HIV concerns/risks?
- What have your friends/partners said about HIV/AIDS?
- Whom have you talked to about using condoms?
- Explain to me when you use condoms. How has that worked?
- Whom do you use condoms with?

- How often do you use condoms with your steady partner?
- How often do you use condoms with partners whom you do not know very well?
- What thoughts have you had about reducing your risk for HIV infection?
- Do you know anyone with HIV infection?
- How does that situation impact your own sense of risk?
- What have you seen or heard about HIV in your/this community?
- When have you reduced your risk?
- What was going on that made that possible?
- How is that working for you?

### 3. Questions to Identify Perceived Barriers to Risk

- What has been the most difficult part of changing your behavior?
- When, and in what situations, do you not use condoms?
- How often do they break?
- When are you least likely to use condoms?
- When do you have the most difficulty in discussing condoms?
- What have you discussed with you partner(s)?
- With which partners has it been hardest to talk about/suggest the use of condoms?
- What was the role of drugs/alcohol in your decision to engage in high-risk sex?
- In what situations are you most likely to be putting yourself at risk for HIV?

## D. Helping Clients Develop a Risk Reduction Plan

### 1. Establishing the Risk Reduction Plan

- It is essential to help clients establish a reasonable yet challenging risk reduction plan that will reduce his/her risk for acquiring HIV. This plan should address the client's baseline risk behavior identified in the risk assessment phase of the session and should incorporate the client's previous attempts and perceived barriers to reducing HIV risks.
- It is important to help the client will operationalize the plan, using *specific and concrete steps*, and establish a back-up plan.
- Open-ended questions to use when negotiating a risk reduction plan might include:

What one thing can you do to reduce your risk right now?

What can you do that would work for you?

What could you do differently?

How/when will you use condoms?  
How are you going to bring up condoms with your sex partner(s)?  
What will you say?  
When do you think you will have the opportunity to first try this (behavior, discussion, etc.)?  
How realistic is this plan for you?  
Who can help you?  
What will be the most difficult part of this for you?  
What might be good about changing this?  
What will you need to do differently?  
How will things be better for you if you...?  
How will your life be easier/safer if you change...?  
How would your drug practices have to change to stay safe?

## **2. Evaluating the Risk Reduction Plan**

- It is important to assist the client in exploring how they did with their risk reduction plan. Some suggested statements for discussion of the risk reduction plan include:

How did that go for you?  
How did the action you took [planned to take] feel to you?  
How did your partner react?  
Was it like you expected?  
Were you happy with how it went?  
What went well?  
Why do you think those things went well?  
What did not go so well?  
Why do you think those things did not go so well?

## **E. General Techniques for Risk Reduction Education**

- Risk reduction education often begins by assessing the client's understanding of HIV disease in the most general sense and correcting misinformation and common misconceptions.
- General education about the virus, disease stages and treatments is valuable but of little use alone in behavior change counseling. Simply put, information does not equal behavior change. Perhaps the greatest failure in early prevention efforts was the misguided public and governmental assumption that knowing about the disease would prevent people from putting themselves at risk. General education also includes educating clients in risk reduction steps, and alternatives to intercourse.
- Any attempt to bring about behavior change must begin by assisting an individual in realizing an accurate sense of personal vulnerability.

- Educating a client and helping him/her perceive risk might begin by assessing the client's conceptions and misconceptions about HIV risk. Though we continue to hear that "people know how not to get HIV" or "people know what activities are risky and who is at risk", this simply isn't always the case. Myths and misconceptions about HIV persist as surely as the misconceptions about pregnancy, and STDs. It is important the clients understanding of HIV and risk be based on fact in order for the client be able to connect himself to HIV in a meaningful way. This may involve bringing the statistics closer to home; emphasizing perceived similarities between client and people with AIDS; association of risk with personal behavior, and of course, correcting misinformation.
- A frequently used technique to assist the client in visualizing the implications of risk and the infectious nature of HIV involves having the client list his or her partners and then trying to name the other partners of those partners. This exercise, entitled, "How crowded is the bedroom?" allows the client and psychologist to visualization the number of individuals (know and unknown) who are indirectly involved in each relationship. How many of those persons listed are known to be HIV-positive or at risk? Do we know that protection was used in each of these encounters? Can we be sure? Questions like these serve to illuminate the unknowns...and reinforce the known risks of intimate relationships.
- This technique may be modified for use with injection drug users. The same ideas apply only one may query, "Who else's stuff is in those works?" or the like. Ask the client to share how many times s/he has shared works with someone in the past six months, or week (choose time). Ask client if s/he can name everyone with whom works were shared in that time period. Do we know their risks? What about others with whom your partners have shared, do you know their risks?
- Client practice assignments can also serve to reinforce and elucidate self-perception of risk behaviors. Counselors may assign the client a simple report based on television news reports, newspapers, etc. in order to prepare for the next session. Clients should be asked to be prepared to discuss what was heard and learned.
- When appropriate, assignments may include:
  1. condom shopping to check out brands and labeling (look for lubricant, shape, size, reservoir tip, latex vs. natural skin, etc.); which brands are the best to use (for the individual) and for oral, anal, vaginal sex?
  2. Discuss 5 misconceptions "I've" held about HIV/AIDS and what fact have I learned to replace that myth?
  3. In the past year (arbitrary time period depending on client), how many times have I done something that put me at risk for HIV and that I'd like not to do in the future?

4. Of all the risks identified, which ones do you think you'd like to work on reducing/eliminating first? Why? This question is of great value as it puts the responsibility for behavior change into the hands of the client. Encouraging the client to choose, explain and then "contracting" for an outcome is an excellent client-centered technique for gradually changing behavior.
- For clients who have had difficulty adopting correct and consistent use of condoms, reasons should be explored. It is important to assess the meanings of, and barriers to condom usage...there are many and very valid for the client. Use or non-use of condoms carries different meaning for individuals and populations. These meanings can and must be examined respectfully and in a culturally sensitive manner. For some, condoms will simply never be an option and risk reduction or harm reduction strategies beyond condom usage must be discussed and employed without judgement.
  - Teaching risk behavior management skills may require demonstrating the use of condoms and lubricants with model displays.
  - Practicing condom use is important for men as well as women. Condom use is a skill and requires practice. This practice may take place during masturbation and/or with a partner as technique to stimulate communication. Counselors may instruct clients to discover ways to make condom use more pleasurable (different shapes/sizes of condoms, lube on the inside, etc.).
  - Obtaining and using the correct lubricant (if desired/necessary) begins with educating the client about the types of lubricant available (water-based, water-soluble, oil-based (not for use with latex, but OK for polyurethane) and the safe usage of each. Proper lubrication reduces the likelihood of condom breakage; overuse may increase the likelihood of slippage and increase risk. Lubricants are not just for anal intercourse. Use of lubricant on the inside of condom to increase sensation and reduce friction (for oral, anal, or vaginal sex).
  - Clients may need to be instructed how to store condoms and encouraged to keep them "handy", where they're used.
  - Counselors may be involved in helping the client disassociate alcohol and recreational drug use from sex. ATOD are linked to disinhibition, counselor understanding the specific drugs used and how and when they are used is imperative in order to assist the client in making the connection between chronic drug use and high-risk sex and planning ways to begin the disassociation process. Recreational drugs, including inhaled nitrites are common, especially among young and gay populations.
  - Certain moods are associated with risk vulnerability. A fear of being alone, loneliness or a willingness to "do anything", anger, feelings of closeness, affection,

desperation or the desire not to be alone/without a partner may mitigate the need for condom use in an individual's mind .

