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*Achieve is a joint publication of
ACRIA and GMHC.*



Still Got It At Seventy

Sexuality, Aging, and HIV



by Katherine Githens
and Emily Abramsohn, MPH

Human sexuality is beginning to be recognized by both doctors and policymakers as an important part of people's health. In his 2001 report, Surgeon General David Satcher stated that: "Sexuality is an integral part of human life...inextricably bound to both physical and mental health...Sexual health is not limited to the absence of disease or dysfunction, nor is its importance confined to just the reproductive years."

But despite this governmental recognition, and the aging of the U.S. population, research in the field of geriatric sexuality has been largely overlooked. Only one large study that explores sexuality in older men and women in the U.S. has been completed: the 2005-06

National Social Life, Health and Aging Project (NSHAP). It enrolled over 3,000 men and women, aged 57 to 85. They were about half male and half female, and completed a face-to-face questionnaire covering the social, psychological, and health aspects of their lives. Detailed information about their sexual relationships, activity, and functioning was gathered and analyzed.

Sex and the Older Adult

NSHAP's findings highlight both the importance of a healthy sex life and the social settings in which people engage in sexual activities. Those who reported their health status as "poor" were less likely to be sexually active. Those who were sexually active and in poor health were more likely to report sexual problems. The data also showed that the quality of, and interest in, sex was associated with good health.

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Luis Scaccabarozzi

Nathan Schaefer

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PUBLICATIONS MANAGER

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PUBLICATIONS ASSOCIATE

Laura Engle

DESIGN

Tom Dolle

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For more information on these trials, contact us at 212-924-3934, ext. 121.

LETTERS TO THE EDITOR

To The Editor:

Reading "The Cult of HIV Denialism" brought back a lot of disturbing memories. Researching and writing a series of articles on HIV denialism in the late '90s led me to the same conclusion: this "movement" exhibits all the classic signs of a cult. But one can understand its attractiveness to anyone facing something as disturbing as an HIV diagnosis. Who wouldn't rather believe that clean living and avoiding drugs is all one needs to do to avoid a lifetime of inconvenient and often unpleasant medications and a likely shortened life expectancy?

My efforts led to my being harassed and called "murderer!" on the streets by the group of denialists who had taken over ACT UP/San Francisco. All of the people who screamed such epithets at me – literally all of them – are now dead, killed by infections that couldn't possibly be related to that "harmless" virus. It would be funny if it weren't so sad.

Strikingly, the leaders – the intellectual forces behind this cult – are overwhelmingly HIV-negative. What is one to make of individuals with scientific credentials who say things that are demonstrably false? Spend some time checking their writings and it doesn't take long at all to find plenty of glaring mistakes. Indeed, one of my own

articles was cited as a reference for a "fact" that it did not contain – I'm convinced the author simply made it up to support his argument.

I don't think it's too much to ask whether some of these people – who are many things, but clearly not stupid – know what they are doing, and are doing it deliberately.

Sincerely,

Bruce Mirken
San Francisco

To the Editor:

Thank you for an awesome publication! I work for the University of Washington at an STD Clinic coordinating HIV testing research. I come across HIV information and materials on a regular basis and none of them have captured my interest like *Achieve*. I just picked up the Spring 2010 issue and I read it front to back in one setting. I totally appreciate the information, especially on inflammation, consent, and HIV deliaism, and I love the "Call to Action"! I am a huge fan of GMHC and I am now going to look into ACRIA as well. I look forward to reading more.

Thanks again,
Joshua O'Neal

The study also found that sexuality in later life takes place, for the most part, within a long-term marital relationship. Men are considerably more likely than women to have a partner later in life; thus much of their aging is done in the company of a partner. This may be due to the fact that men are often married to younger women, and that women often live longer than men. A man's sexual relationship also tends to be more fulfilling than a woman's because he has a partner, despite health difficulties that come with old age. Women, on the other hand, are more likely to experience aging, health problems, and death alone. Without a committed partner, many women do not have sex, which helps to explain the differences between the sexual activities of older men and women.

Sexual activity among older adults declined with age: 73% of people aged 57 to 64 were active, 53% of those aged 65 to 74 were active, and only 26% of those aged 75 to 85 were active. About half of the men and women who reported sexual activity also reported at least one sexual problem. The most common female sexual problems were: low desire (43%), difficulty with vaginal lubrication (39%), and inability to climax (34%). For men they were: erectile difficulties (37%), lack of interest in sex (28%), and anxiety about performance (27%). About 14% of men reported using medication or supplements in order to improve sexual functioning, as these medications are readily available. Proven interventions for female sexual problems are not widely available, and much less attention has been paid to older female sexuality.