- Alcohol and other drugs (AOD) affect condom use and safer sex practices, but mood and affective factors (esp. loneliness and the presence of affectionate feelings) are also important predictors of risk taking and safer sex abandonment.
- Clients may need assistance learning to how communicate thoughts and wishes about safer sex to a close relationship partners as well as casual partners
- Cognitive interventions to facilitate risk behavior change are useful as it is tough to encourage people to adopt behavior changes that may be less pleasurable, awkward. Often an individual's desire for behavior change is met with resistance from sexual or drug-sharing partner. Despite an individual's willingness and desire to adopt safer behaviors, these influences are often strongest.
- Cognitive modification exercises for strengthening of efficacy beliefs include:
  1. client-generated desired-outcome self-statement lists: I can; I will; I am able to; I feel good about myself when...
  2. reframing negative self perceptions
  3. actively practicing aloud self-statements
- Countering negative attributions about condom use, safer sex (or other risk behaviors including drug-related behaviors) begins by acknowledging the losses associated with behavior change. An individual who injects drugs may feel very strongly about those with whom s/he uses. The group may provide a sense of community and security. Keeping your works to yourself and refusing to share implies distrust, among other things, and can fracture the group. Loss of community whether real or imagined is a powerful motivator for maintaining status quo.
- Negative perceptions of safer sex or drug use must be reframed in terms of the benefit to the individual when and where appropriate.
- Intentions to reduce sexual or drug-related HIV risk are simply not enough. Maintenance of behavior change intention, as well as permission to fail along the way and try again is important. Clients may perceive their failure to immediately adopt safer behaviors as "failing the counselor". Clients must be reminded often that behavior change is difficult and takes time. Encourage clients to set small, achievable goals as steps along the way to safer behaviors.
- Individuals with unsupportive sexual and/or drug-using partners may require assertiveness training. Counselor and client must acknowledge and discuss potential for loss of relationship, support, and conflict. Assertiveness training involves instruction and modeling; brainstorming scenarios (people involved, locations); goal setting; role play/behavior rehearsal, repeated practice, reinforcement, and feedback.

- Applying assertiveness skills in real life requires that counselor and client prepare for obstacles and potential consequences. As clients begin to attempt behavior change prepare for, analyze, and reframe “failures” or shortfalls: “What was different about the connection you made with Joe that allowed you assert your intention to use...and actually use a condom?” rather than “Why didn’t you use a condom with Ken?”
- Shortfalls must lead to further strategizing as client and counselor learn from shortfalls as well as successes. Client must recognize that risk avoidance is an ongoing process; triggers and temptations will always be there. Practice is important for self-reinforcement in the face of negative reinforcement from partner(s).
- A long-term goal to be able to face possible losses, negative reinforcement, or deferral of pleasure and feel OK with it may take considerable time.

## **F. Special Considerations for Diverse Populations**

### **1. Harnessing the Power of Culture for Prevention Counseling**

- Knowledge of a particular culture, though useful, is less important than a willingness to learn about an individual’s interpretation of that culture.
- Houston-Hamilton and Day (1998) offer four steps to “working downhill” for HIV prevention:
  - a) find ways to regularly acknowledge to self and client that each individual has both cultural and personal histories and that these are integral to a sense of self and a shared worldview;
  - b) incorporate a full range of sensory information and expressive resources to uncover the style and medium that make prevention messages most accessible, understandable, and acceptable to client;
  - c) modify prevention messages, modes, and materials as new information emerges that may make culturally-biased concepts clearer to individuals with different backgrounds and worldviews;
  - d) account for cultural dynamics on both sides of the therapeutic arrangement.

### **2. Seriously and Persistently Mentally Ill (SPMI)**

- Those with severe and persistent mental illness and the developmentally disabled are at increased risk for HIV and other sexually transmitted diseases. Because of their disabilities, they may be more susceptible to trading sex for material goods like cigarettes. These populations are often overly compliant by nature or due to medications. Often the seriously or

chronically mentally ill or developmentally disabled are more susceptible to coercion and victimization.

- U.S. studies of the prevalence of HIV infection among people with severe mental illness range from 5.2% among psychiatrically hospitalized men in New York City (Cournos, 1991) to 19.4% among homeless mentally ill men in a shelter in New York City (Susser, Valencia & Torres, 1994).
- Seriously mentally ill adults, particularly those living in larger U.S. cities, have been identified as having high-rates of HIV infection and high-rates of HIV risk behaviors. When infected, adults with serious and persistent mental health problems will require considerable support and care.
- According to McKinnon (1996), many people with severe mental illness engage in sexual risk behaviors that increase their risk of exposure to HIV. One half to two thirds of patients have been sexually active in the past year, and one third to one half report multiple sex partners in the same time frame. Many patients engage in same sex intercourse intermittently. Condom use overall appears to be inadequate.
- Sharing of injection equipment has been reported by one in 20 psychiatric patients, indicating that a huge number of people with severe mental illness may be at risk for exposure to HIV through contaminated injection paraphernalia. Using alcohol and drugs in conjunction with sex and trading sex to get drugs or other goods appear to be common practices among many segments of the psychiatric population (McKinnon, 1996).
- Mental health care providers who work with people with severe mental illness are in the unique position of being gatekeepers to HIV testing, treatment, and prevention opportunities for these patients. The first step in this process is to obtain an adequate risk history.
- Few mental health providers are trained to take sexual or drug-use risk histories. As a result, questioning about sexual and drug use practices is often not sufficiently detailed to assess HIV risk (McKinnon, 1996).
- Sex education is often neglected among those with severe mental illness is sex education. Mental health staff often fear that chronically ill patients are unable to tolerate any form of sex education, fearing that they may regress or be unable to understand the material being presented.
- Drop-in groups focusing on sex education and HIV education have been successful with this population (Brady, 1996). Educational meetings are most effective when conducted in short, repetitive sessions that are lively and entertaining.