STIs and the Older Adult

Although the amount of sex people were having decreased, they still experienced sexually transmitted infections. Genital herpes and HPV are the most common infections among older women. Genital herpes prevalence among men and women over 70 was 28%, and the rate was higher in women than in men. Chlamydia, gonorrhea, and syphilis cases



Women were less likely than men to discuss sex with a physician, either out of embarrassment or because of societal norms, and doctors may not talk to their older patients about sex due to preconceived notions about sexuality at their age.

occurred in less than 1% of older women, but the percentage is likely an underestimate due to the lack of a uniform tracking system and STIs being overlooked by doctors. High-risk HPV, an important factor in cervical cancer and dysplasia, was found in 6% of the women. Cervical cancer is one of the leading causes of female cancer deaths, and 20% of cases occur in women over 65. Many of the screening and prevention practices for cervical cancer, including the HPV vaccine, have age-based criteria that exclude older women.

While some of these STIs were contracted in later life, many of the infections likely occurred earlier and have either

stayed dormant or persisted through the years. In a recent study of women aged 67 to 99, however, 1% were diagnosed with an STI during the nine years of the study, highlighting the fact that older women are still very much at risk for new STIs. Further complicating the diagnosis of STIs in older women is the fact that many can produce symptoms similar to those experienced by postmenopausal women. For example, chlamydia and gonorrhea can present as pelvic pain and pain during intercourse, problems often encountered in older women.

A recent multinational survey of people 40 to 80 years old also showed that women were more likely than men to rate

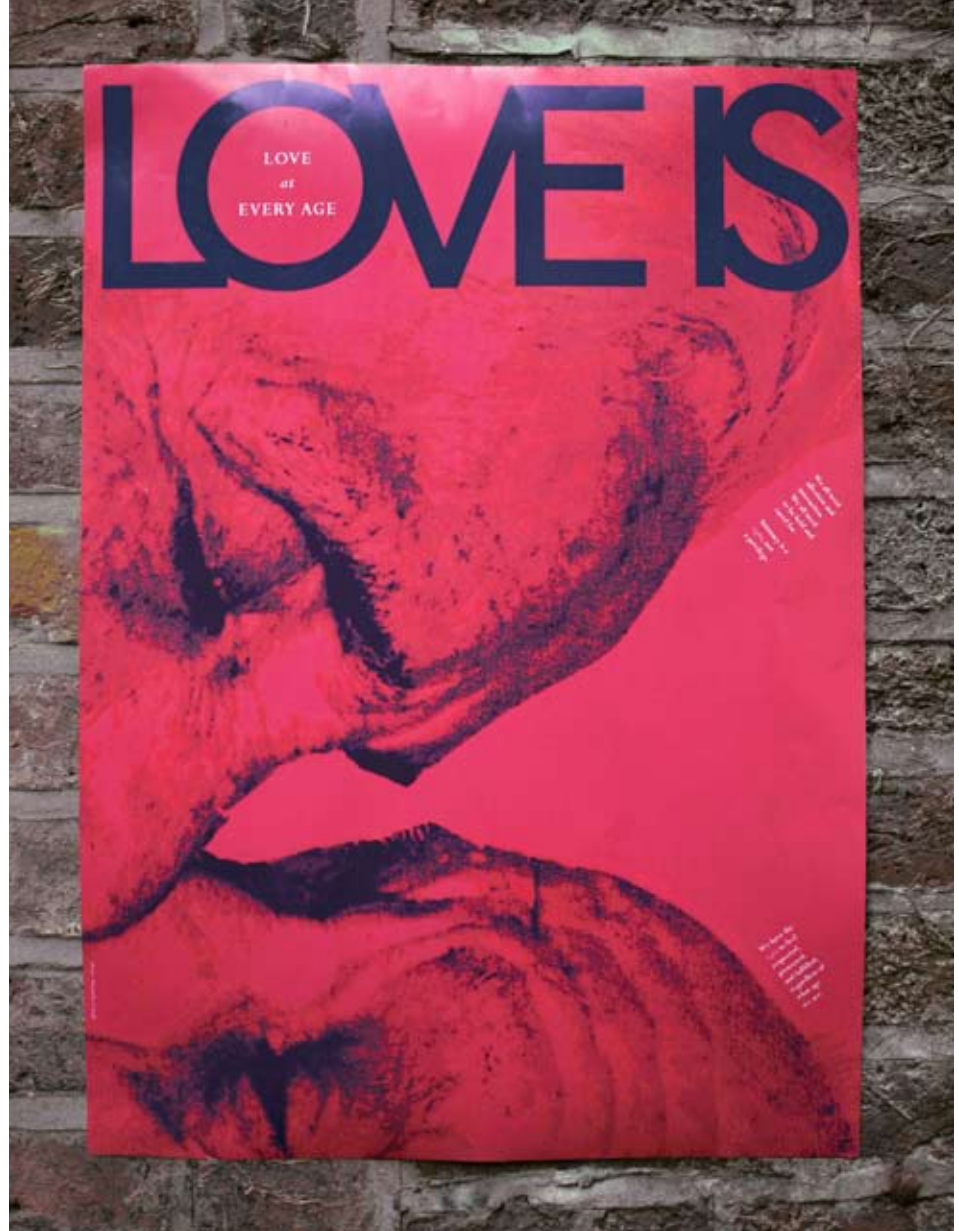
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sex as an unimportant part of life and to report lack of pleasure with sex. Despite similarly high rates of sexual problems among women and men, women were less likely than men to discuss sex with a physician, either out of embarrassment or because of societal norms, and doctors may not talk to their older patients about sex due to preconceived notions about sexuality at their age. This can compound the issue of STIs among older adults, especially women.

HIV and Older Adults

The majority of new HIV cases in the U.S. occur among people under 50. 10% of new HIV infections in the U.S. occur in people over 50, although this number is as high as 17% in some areas. Almost a third of these new infections are among older women, particularly within minority racial and ethnic groups. The likelihood of receiving an HIV and AIDS diagnosis at the same time increases with age. The CDC estimates that by 2015, half of all people with HIV in the U.S. will be over 50, and that more than a third will be women. The longer survival of people diagnosed earlier in life also accounts for the increasing number of older adults with HIV.

Many HIV prevention messages target the younger population, and counseling and testing is rarely offered to older adults by their physicians. STI prevention strategies have not been well tested among older adults, and few older women report using condoms. With relationship changes later in life, new sexual encounters are not uncommon for older men and women who have experienced divorce or death of a partner. While younger women use condoms for pregnancy prevention, this motivation is not present in women who are past childbearing age. Condoms should be applied when the penis is fully erect, but some older men do not reach full erection until after sex is initiated. Water-based lubricants can be used to combat vaginal dryness and friction. Any questions about the use of any product, or general questions about sexual activity, should be directed to a physician or other provider knowledgeable in older adult sexuality.



Sexual problems experienced in older adults may increase the risk of contracting an STI, especially in women. Vaginal dryness and thinning of the vaginal walls can create a hospitable environment for the transmission of some STIs, as the tissues in the vagina can easily become inflamed during sex. Also, with the emergence of medications to treat male erectile dysfunction, such as Viagra, many older men are able to experience an extended sexual life, but may not have received the prevention messages needed to protect themselves and their partners.

Lack of Communication

Although they have largely been ignored in terms of sexuality research, older adults are sexually active. They deal with many problems ranging from lack of interest in sex to discomfort during it. Many of these issues could easily be dealt with by physicians, but a lack of commu-

nication and knowledge makes many feel helpless. The topic of geriatric sexuality would greatly benefit from more attention from both researchers and clinicians, if only to improve the quality of life of older adults.

In one study, adults over 65, physicians, and nurses were asked about their knowledge of safer sex and HIV risk. The results show a great discrepancy in the understanding of HIV transmission among older adults on the part of both patients and providers. Many older adults were quite aware of the term “safe sex,” noting the use of condoms and utilizing the term “protection.” Older adults were also very aware of the risk of getting HIV; more than half of the 20 respondents who underwent in-depth interviewing expressed moderate to extreme concern about HIV. This was in great contrast to the ideals and perceptions of the physicians and nurse-practi-

tioners, among whom only about 6 out of 20 expressed concern of HIV risk among their older patients.

Barriers to communication between older adults and their physicians about HIV risk also exist. In the above study, physicians and nurse-practitioners listed lack of time during a patient visit, more pressing medical issues, trying not to embarrass the patient, and just assuming that they are not sexually active due to their age as reasons they do not talk to their older patients about HIV. The patients interviewed also made the point that they would be open to these discussions, but they would not bring the issue up themselves. This is a very important gap to address as it often results in a missed opportunity to counsel and treat older adults in a clinical setting.

Conclusion

The NSHAP study debunks the conventional wisdom about a sexless old age. Adults continue to be sexually active late into life, especially those with a spouse or long-term partner. And although older men are more sexually active, this is largely due to the lack of partners available to older women. We need to change our thinking about what it means to age successfully and to embrace the idea that human beings are sexual beings throughout their lives. Part of this involves outreach and education to physicians who care for older adults to make them aware that the topic of sexuality and sexual health is just as important to address in clinical settings as other health issues.

The study also underscores the need for STI education and prevention efforts in our older population. STIs are prevalent in this group, and older adults who are unaware of this issue are at risk for infection or for infecting others with STIs such as HIV. While adults over 50 currently account for 10% of new HIV infections, this proportion will surely grow if we do not give them the information they need to keep themselves healthy. Prevention efforts targeted at older adults could ensure that this rate of infection remains stable or even decreases. Part of this effort involves changing the CDC testing guidelines for HIV to include people of all ages, not only those aged 13 to 64. The fact that Medicare will now reim-

burse HIV testing for those over 64 is an important step in the right direction.