- "Sex, Games and Videotapes" is a program for homeless mentally ill men in a New York City shelter. It is built around activities central to shelter life: competitive games, storytelling, and watching videos (Susser, E., Valencia, E., & Torres, J, 1994). For many of these men, sex is conducted in public spaces, revolves around drug use, and must be conducted quickly. As an example of a program activity, a competition to see who can demonstrate condom use, teaches skills for using a condom quickly. This program reduced sexual risk behavior threefold.
- There have been few attempts to describe interventions with HIV-positive psychiatric patients (Empfield, 1996). Psychotic patients may incorporate the imagery of AIDS into delusional systems but not really understand the meaning of the diagnosis. In a general hospital setting, psychiatric patients may be terrified by unfamiliar surroundings and by the technology of acute medical care.
- Prevention education efforts with the SPMI population must take into account impairments and cognitive functioning and adapt accordingly. These impairments may include:
  - 1) limits in perceiving long-term consequences of high risk behaviors;
  - 2) impairment of cognitive, emotional, social and behavioral skills necessary for risk reduction;
  - 3) lack of material resources and supports which may inhibit behavioral change (purchasing condoms or acquiring clean works requires resources;
  - 4) those with a history of sexual abuse may find meaning in being a sex object – assertiveness about safer sex involves forfeiting their sense of self.

Educational interventions must be brief, clear, relevant, enjoyable, non-threatening and promote participation in additional counseling that promotes drug use prevention and treatment. Educational interventions must also be ongoing, just like risk assessment.

**The following information was taken from UCSF Center for AIDS Prevention Studies Fact Sheet Series. The information was obtained on February 24, 2002 from: <http://www.caps.ucsf.edu/Fsindex.html>**

### **3. Women**

- Heterosexual contact is the leading risk exposure category for all women (38%), and 29% of those are due to sex with an injection drug user (IDU). Injection drug use accounts for 32% of all cases. The majority of women who have sex with women (WSW) acquired HIV via drug use or sex with a man, although a few women have been identified infected via same-sex contact.

- Women are one of the fastest growing populations being infected with HIV, and the number of AIDS cases among women increases steadily each year. African American and Hispanic women have been disproportionately affected by AIDS. AIDS rates for African American and Hispanic women are 17 and 6 times higher than for white women.
- Male-to-female transmission is estimated to be eight times more likely than female-to-male. Reasons for this are twofold: there are more men than women in the US infected with HIV, which increases the likelihood that women would have an infected sex partner; and HIV is more easily transmitted from men to women due to the greater exposed surface area in the female genital tract.
- Sexually transmitted diseases (STDs) other than HIV can increase the risk of new HIV infections at least two to five times. Genital ulcers and immune response associated with STDs make it easier for HIV to enter the body. There are an estimated 12 million new cases of STDs every year, and populations at highest risk for HIV infection also have disproportionately high rates of other STDs. [4](#) Treatment of STDs can be an effective HIV prevention strategy.
- Injection and non-injection drug use puts women at increased risk for HIV infection and is strongly linked to unsafe sex. Women who smoke crack cocaine, particularly women who have sex in exchange for money or drugs, are at high risk for HIV infection via sexual transmission.
- Sexual abuse and coercion places many women at risk. Physical and sexual abuse are common throughout life among women at high risk for HIV infection. Childhood sexual abuse is also common. Women who have been abused are more likely to use crack cocaine and have multiple sex partners.
- Women do not wear the condom. For women to protect themselves from HIV infection, they must not only rely on their own skills, attitudes, and behaviors regarding condom use, but also on their ability to convince their partner to use a condom. Gender, culture and power may be barriers to maintaining safer sex practices with a primary partner. HIV prevention strategies must target both women and men in heterosexual couples and address gender norms in sexual decision-making.
- Women are disproportionately represented among the poor. Because of this, women are less likely to have health insurance and access to health care services. Many minority women living in poverty are also disproportionately affected by HIV. For these women, the struggle for daily survival may take precedence over concerns about HIV infection, whose impact may not be seen for several years.
- Like many people in committed relationships, women may find intimacy in their relationship to be more important than protection against HIV. Unsafe sex may be linked to emotional and social (not necessarily financial) dependence on men.

The ideal of monogamy, including assuming their partner's fidelity, may increase AIDS risk denial.

- Women are more likely to protect themselves from pregnancy using methods that do not depend on partner cooperation, such as oral contraceptives. However, oral contraceptives like the pill do not protect against STDs and HIV. Female-controlled methods to prevent HIV transmission are needed. Traditionally, abstinence, condoms and dental dams have been the main methods of protection. In 1993, Reality®, a female condom, was introduced on the market but to date, results have been mixed as to its efficacy, affordability and interest in use.
- Vaginal microbicides that would prevent STD transmission but allow for pregnancy have been developed and piloted in some prevention programs. Further efforts need to include large-scale efficacy trials and to increase scientific interest and support from pharmaceutical companies to develop microbicides that prevent HIV infection.
- Comprehensive, women-specific prevention interventions need should address sexuality, family, culture, empowerment, self-esteem and negotiating skills.

#### **4. Men Who Have Sex With Men**

- Men who have sex with men (MSM) are not a single homogenous group, they have many different identities and associated risks for HIV and other infectious diseases. MSM refers to any man who has sex with a man, whether he identifies as gay, bisexual or heterosexual.
- Despite success in changing sexual behaviors, MSM continue to be disproportionately affected by HIV/AIDS. MSM account for the largest percentage of persons with AIDS in the US (53%), even as the percentage of AIDS cases among IDUs (25%) and heterosexuals (10%) has increased.
- Risk for HIV among MSM is embedded in many other core issues such as dating and intimacy, sexual desire and love, as well as alcohol and recreational drug use, homophobia, abuse and coercion, racism and self-esteem. HIV prevention intervention strategies must be informed by of all these elements.
- There is not enough sexuality education for young people in the US, and almost no same-gender sexuality education. Like many teenagers, young MSM may only learn about sex through distorted media or pornographic images. In general, men in today's society are pressured to prove their manhood through sexual activity and aggressiveness, while women receive messages on moderation and caretaking. Given this, many MSM face additional challenges learning about dating, intimacy and forming relationships, or about desire, sexual functioning and arousal. Discomfort with one's sexuality and identity can lead to sexual risk taking.

- HIV is not the only sexual health concern for MSM. Other sexually transmitted diseases (STDs) such as herpes and genital warts can negatively affect health and sexuality. Several states have seen an increase in drug-resistant gonorrhea among MSM, making it more difficult to treat.
- Homophobia and racism are prevalent in the US. Internal and external homophobia and racism can lead to low self-esteem, which can lead to increased risk behavior such as sexual aggression, difficulty negotiating safer sex, and drug or alcohol abuse.
- MSM of color are disproportionately affected by many social and health-related ills such as HIV. African American and Latino MSM are more likely than their White counterparts to engage in high-risk activities and to be HIV-infected. Social and cultural factors may limit the ability of MSM of color to protect themselves from HIV. A study of Latino gay men in urban centers found that men who reported high-risk behavior also reported significantly higher rates of financial hardship, experiences of racism and homophobia, incidence of domestic violence and a history of coercive childhood sexual abuse.
- The prevalence of drug use is higher among MSM than among heterosexuals, although decreases recently have been noted in all alcohol and drug use categories except amphetamines. In many areas of the US, gay bars--often sex-charged environments where alcohol and drugs are prevalent--are the only venues for MSM to meet and socialize with each other. Drug use may vary greatly by region and subculture.
- Substance use puts MSM at risk for HIV for several reasons: 1) MSM-IDUs are at risk if they share infected injection equipment; 2) substance use is associated with high risk sexual behavior; 3) background HIV prevalence rates are higher for MSM-IDUs and MSM who abuse drugs but do not inject, increasing the likelihood of transmission.
- Substance use can serve as a trigger or an excuse for unprotected sex. Some MSM have trouble having sex without getting high first; others prefer having sex while high, believing recreational drugs increase their libido. For some MSM, drug use provides a sense of community and bonding at gay clubs and circuit parties. A survey of MSM who attend circuit parties found that serodiscordant unprotected anal sex was more likely to occur among men who used amphetamines (speed), Viagra and amyl nitrites (poppers).
- For many MSM-IDUs, drug use, rather than sexual orientation, forms their personal identity. Many MSM-IDUs identify as heterosexual. Too often MSM-IDUs are missed in prevention programs that target MSM but leave out IDUs, or programs that target IDUs but don't address sexual orientation. MSM-IDUs have