Lastly, the NSAHP should be replicated on the older LGBT population. Sexuality in later life takes place, for the most part, within long-term marital relationships. Such long-term relationships are not a dominant characteristic within LGBT communities. This may affect the sexuality and health of those too-often marginalized communities. Similarly, NSHAP should be conducted in other countries to determine whether the patterns seen in older U.S. adults are similar to or different from older adults in cultures around the world. ■

Adapted from:

“Sexuality, Sexual Function, and the Aging Woman” by Stacy T. Lindau, MD, MAPP, in *Hazzard’s Geriatric Medicine & Gerontology, Sixth Edition (2009)*

Katherine Githens is a research assistant working on sexual health projects in Dr. Lindau’s research lab.

Emily Abramsohn is a Research Core Coordinator at the University of Chicago Medical Center.



Let's Talk About Sex

INTERVIEWING OLDER ADULTS ABOUT HIV AND RISK

by Luis Scaccabarozzi

When it comes to HIV education, images of older adults are sorely lacking. Take a look at any of the ads for HIV medications, even those aimed at people who have been using the drugs for some time, and you'll see attractive young men or women.

Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies) is an intervention based on several behavioral change models that targets a large number of communities, including men and women at risk, homeless individuals at risk, young MSM, substance users, etc. ACRIA's adapta-

tion of the program is aimed at older adults who are living with HIV or who are at risk. Our target populations are MSM, women, transgender individuals, people of color, and Spanish-speaking communities.

The goal is to reach them through the actual stories of people they can identify with. We speak to issues that are specific to older adults: ageism, loneliness, the need for intimacy, higher rates of depression, and so forth.

The "role model" stories come from over 100 interviews completed over two years. We chose stories that had common issues and used characters that would have the greatest community impact. The ultimate goal is to create behavior change.

The process of gathering the stories has been eye-opening, especially the ease with which older adults speak about their intimate sexual behaviors. It's hard for anyone to speak about their sexual risk, but especially so for a widow who had only one sex partner for 40 years and now finds herself playing the dating game. One woman commented, "I never had any man but my husband. Now I'm 65, met someone at the senior center, and we're having sex! I don't know anything about his sexual history and we never even talked about HIV before having sex."

It's also a challenge talking to someone who never identified as a gay or bisexual man, and who recently tested

positive for HIV. It's about creating a comfort level and finding an appropriate space. The interview is recorded, which alone creates discomfort. We do allow anonymity, but many interviewees felt comfortable enough to allow their real first names to be used – they want to be able to identify themselves if they see the story in public.

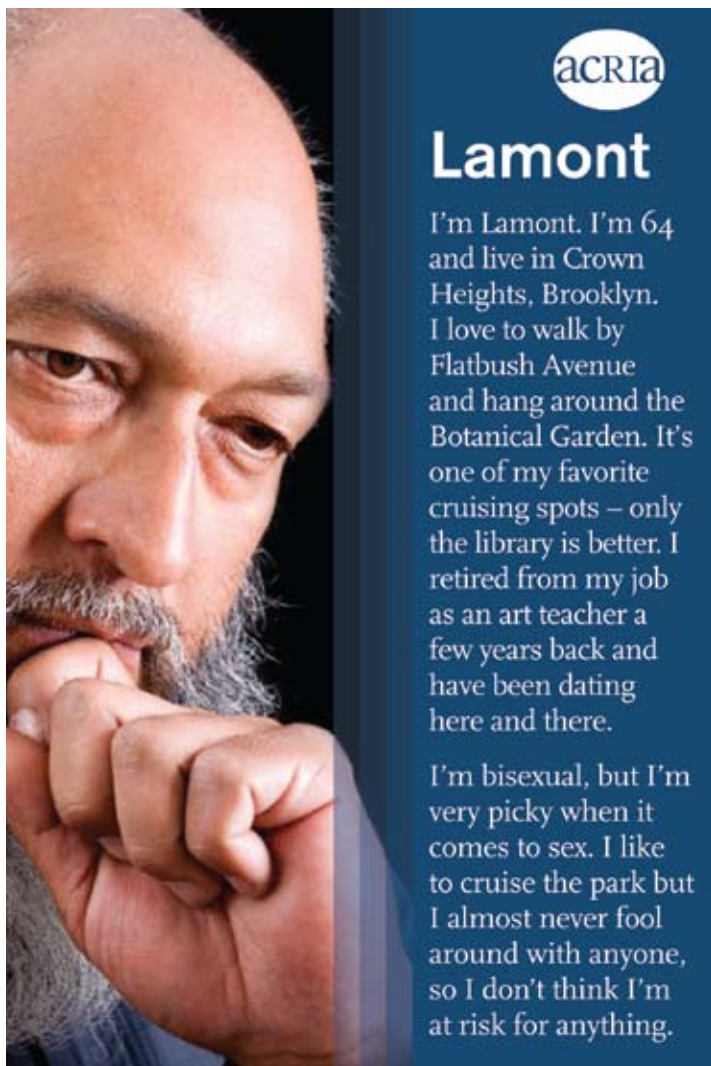
Many older adults with HIV said it was because of loneliness that they engaged in sexual activity without disclosing their HIV status. Those who were HIV negative or untested also had high-risk sex out of a need for intimacy. This occurred regardless of whether the initial intention was to have sex. And many didn't know how to use a condom or simply didn't have one. One man told us, "There were other men in the park who were willing to have sex with me without using a condom. Look at me – I'm 61 and if I can have sex or feel loved, even for a few moments, then I won't demand a condom."