high rates of HIV infection, high frequency of unprotected sex and high rates of poverty, addiction and its related social and physical ills.

- The perception of sexual risk for HIV varies among MSM and may change from one sexual situation to another. Throughout the HIV epidemic, MSM have engaged in sophisticated decision-making about what they consider to be risky. Some men decide for themselves it is OK to not use a condom if they are the top (insertive partner), if they are having oral sex or if their or their partner's viral load is undetectable. MSM may make these decisions because the scientific evidence of HIV risk is cloudy, or simply because they are comfortable with some level of risk. HIV prevention programs should help MSM to make realistic and healthy choices based on factual information.
- MSM have engaged in a hierarchy of strategies for maintaining safer sex that are fluid and context-dependent. Most MSM are able to manage sexual risk with effective strategies such as monogamy with concordant partners, consistent condom use with repeated testing, condom use outside of relationship or abstinence. Other MSM use strategies that are not known to be effective (see above paragraph). A small minority of MSM choose to engage in known risk activities such as unprotected anal intercourse without knowledge of partner serostatus.
- Unprotected anal intercourse between an HIV+ and an HIV- man remains the greatest risk for HIV transmission among MSM. This has proven to be the biggest challenge for HIV prevention. The intimacy of skin-to-skin contact during intercourse is a powerful and important draw. Many MSM feel their sexual identity, as well as the hard-won goals of gay sexual liberation, are based on having sex--including anal intercourse--in a free and unconstricted manner.
- A majority of MSM consistently manage sexual risk, yet there is little understanding or research of men who are largely safe, and how their values of nurturance and caretaking, ethics, hopes for collective survival, or relations with friends and community help support them. Only recently have HIV+ MSM been targeted with messages and programs featuring "prevention altruism" that make use of MSM's strengths. HIV prevention efforts need broader, more emotionally-resonant concepts that build on what is good in MSM's lives.
- Various studies found that 26% to 50% of young men who have sex with men (MSM) report recent unprotected anal intercourse, and much of this unprotected sex occurred with a partner of unknown or different HIV status. Rates of sexual risk-taking among young MSM are also increasing. A large number of urban young MSM are already infected with HIV. Young MSM of color, especially African American men, are disproportionately impacted.
- For some young MSM, individual factors can lead to unsafe sex, such as: feeling invulnerable to HIV; having high levels of optimism about HIV antiviral

medications; perceiving that unsafe sex is more pleasurable than safer sex; being depressed or sad; having conflicting allegiance with either their racial or sexual identity; and using alcohol or other drugs (e.g. speed/crystal, poppers).

- Protecting one's health is not necessarily a young MSM's top concern. Interpersonal motivations may be more pressing—wanting to fit in, to find companionship and intimacy. However, interpersonal issues can also contribute to unsafe sex, such as finding it difficult to communicate or negotiate safer sex with a sexual partner. Young MSM who are in a relationship are more likely to have unsafe sex than single young MSM.
- Societal factors may also influence the risk-taking of young MSM. Many young MSM find themselves isolated or rejected by traditional sources of support like family, school, or religious community. Homophobia, racism and poverty also place young MSM at risk. Some young MSM, especially those living on the street, are struggling with daily needs like avoiding violence, finding a place to live, or obtaining food. These pressing needs may overshadow the concern for safer sex and injection practices.
- Young MSM have few public places to meet each other. Gay bars and public cruising areas are some of the more visible and accessible places, offering anonymity for young men exploring their sexual identity. These venues are also associated with high levels of risk-taking. They are highly sex-charged and the bar scene's emphasis on alcohol sets the stage for engaging in sex while intoxicated. This is consistently found to contribute to unsafe sex.
- Little is known about the Internet's role in the lives of young MSM, including how young MSM use the Internet to obtain social support, make new friends, find romantic partners, and/or cruise for sex.
- The Mpowerment Project is a multilevel, sex- and gay-positive, peer-based intervention in which young men take charge. Because HIV may not be particularly compelling for many young MSM, the project focuses on young MSM's social concerns. The young men plan and coordinate activities to create a stronger and healthier community for themselves in which safer sex becomes the mutually accepted norm. Participants in the Project have reduced rates of unprotected anal intercourse with casual partners and boyfriends. Mpowerment, proven effective as an HIV prevention intervention, provides CBOs with training and a manual for replication.
- The American Psychological Association has implemented the Healthy Schools Project for Lesbian and Gay Students. The Project trains school psychologists, counselors, nurses and social workers to work effectively with gay, lesbian and bisexual students. The goal is to make schools a friendlier environment for these students and make HIV prevention education more relevant to them.

- Effective programs for young MSM must address the context of their lives and the individual, interpersonal and societal factors that put them at risk. Comprehensive health and sexuality education must target both those who identify as gay or bisexual and those who do not. Unfortunately, many school-based programs focus on reproduction or abstinence until marriage, further marginalizing young MSM.

## 5. Adolescents

- HIV infection is increasing most rapidly among young people. Half of all new infections in the US occur in people younger than 25.
- Unprotected sexual intercourse puts young people at risk not only for HIV, but for other sexually transmitted diseases (STDs) and unintended pregnancy. Currently, adolescents are experiencing skyrocketing rates of STDs. Every year three million teens, or almost a quarter of all sexually experienced teens, will contract an STD. Chlamydia and gonorrhea are more common among teens than among older adults.
- Some sexually-active young African-American and Latina women are at especially high risk for HIV infection, especially those from poorer neighborhoods.
- Adolescence is a developmental period marked by discovery and experimentation that comes with a myriad of physical and emotional changes. Sexual behavior and/or drug use are often a part of this exploration. During this time of growth and change, young people get mixed messages. Teens are urged to remain abstinent while surrounded by images on television, movies and magazines of glamorous people having sex, smoking and drinking. Double standards exist for girls—who are expected to remain virgins—and boys—who are pressured to prove their manhood through sexual activity and aggressiveness. And in the name of culture, religion or morality, young people are often denied access to information about their bodies and health risks that can help keep them safe.
- A recent national survey of teens in school showed that from 1991 to 1997, the prevalence of sexually activity decreased 15% for male students, 13% for White students and 11% for African-American students. However, sexual experience among female students and Latino students did not decrease. Condom use increased 23% among sexually active students. However, only about half of sexually active students (57%) used condoms during their last sexual intercourse.
- Not all adolescents are equally at risk for HIV infection. Teens are not a homogenous group, and various subgroups of teens participate in higher rates of unprotected sexual activity and substance use, making them especially vulnerable to HIV and other STDs. These include teens who are gay/exploring same-sex

relationships, drug users, juvenile offenders, school dropouts, runaways, homeless or migrant youth. These youth are often hard to reach for prevention and education efforts since they may not attend school on a regular basis, and have limited access to health care and service-delivery systems.