Most older adults said that to reach people in their age group we had to tell stories about people who looked like them and had similar sex and intimacy issues. They were tired of prevention messages aimed only at young adults. This was especially true of older adults who never thought of themselves as being at risk, mostly because the images used in prevention messages "never spoke to them."

In focus groups before we began the interviews, participants said things like, "You need to make the HIV test normal, an everyday test, so that when we have one done it's as if we're just peeing in a cup."

The final key to the process is finding the right people to distribute the stories on palm cards to the population we are targeting. Fortunately, our peer educators come directly from the people we interviewed. They've been able to arrange HIV tests for over 500 older adults in a six-month period. Part of that success came from presenting an HIV test as just one more test, much like a prostate test, breast exam, or cholesterol test. But in the end it was about a group of older adults who came together, learned about HIV and sexual risk, and left the program with the feeling that they can talk about sex to their own service providers and to their peers. ■

Luis Scaccabarozzi is Director of the HIV Health Literacy Program at ACRIA.





Men on the Down Low

by Adrian Guzman, MPH

Men who have sex with both men and women but who do not identify as gay or bisexual have been the subject of much media attention. But the media have not always presented the most accurate information about these men and their experiences and, as a result, there remain many misconceptions.

While the term “on the down low” (also known as “the DL”) may be a relatively new way to describe these men, the concept is not. A 2008 *Archives of Sexual Behavior* special issue on African-American and Latino bisexuality traces the term to its origins in African-American slang where it originally described “secretive behavior,” usually by African-American men. By the late 1990s, the term was mainstreamed through usage in R&B and rap songs indicating infidelity.

A high-profile 2003 *New York Times Magazine* article described the phenomenon as “an organized, underground subculture largely made up of black men who otherwise live straight lives.” One year later, *The Oprah Winfrey Show* dedicated an entire episode to “blow[ing] the lid off this sexual underground,” with Winfrey interviewing J.L. King, author of the autobiographical *On the Down Low: A Journey into the Lives of “Straight” Black Men Who Sleep with Men*. Numerous self-help books followed, including a “survival guide” for women written

by King’s former wife. Despite this widespread media coverage, no consistent definition of these men exists.

However, many of the reports by these media outlets – including the *New York Times Magazine* article and the *Oprah* episode – have one thing in common: they explicitly link what they term “men on the down low” to the spread of HIV, without providing any evidence to support this claim. Furthermore, they specifically identify African-American and Latino men within this group as high-risk vectors of HIV transmission.

During a June 2010 segment of ABC’s *The View*, D. L. Hughley stated, “HIV in the African-American community [is primarily affecting] young women who are getting it from men who are on the down low.” Co-host Sherri Shepherd described men on the down low as “black men who’ve been going out. They are having sex with men and they’re not telling their girlfriends or their wives that they’re gay... It’s so big in the black community with women because they’re having unprotected sex with men who have been having sex with men.”

On ABC’s *The View*, D.L. Hughley stated, “HIV in the African-American community [is primarily affecting] young women who are getting it from men who are on the down low.” GLAAD issued a statement condemning the comments as “inaccurate and dangerous.”

Several gay rights advocates and organizations immediately issued statements criticizing the comments as inaccurate and misrepresentative. The Gay & Lesbian Alliance Against Defamation (GLAAD) issued a statement condemning the comments as “inaccurate and dangerous” and “fuel[ing] a climate of homophobia and racism.” GLAAD cited a 2009 CDC statement indicating that the proportion of HIV infections in African-American women that come from bisexual male partners is “relatively few” and that more are from “male partners who are ... injecting drugs or ... have other risks that may put those female partners at risk of acquiring HIV.”

Where’s The Data?