- Schools are an important venue for educating teenagers on many kinds of health risks, including HIV, STD and unintended pregnancy. Across the US and around the world, studies have shown that sexuality education for children and young people does not encourage increased sexual activity and does help young people remain abstinent longer. Effective educational programs have focused curricula, have clear messages about risks of unprotected sex and how to avoid risks, teach and practice communication skills, address social and media influences, and encourage openness in discussing sexuality. In addition, HIV prevention programs that are carefully targeted to adolescents can be highly cost effective.
- Young people need to get prevention messages in lots of different ways and in lots of different settings. Schools alone can't do the job. In the US, many schools are being hampered by laws and funding that prohibit comprehensive sexuality education. Although abstinence programs are effective at delaying the onset of sexual activity, they typically do not decrease rates of sexual risk activity among adolescents the way that safer sex interventions do.
- Youth who are not in school have higher frequencies of behaviors that put them at risk for HIV/STDs, and are less accessible by prevention efforts. Programs targeting hard-to-reach adolescents at high risk for HIV are necessary in many different venues outside of schools. Programs based in venues such as residential child care facilities, alternative schools and youth detention centers are needed.
- Families play an important role in helping teenagers avoid risk behaviors. Frank discussions between parents and adolescent children about condoms can lead teens to adopt behaviors that will prevent them from getting HIV and other STDs. Research has shown that when mothers talked about and answered questions about condom use with their adolescents prior to sexual debut, the adolescents reported greater condom use at first intercourse and most recent intercourse, as well as greater lifetime condom use.
- HIV prevention programs for adolescents must consider the developmental needs and abilities of this age group. Programs should focus on contextual factors that lead young people to engage in higher rates of sexual activity and lower rates of condom use, such as low self-esteem, depression, substance use, gang activity, stress of living in turbulent urban environments, or boredom/restlessness related to unemployment.
- Any program for adolescents should be interesting, fun and interactive, and involve youth in the planning and implementation. This is especially true for out-of-the-mainstream youth and youth from diverse cultures. Programs for hard-to-

reach youth who are most at risk for HIV infection should be implemented in venues outside of schools, such as runaway/homeless youth shelters, shopping malls, detention facilities and recreation/community centers. Adolescents not only need correct information and practice in self-protective skills, but also easy access to condoms in order to keep themselves risk-free.

## **6. People with Substance Abuse Disorders**

- Although sharing used needles is a high risk for HIV transmission, substance abuse and HIV goes beyond the issue of needles. People who abuse alcohol, speed, crack cocaine, poppers or other non-injected drugs are more likely than non-substance users to be HIV positive and to become seropositive. People with a history of non-injection substance abuse are also more likely to engage in high-risk sexual activities.
- Many injection drug users (IDUs) use other non-injected drugs primarily. When an IDU is HIV-positive, needle sharing may be the primary risk factor, but other non-injected drug use may have a great effect on risk behaviors. Crack cocaine use has been shown to be strongly associated with the transmission of HIV.
- There are probably a lot of reasons why substance abusers are at higher risk for HIV. The reasons most likely vary by drug and social context—crack abusers may have different risks than alcohol abusers, for example. For non-injecting substance abusers, HIV infection is not caused by drug use but by unsafe sexual behavior. Recently, observers have found an association between HIV infection, heavy crack use and unprotected fellatio among prostitutes. This may be due to poor oral hygiene and oral damage from crack pipes, high frequency of fellatio, and inconsistent condom use.
- It is often believed that having unprotected sex while under the influence of drugs or alcohol accounts for substance abusers' HIV risk. However, sexual networks and sexual mixing might better explain risk. Many people who are in treatment or using drugs or alcohol are primarily selecting sexual partners from similar networks. They might include people who have used needles, have traded sex for money or drugs, have been victims of trauma, or have been incarcerated. All of these populations may have higher rates of HIV infection, making transmission more likely.
- In American social culture, drug use and sex have become hopelessly linked. For many people, straight or gay, bars are the main method for meeting people. Ads and commercials portray alcohol as seductive. Honest conversations about sexuality, including homosexuality, are lacking in schools, homes and the media. This can lead to greater sexual inhibitions that might be eased through drinking or using drugs.

- The goals of HIV prevention and substance treatment are often conflicting. Many treatment programs focus on stopping substance abuse altogether, and 12 Step programs often advocate sexual abstinence while in recovery. On the other hand, many prevention programs focus on safer sex and harm reduction, acknowledging that relapse could occur. These conflicting cultures may make it difficult to integrate HIV prevention interventions into substance abuse programs.
- Gender specific programs are needed that address women's substance use needs. Women have a higher physical vulnerability to alcohol and higher levels of traumatic events associated with substance use than men. Gay and lesbian-specific treatment is also needed. In addition, specific treatment is needed for drugs such as crack cocaine and new drugs as they arrive on the scene.
- Prevention programs for substance abusers need to be integrated into existing services. The HIV epidemic has closely paralleled the epidemics of substance use and incarceration. Substance treatment agencies and prisons and jails need training and authority to incorporate HIV prevention education into their programs. Funders should increase funds and require substance abuse programs to expand treatment to include HIV education.
- Prevention programs don't need to depend on causality-that drug abuse causes risk behaviors. A comprehensive HIV prevention strategy uses many elements to protect as many people at risk for HIV as possible. Because of high rates of HIV and risk behaviors among substance abusers, programs are urgently needed in this population.

## **7. People Living with HIV**

- Every new HIV infection involves an HIV+ person. The Centers for Disease Control and Prevention (CDC) estimate that there are 600,000-900,000 people living with HIV in the US. Yet very few prevention interventions have been directed to HIV+ women and men. In the past, prevention efforts had not been directed toward HIV+ persons for fear of "pointing the finger" or blaming HIV+ persons for the epidemic. Few efforts have addressed altruism-the responsibility of HIV+ persons to not transmit the virus to others and the opportunity for HIV+ persons to actively contribute to ending the epidemic. Prevention efforts need to address both issues: taking responsibility for one's own health and the health of one's partners, children, other family members and community.
- Couples where one partner is HIV+ and the other is HIV- often wrestle with issues such as how to maintain sexual satisfaction and trust. For some couples, the risk of losing commitment and intimacy in a relationship is more threatening than the risk of transmitting HIV.

- A precondition of reducing your risk is knowing you're HIV+ and getting help. There are an estimated 200,000-250,000 Americans unaware that they are infected with HIV. It is imperative to help HIV+ persons get tested before they unknowingly infect others. Finding out HIV status can also allow early access to life-prolonging treatment and services.
- Incorrect assumptions and denial of responsibility between partners can lead to risky behavior. Many HIV- persons are unaware of their partners' status or risk behaviors and may make assumptions that they are not at risk for HIV because they are married, in a relationship, their partner looks healthy, or simply because their partner did not ask to use a condom. HIV+ persons may make the same assumptions that their partner is also HIV+ because the partner didn't ask about serostatus or suggest using condoms. Likewise, there may be a difference of opinion on who's responsible for keeping safe, the HIV+ person, the HIV- person, or both.
- Disclosure can be a way of beginning a discussion about safer sex or drug use. Yet disclosure of one's serostatus is difficult for many HIV+ persons, especially women, who may fear stigma, rejection or violence from their partners. Practicing safer sex with all partners and always using clean needles is one way of preventing transmission without having to disclose status. However, in many communities where this is not the norm, simply using a condom can disclose HIV+ status, even without saying it.
- HIV is a disease that is often mistakenly associated with careless sexual behavior. However, many HIV+ persons become infected within a loving relationship. Research has shown that people are often more comfortable disclosing and practicing safer sex with partners outside of their main relationship.
- Many HIV+ persons face complex issues that can affect their ability to engage in safer sex or drug-using behaviors. Depression, substance use and abuse, history of violence and abuse and sexual compulsivity are all issues that may need to be addressed. Many of these issues cannot be addressed in a prevention program and may require referral to longer-term counseling or other social services.
- Legal, political and environmental factors can be barriers to HIV prevention among HIV+ persons. For example, the lack of access to sterile syringes and needle exchange programs, as well as laws prohibiting possession of syringes, hamper the ability of IDUs to engage in safe behaviors. Fear of arrest for carrying drug paraphernalia has been associated with sharing syringes and other injection supplies.
- Couples counseling for serodiscordant couples (where one partner is HIV+, the other HIV-) has proven highly effective at reducing new HIV infections.

- HIV+ persons are a unique population in that they require both care and prevention, which requires better coordination between these two worlds. Health care providers need to be trained to deliver HIV prevention, as seroconversion can provide a strong motivation to change risky behaviors. HIV prevention programs need to address HIV+ persons and include STD, hepatitis and TB screening and treatment as well as referrals to drug treatment, family planning and mental health services. HIV+ persons' partners, children and families must be included with support and education.
- There is currently an unacceptably high number of persons who do not know they are HIV+ unknowingly infecting others. The social network approach (encouraging HIV+ persons to provide information and outreach to peers who might be positive) is one way to create a more efficient and targeted approach to HIV testing and counseling for those at greatest risk.
- There are many things we don't know about the relationship between new anti-HIV drugs and HIV transmission. How much do they affect a person's infectiousness and how does that affect transmission? Is re-infection or super-infection a valid concern? These questions need to be researched, and the answers disseminated widely so that HIV+ persons can make informed decisions about preventing transmission of the virus.

## **8. African-Americans**

- While African-Americans comprise 13% of the US population, they are disproportionately affected by HIV, accounting for 37% of total AIDS cases in the US. In 1998, almost two-thirds (62%) of AIDS cases among all women were among African-Americans. Likewise, African-Americans accounted for over half (53%) of all AIDS cases among injection drug users (IDUs).
- HIV transmission in African-American communities is primarily viewed as a problem among heterosexual IDUs and their sexual partners. Among African-American men, however, the cumulative proportion of AIDS cases attributed to homosexual/bisexual activity (38%) is greater than that attributed to injection drug use (35%).
- Injection drug use has played a major role in HIV infection among African-Americans. Although the majority of IDUs in the US are White, HIV infection is higher for Black IDUs than White IDUs. Unemployment and poverty are significant co-factors which may have led to high rates of addiction and high rates of risk behaviors such as sharing needles. In fact, the HIV and drug use epidemic among African-Americans is focused in a small number of inner-city urban neighborhoods of color, an indication that the epidemic may have more to do with geography and poverty than race.

- While attitudes in the African-American community are slowly changing, homophobia and negative attitudes toward gay men still exist. For young African-American men who have sex with men (MSM), these negative attitudes may cause low self-esteem, lack of community and psychological distress, all of which contribute to risk-taking behaviors.
- Many African-American women, especially adolescent women, are at high risk for heterosexually acquired HIV. African-American women may not want to or may not be able to negotiate condom use because they may think it would interfere with physical and emotional intimacy, imply infidelity by themselves or their partner or result in physical abuse. Some women may also be in denial or be unaware of their own risk. It is thought that a majority of these women are infected through heterosexual sex with IDUs and/or gay or bisexual partners.
- Communities of color in this country, including African-Americans, have experienced persistent inequalities in social benefits, health care, education and job opportunities. Economic disparities continue to exacerbate the health status of African-Americans and other communities of color in the US. As a result, African-Americans report high rates of diseases and mortality. In addition, many African-Americans hold a distrust of government programs and health institutions. Some African-Americans believe that the effects of AIDS on the community are the results of deliberate efforts and omission of responsibility by the US government. Effective community-based prevention programs must address these concerns.
- AIDS has been seen as a primarily gay issue in the African-American community. In addition, homophobia exists in the African-American family, church and community on both a personal and institutional level. Many homosexually active African-American men may have been reluctant to respond to the AIDS epidemic for fear of alienation.

## 9. **Latinos**

- HIV continues to be a major health threat for Latinos in the US, many of whom are disadvantaged due to racism, economic disparities and language barriers. Latinos in the US (including residents of Puerto Rico) are disproportionately affected by HIV, accounting for 18% of total AIDS cases while comprising 14% of the US population.
- Latinos in the US include a diverse mixture of racial and ethnic groups and cultures. Latinos share common factors with other ethnic groups that increase vulnerability to HIV, such as discrimination, poverty, lack of information, substance use and negative attitudes toward condoms.
- In 2000, 47% of AIDS cases among Latino men were attributed to sex with men, 33% to injection drug use, and 14% to sex with women. In the same year, 65% of

AIDS cases among Latina women were attributed to sex with men, and 32% to injection drug use.<sup>1</sup> Thus, among both male and female Latinos, as with most other groups, unprotected sex with an HIV+ man is the most common route for becoming infected with HIV, followed by the sharing of an unclean syringe/needle with an HIV+ person.