The public health field has had difficulty obtaining data regarding men who have sex with both men and women but who do not identify as gay or bisexual, and only a few notable studies exist. A 2005 report published in the *Journal of the National Medical Association* reviews relevant data on this behavior among African-American men, how it does not always align with sexual identity, and how it relates to HIV risk. These studies refer to this behavior in a variety of ways, including “men on the down low,” “men on the low low,” “non-gay-identified men who have sex with men and women (MSMW) who do not disclose their same-sex behavior to their female partners,” “secretive bisexual-

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minority men than it is among white men. The 2005 *Journal of the National Medical Association* review found that, across 18 studies of African-American MSM, up to 71% report bisexual behavior and up to 40% identify as bisexual.

Race/Ethnicity

The few studies that include more diverse racial and ethnic communities suggest that bisexual behavior without disclosure is more common among African-American and Latino men than among white men. A 2000 Virginia-based study published in *AIDS Education & Prevention* found that, among its participants, white MSMW are significantly more likely than African-American MSMW (62% versus 46%) to disclose their bisexual or gay behavior to their families, heterosexual friends, health care providers, fellow churchgoers, and others.

ity,” and others. For the purpose of presenting available data most efficiently, this article will use MSMW to describe non-gay-identified men who have sex with men and do not disclose their same-sex behavior to others, including their primary female partners.

Research on this group is limited in several ways. Most studies do not separate analyses of MSMW from those of men who have sex only with men. Studies that focus on MSMW tend to examine either their relationships with male partners or their relationships with female partners, with few discussing how the two may overlap and affect each other. Further, most studies focus on men who openly identify as bisexual, thus leaving out those who do not. Most research on MSMW focuses on African-American and Latino men, with little attention paid to the experiences of white Anglo MSMW.

While these limitations are often due to the researchers’ methods, the most significant barrier to studying MSMW is the very nature of their behaviors. Men who do not reveal their same-sex behavior to friends, family, or primary partners are less likely to make themselves available to researchers. They are also less likely to be exposed to public health information addressing this behavior, and are even less likely to seek it out themselves.

What Is Known About MSMW?

As mentioned, the majority of research on MSMW focuses on African-Americans and, to a lesser extent, Latinos. Very little work has been done regarding the behaviors, attitudes, and sexual identities of white MSMW, and even less on that of Asian-Americans and Native Americans. There is little reliable information on the prevalence of bisexual behavior among white men who do not disclose their same-sex behavior. Research shows only that the prevalence of bisexual behavior is much higher among ethnic

Sexual Identity

The 2005 *Journal of the National Medical Association* review indicated that, like African-American and Latino men who have sex only with men, ethnic minority MSMW are less likely than white men to identify as “gay.” They are similarly less likely to join gay-related organizations and read gay-related media. Numerous studies show that men who disclose their same-sex behavior are more likely to consider themselves part of the “gay community” than men who do not.

There is little data on the prevalence of bisexual behavior among white men who do not disclose their same-sex behavior, compared to data on African-American and Latino men. Research only shows that bisexual behavior is much higher among ethnic minority men than among white men.

A 2006 12-city study published in *AIDS & Behavior* found that, among its participants, not revealing same-sex behavior was associated with higher levels of internalized homophobia, suggesting that these men may conceal this behavior due to shame, guilt, and other negative associations with a gay or bisexual identity.

Sexual Behaviors

A 2008 review in *Archives of Sexual Behavior* found that MSMW report significant numbers of both male and female partners, with almost twice as many male partners as female partners. In addition to reviewing other data, the study collected separate

data from MSMW in New York City. There, MSMW reported 6.7 male partners in the past year compared with 3.2 female partners. At the same time, these men reported more frequent sex with female partners than with male partners in the past year. More reported having anal sex with their male partners than with their female partners, and significantly more reported vaginal sex with their female partners than anal sex with either their male or female partners. This may be partly due to the fact that many of these men are more likely to be in relationships with or married to their female partners, thus increasing the opportunities to have sex with them. Their desire to keep their sexual activity with male partners hidden may contribute to its lower frequency.

The MSMW in this study were much more likely to report having insertive sex (topping) than receptive sex (bottoming) with their male partners, unlike openly gay men who report both topping and bottoming equally. This may be because these men view bottoming as a higher risk activity or too threatening to their heterosexual identity.

In terms of high-risk behaviors, 18% to 31% of MSMW reported unprotected anal sex with male partners in the past year, and 42% to 67% reported unprotected vaginal sex with female partners. This may be because these men perceive sex with their female partners to be inherently less risky, and because insisting on condoms may cause their female partners to doubt their fidelity.

This study also found that, contrary to widely held beliefs, MSMW report having both male and female partners in addition to their primary female partners. They did not report only one-time, anonymous sexual encounters; many were involved in regular, ongoing relationships with multiple steady partners. It is possible that many MSMW opt for ongoing relationships because of the difficulty in finding reliable, discreet partners, as well as a desire to limit the risk of unintended pregnancies and HIV.

HIV Risk and Transmission

Given the higher rates of unprotected sex, HIV among MSMW is of particular concern, and most studies on this community are done within the context of HIV. The introduction to the 2008 *Archives of Sexual Behavior* special issue states that numerous studies have found that African-American and Latino MSMW are at significantly greater risk for HIV than their exclusively homosexual or exclusively heterosexual counterparts. This mirrors the fact that HIV continues to affect ethnic minority communities, especially African-Americans, disproportionately.

Social and Cultural Factors

It is obvious that the public health field continues to struggle to learn more about MSMW who do not disclose their same-sex behavior. These men are difficult to reach and do not respond to conventional outreach methods. The glaring lack of research is of particular concern given the high rates of unprotected sex and elevated risk of HIV and STIs.

Many researchers have sought to understand MSMW better in terms of sexual identity, sexual decision-making and risk-taking,

and acceptance within heterosexual and racial/ethnic communities, to reach out more successfully to this community and dispel the myths put forth by the media. In particular, researchers have focused on the social and cultural barriers in African-American and Latino communities that may inhibit disclosure of same-sex behavior.

A 2008 study in *Archives of Sexual Behavior* reviewed several other studies indicating that, among African-American men, the heterosexual and hypermasculine gender norms exhibited by religious and family networks may encourage MSMW to hide their same-sex behavior. These men may fear social rejection, humiliation, and possibly physical assault as consequences of coming out. Worse, they may also experience a lack of social support networks to aid them in exploring their sexuality and disclosing their same-sex behavior to others. While white MSMW face these difficulties too, studies indicate that African-Americans and Latinos are disproportionately affected by these barriers.



Moving Forward

The public health field has a responsibility to continue to reach out to and learn more about MSMW. Its work must incorporate the complex social and cultural issues affecting MSMW from all walks of life, and examine the barriers they face in exploring their sexuality. Further, misrepresentations about the HIV epidemic and MSMW – particularly African-American and Latino MSMW – persist among the general public. The media have a responsibility to report accurately and sensitively on the information collected thus far by public health researchers. Finally, the LGBT community and its allies must work together to create safe, open spaces that allow for further discussion of these issues. ■

Adrian Guzman is Executive Editor of the Public Interest Law Journal.



I'm Not Gay

by Joseph

Never was, never will be. I can't claim to be something I was raised to hate. I'm just me, and I do what makes me feel good. Besides, my folks raised me as a Christian and they would be really disappointed in me if I didn't live my life in the same steps that they were raised. So I'm not gay, even though I have sex with guys. And no, I'm not in denial. There are just some things about the lifestyle that I don't do. I don't club, I don't go to the Village, I don't do that Ball stuff, I don't geek over Beyoncé, I just live my life – I do what I want to do.

There's such a negative stigma that comes along with identifying yourself as gay. I don't like feeling like I have to participate in a certain set of actions because of who I sleep with. It's the same thing as identifying yourself as black or white or Baptist. There's a set of standards that people automatically are gonna put in your face – that this is what you do because this is who you are. There are so many things that come with the gay stigma that I just don't want to be a part of. I have a good friend who feels the same way – he avoids labels.

This all began when I was 12 and my best friend was 15. It just started with, "Oh, do this," or, "How does that feel?" and then kind of progressed into full-fledged sex. When I was 15 we got it on, on the floor of my bathroom in the middle of the night. He topped me. But that was it – that was the first and last time I had sex with him. I felt disgusted. I thought that it would be different. There wasn't anything good about that situation for me.

So I stopped having sex and started looking for stuff online. I googled "gay porn" and pretty much went through all the previews and free stuff I could find. I was more curious than anything else. I wanted to know what it was about. I lied about my age in chat rooms, told everybody I was from California – stuff kids do. It was interesting and exhilarating and all this good stuff, but after I began having sex again and started dealing with guys on that level, it changed and I found myself not enjoying it as I thought I would. It was a lot of, "I'm going to do this because I want him to feel this way," or "This is what I think I should be doing." It wasn't stuff that I wanted to do myself. I felt like I had to do it for the other person – like, if I do it he'll like me or be friends with me.

In high school, we only spent a few days on STDs and HIV in Health class. It was as broad as they could make it – you

If you go to hang out with a guy, and you're taking condoms and lube because you're expecting to have sex – that's gay. But if it's like, "Oh, we're just going to hang out," and then we just happen to have sex, then it's just sex.

learned about everything: the reproductive system, hygiene, brushing your teeth, and then they'd also tell you some stuff like, "You need to use condoms and birth control so you won't get pregnant." They skidded over some stuff, like gonorrhea and chlamydia, but they never said anything about oral sex or about two guys having sex. Anal sex wasn't spoken about at all. The face of HIV was gay men – I guess it's easy to push it off on gay people cuz "that's where it came from," but they need to teach teenagers that this is real. It affects everybody.