- HIV risk dynamics among immigrant and migrant Latinos can be more complex than among US born Latinos, as they are dealing with conflicting cultural norms while trying to adjust to life in a new country. For some, this results in higher risk; for others, lower risk. Levels of acculturation, poverty, employment, migrant labor conditions and connection to traditional Latino values can influence HIV risk.
- The social and political climate in the US today poses serious problems for effective HIV prevention in Latino communities. Racial and ethnic discrimination, anti-immigrant attitudes, policies on mandatory testing for immigrants, and fear of deportation for undocumented immigrants can prevent many Latinos from receiving and accessing adequate resources and services for HIV prevention, including HIV counseling and testing.
- Traditionally in Latino cultures, sex and sexuality are not discussed. For some Latina women, this sexual silence dictates that they should not know about or talk to men about sex because it suggests promiscuity. Therefore, their ability, comfort and success in insisting on condom use with male partners may be limited.
- Sexual silence can prevent MSM from discussing their sexual preference, instilling low self-esteem and personal shame.<sup>8</sup> In addition, the lack of parental discussions and education regarding sex and condoms seems to contribute to the disproportionate number of unintended pregnancies, sexually transmitted diseases and HIV cases among Latino youth.
- Injection drug use is one of the main risk factors for HIV transmission, yet many IDUs do not have access to clean needles and drug treatment. Access is even more difficult for monolingual, immigrant Latino IDUs who may not use needle exchange sites or other public services due to lack of knowledge and fear of being recognized or deported.
- Familismo is a traditional Latino commitment to family and a central support to family members. Familismo can be a powerful incentive in helping heterosexual Latino men reduce unprotected sex with casual partners outside of primary partnerships. However, for many Latino MSM, familismo and homophobia can create conflict because families may perceive homosexuality as wrong. MSM are forced to separate their sexual identity from their family life, leading to low self-esteem and personal shame.

- Machismo may lead men to view sex as a way to prove masculinity. This can mean that frequency and type of sex are most often determined by men, leaving women in fear of violence or abandonment if they resist male sexual advances.<sup>7</sup> Machismo may also be used as an excuse for unprotected sex.

## **10. Asian and Pacific Islanders**

- Asians and Pacific Islanders (A&PIs) are as susceptible to HIV infection as are other racial or ethnic groups. A&PIs are the fastest growing population in the US. While the number of reported AIDS cases among A&PIs remains small -- about 1% of total cases reported in the US -- underreporting and a lack of detailed HIV surveillance about A&PIs may mask the true nature of the epidemic among A&PIs.
- A&PIs are extremely diverse, comprising over 40 different nationalities that speak over 100 languages and dialects. A&PIs include Chinese, Filipinos, Koreans, Hawaiians, Indians, Japanese, Samoan, Vietnamese, among others.
- The proportion of men who have sex with men (MSM) to injection drug users (IDUs) with AIDS in A&PI men (75% / 5%) is very similar to White men (76% / 9%). Among women, 46% of A&PI women report sex with an HIV+ or high risk partner as a risk indicator, compared to 39% for White, 36% for Black, and 46% for Hispanic women.
- A&PIs are often stereotyped as the "model minority" in terms of health, education and economics. However, A&PIs are often underserved in health care. Because of the rapidly increasing size of and the differences within the A&PI communities, there is still little data on health status and behavioral risks.
- Many gay A&PI men do not perceive themselves to be at risk for HIV.
- Immigrant A&PI women who work in massage parlors often engage in activities that put them at risk for HIV infection. However, for many of the women, immediate survival needs take priority over HIV prevention, or even health care. Problems with the police, sex work, immigration, family planning and language barriers all need to be addressed as risk factors for this population.
- There are cultural, linguistic, economic and legal barriers to HIV prevention among A&PIs. For example, cultural avoidance of discussing issues of sexual behavior, illness and death can be barriers to HIV prevention. In addition, although A&PI MSM are at significant risk for HIV, the lack of peer and community support for sexual and racial diversity often are barriers to self-esteem and positive self-identity. Foreign-born A&PIs may have low or no English skills, and very few programs provide interventions in A&PI languages.

- The exclusion of most HIV+ individuals under US immigration law prevents many A&PIs from obtaining permanent immigration status and scares immigrants away from government services such as HIV testing. The disqualification of many immigrants from Medicaid, SSI and other public benefits under the welfare and immigration laws also deters A&PIs from preventive health care, including HIV prevention.
- Effective HIV prevention and education programs for A&PIs can use many culturally appropriate strategies. For example, given strong group and collective norms, it is important to implement interventions that incorporate the entire family and community rather than focus solely on individual behavior change. For more marginalized A&PI populations such as A&PI gay men, peer-based programs are important. Interventions that include the development of nonverbal and other more indirect communication skills also are more culturally appropriate. Outreach activities can be conducted at cultural events, bars, churches and temples, beauty parlors and massage parlors.

## **11. American Indian and Alaskan Natives**

- American Indians and Alaskan Natives (AI/AN) represent a unique population within the US, not only because of their oppression suffered in the development of this country but also because of their ongoing struggle to gain recognition in the HIV/AIDS epidemic.
- The long history of oppression of AI/AN in the US has had a devastating effect on the health and well-being of Native Peoples. This history, including colonization, outlawing Native languages and spiritual practices, and centuries of forced relocation, has created justified mistrust of US government programs and health institutions. This legacy continues to shape the experience of AI/AN as they are disproportionately impacted by poverty, ill health, family violence and drug and alcohol abuse. All of these factors are associated with HIV risk.
- Through the end of 2000, AI/ANs comprised 2,337 AIDS cases and 871 HIV cases. AI/AN constitute approximately 1% of the total US population, and just under 1% of reported AIDS and HIV cases. Although these numbers appear small relative to other populations, the impact is considerable. Underreporting and the lack of detailed HIV surveillance of AI/AN may result in significant undercounting of HIV infections. Further, AI/AN are often misclassified in terms of race/ethnicity on data collection forms, due to assumptions about names, skin color, residence and even intentionally misleading self reporting.
- HIV research among AI/AN has a short history starting in the early 1990s, with few studies on risk behavior. According to the CDC, for AI/AN men, the leading exposure category for HIV is men who have sex with men (MSM) at 51%, MSM and injection drug use (IDU) 13% and heterosexual IDU 12%. Among women, the primary exposure risk is heterosexual contacts at 41%, followed by IDU at

32%. However, this data does not include data from California, which has the largest Native population of all 50 states.

- AI/AN populations are disproportionately impacted by social, behavioral and economic factors that are associated with HIV risk. Native Americans also experience high rates of drug and alcohol use, STDs and violence. Alcohol use in the AI/AN population has resulted in the highest alcohol-related mortality rates for all US populations.
- One study of AN drug users found that alcohol use was the factor that put them at greatest risk for HIV. Many individuals reported blacking out while drinking, and later learned that they had unprotected sex with complete strangers or persons they would not otherwise accept as partners.
- This same study showed that drug using Alaskan Native women are at high risk for gonorrhea infection and HIV infection. AN women were more likely to inject drugs than any other ethnic group among women, and they were more likely to have white male injectors as sex partners. Sex pairs composed of AN women and white men were the least likely of any ethnic pair combinations to use condoms.
- HIV is often rendered invisible within AI/AN communities that are facing many other severe and more visible health and social problems such as alcoholism, diabetes and unemployment. As a result, there is often great denial about HIV as a problem in AI/AN communities. Like in many other tight-knit communities, confidentiality can be difficult to maintain in AI/AN communities, especially in rural areas. This can be a barrier to important prevention activities such as testing for HIV, discussing sexual practices with health care providers, obtaining drug treatment, or buying condoms in local stores.
- Prevention services for AI/AN MSM are severely underfunded, and those that exist may not reach MSM at risk. AI/AN MSM have a wide range of identities, from “gay” to “two-spirit” and may not access services addressed to urban gay men. AI/AN MSM may feel isolated and not seek out needed services because of stigma and denial about homosexuality in some AI/AN communities.
- The AI/AN population is highly diverse, with over 550 federally-recognized tribes. AI/AN consider themselves to belong to Indian nations that are sovereign, with complex relationships between tribal, state and federal governments. Many state and local governments erroneously assume that the IHS is solely responsible for the health-related needs of AI/AN. Less than 1% of IHS budget goes to urban populations, yet more than half of all AI/AN in the US live in urban areas. As a result, AI/AN tribes and organizations are often denied funding opportunities available to other citizens.

## **12. Heterosexual Men**

- In the US, new AIDS cases are increasing among people who were infected through injecting drug use (IDU) and heterosexual sexual contact. The rise in IDU infections in heterosexual men has led to the rise in HIV infections in women, as more women become infected from men who are IDUs. For this reason, sexual behavior change among heterosexual men will be key to controlling the HIV epidemic for heterosexual men, women and children.
- Prevention programs in the US have addressed the drug-using risks of heterosexual men. However, few have addressed their sexual behavior. Women have been the primary focus of sexual behavior change among heterosexuals. If heterosexually-identified men are reached, often it is by default because the intervention was targeting another audience.
- Injection drug use poses the highest risk to heterosexual men. Use of other non-injected substances such as methamphetamines, crack cocaine and alcohol can increase sexual risk taking, which increases risk of HIV infection.
- Men can get infected from having unprotected intercourse with an HIV+ woman, although the risk is much lower than the risk from sharing infected injection equipment or having sex with an HIV+ man. The risk increases when men or their female partners have STD infections. The greatest sexual risk behavior for heterosexual men is unprotected anal sex with an HIV+ man. Because of homophobia and fear of rejection, men may be unlikely to report having sex with men, identifying sex with women as their only risk factor.
- Men in certain settings are at greater risk. In the US, 90% of prisoners are men. Among the incarcerated, rates of HIV are 8-10 times higher than in the general population. Injection drug use, other illicit drug use, tattooing and unprotected anal sex with other men are all risk behaviors for HIV in prison or jail. Clean needles are not available in jail and prisons in the US and condoms are only available in a few.
- Men in this society are not trained or coached to develop a health plan for themselves. Between childhood vaccinations and post-middle age checks for prostate cancer, many heterosexual men typically do not visit a doctor's office. Heterosexual men and African Americans in particular, are least likely to be tested for HIV, enter into treatment, and keep medical appointments.
- Many heterosexual men do not have enough knowledge about HIV and other STDs, and do not believe it concerns them. HIV is still seen as a "gay white man's" problem because of the lack of materials targeted to straight men and lack of heterosexual peer educators. Men may be reluctant to use HIV/AIDS services that are run by or targeted to gay men. Men wear the (male) condom and ultimately have the power to use them or not. Men may be concerned about pregnancy, STD and HIV prevention, but may have difficulty bringing up the subject of condoms with their partners. Some men wait for the female partner to

begin that discussion—if she doesn't, they often do not mention condoms themselves.

- Young men of color often see themselves as an "endangered species." For many inner-city youth, the dangers and concerns of daily survival far outweigh any future concerns such as HIV. The realities of poverty, violence and addiction enforce Black men's belief that they will not live past the age of 25. For many inner-city youth, the likelihood of being shot or sent to prison is their greatest concern.

### **13. Male-to-Female Transgender Persons**

- Transgender is an umbrella term used to describe persons who cannot or choose not to conform to societal gender norms associated with their physical sex. Such individuals have gender identities, expressions or behaviors not traditionally associated with their birth sex. Transgender persons live their lives to varying degrees as their chosen gender and may self-identify as female, male, trans-women or -men, non-operative transsexuals, pre-operative transsexuals, transsexuals who have completed surgical sex reassignment, transvestites or cross-dressers, among others. These terms vary regionally and over time.
- Male-to-female transgender individuals (MTFs) have higher rates of HIV-related risks and HIV than female-to-male transgender persons. MTFs have high rates of HIV infection, with overall rates of 35% in San Francisco in 1997 and 22% in Los Angeles in 1998. Infections among MTFs continue to rise, with an estimated rate of new infections of 3-8% per year. African American MTFs have higher rates of HIV than other racial/ethnic groups.
- Injection drug use is also common among MTFs, putting them at high risk for HIV. MTFs may inject female hormones as well, in order to feminize their bodies. HIV risk through hormone injection varies regionally, with New York reporting more risk than in San Francisco, due to differences in availability of hormones and hormone syringes.
- Transphobia, or the pervasive social stigmatization of MTFs, greatly exacerbates their HIV risk. This intense stigmatization results in their social marginalization, which includes the denial of educational, employment and housing opportunities. It also creates multiple barriers to accessing health care. Such marginalization lowers MTFs' self esteem, increases the likelihood of survival sex work and lessens the likelihood of safer sex practices. All of this leads to high rates of HIV, STDs, drug use and attempted suicide.
- MTFs primarily have sex with men and are likely to engage in receptive anal sex, which puts them at increased risk. Some MTF sex workers are willing to not use condoms with their paying partners if they are offered more money. However,

some studies show that most unprotected sex occurs with primary partners, not paying partners.

- Psychosocial factors such as poverty, low self-esteem, depression, feelings of isolation, rejection, and powerlessness are cited by MTFs as barriers to sexual and drug risk reduction. For example, many MTFs state that they engage in unprotected sex because it validates their female gender identity and boosts their self-esteem. For many MTFs, securing employment and housing are more pressing issues than HIV and must be addressed before HIV prevention efforts can be effective.
- Many transgender individuals do not access HIV prevention or health services due to the insensitivity of service providers and health care staff or fear of being revealed as transgender. Some HIV prevention programs for MTFs face challenges renting space due to transphobia.
- Peer-based prevention efforts for MTFs should be developed and evaluated, including: 1) late night/early morning outreach for sex workers; 2) needle exchange programs that offer hormone syringes; and 3) individual and group interventions that focus on the psychosocial barriers to HIV risk reduction. Hiring and training MTFs for prevention programs would provide much-needed employment opportunities to this community as well as facilitate culturally appropriate HIV prevention efforts. Making hormone therapy more accessible may be a good way to encourage MTFs to use health services where they could obtain HIV prevention information. Such interventions will be most effective if they are coupled with housing, education and employment efforts. Prevention efforts need to include partners and friends of MTFs.
- MTFs have been invisible in the Centers for Disease Control and Prevention (CDC) HIV classification system, showing up as either men who have sex with men or heterosexual women. Transgender-specific categories need to be included on all federal and local data collection forms.