I ended up learning a lot of stuff from TV. They had this one thing on MTV a long time ago. They had everybody in the *TRL* studio and they had an open forum for an hour. People could stand up and ask questions. That's where I learned the whole oral sex thing – that there are certain variables going on that can make it riskier. I didn't know that. I also saw a lot of ads out there that said things like, "I'm gay, I'm HIV positive and my partner isn't, and we play safe." But ads that aim directly at gay people are difficult for me because I think it's not about: "You're gay, you have to be safe." It's about: "You're having sex, you have to be safe." Like, if you go to hang out with a guy, and you're taking condoms and lube because you're expecting to have sex – that's gay. But if it's like, "Oh, we're just going to hang out," and then we just happen to have sex, then it's just sex. If me and a guy have had sex before, that's just what we do. It's not: "I'm gonna come over and we're gonna have sex." It's like: "We're gonna chill, watch some movies, play some video games," and then if we have sex, we have sex. So it's hard to plan ahead sometimes.

Now I'm 23 and I couldn't even tell you how many dudes I've had sex with. I think I lost count three years ago when the number reached over 100. And with that has come some scares, but I'm lucky enough to have never caught anything serious. One of the biggest problems is just finding a place where I can get tested for free, anonymously, and not have all these people in my face asking me who I'm sleeping with. I went to this testing spot in Harlem a couple months ago. It wasn't terrible, but I

knew it was a spot specifically for gay people. If that wasn't the case, then everyone who worked there was gay, and that made me a little uncomfortable. I don't have a problem with anyone who is gay or anything like that, but I just don't connect with them on that level. Maybe there could be some kind of "H.I.V. isn't G.A.Y." campaign – haha.

I see leaflets about HIV, but you get one and you put it away and then when you get home you forget about it, find it two months later and throw it in the garbage. I don't see people reading stuff like that. It has to be something you hear, something you see, or somebody telling you something. Online, it's so easy to find whatever you want. If you have the intent of, "I'm not gonna use a condom," then you can find 1,800 people who don't use condoms. At the hookup sites, you see profiles that say, "Anything goes, HIV status unknown and don't care," and these other guys who claim they're negative but have raw sex and bareback, and it's like, "You can't possibly think you're negative and you're doing all that with all these random people." And then they have bareback sex parties – and it feels good, I know it feels good. We all know it feels better, but I can't. Not with strangers. Sometimes I feel guys just don't care.

Make it as serious as it is.
You can't sugarcoat it.
Sometimes you just need that
real good smack on the back of
your head to make you obey.

I say just be real and put it out there. You have ads for straight people, you have ads for gay people, you have ads for everybody – put the message out, no matter who you're having sex with, no matter who you're having a relationship with, no matter who you're in the bed with, you still need to protect yourself. And make it as serious as it is. You can't sugarcoat it. Sometimes you just need that real good smack on the back of your head to make you obey. Like, this is really serious – you see TV shows about it, you see movies that say, "Oh, he made a mistake, he didn't use a condom, now he has HIV, end result." But people don't talk about it, like, "This is how he got HIV. He got so wrapped up, you know – he was at the club, he got high off of this, and went home and made a really bad decision." Make that kind of stuff available – real stories: "This is my life, this is where I'm coming from. This is how I got HIV. It could be you." It's not about: "Oh, I'm gay, I'm straight." It's: "I'm human, I have sex, I could put myself at risk." ■



How To Transform HIV Prevention

by Raquel Sapién and Robert Valadéz

From the onset of the epidemic, HIV has greatly affected the world's most vulnerable populations, and among those most affected are women and gay and bisexual men. There is little information available, however, about how HIV has affected transgender women and men, despite evidence suggesting that they may be at high risk. With rates of new infections on the rise among gay and bisexual men, public health officials are beginning to scratch their heads over what may be occurring among transgender people. We must understand how HIV prevention and treatment can be tailored to meet the needs of this highly misunderstood population.

What does “transgender” mean?

Transgender men and women are generally defined as people whose gender identity, expression, or behavior differs from their biological sex. Contrary to popular belief, not all transgender people choose to undergo sex reassignment surgery. Many do take hormones, however, to change their appearance to match the gender with which they identify.

From the “hijra” in India to the “two-spirit” of Native American tribes, transgen-

der people have been recognized in many civilizations and in many different regions of the world. Sadly, their history has been riddled with misconceptions, intolerance, and perhaps most troubling, neglect. All of these factors have contributed to disparities that leave transgender people vulnerable to a host of health issues, including HIV. Despite building political momentum in recent years by working in solidarity with the larger gay, lesbian, and bisexual movement, transgender people are often still invisible or ignored in discussions ranging from education to health care.

The lack of a national monitoring system that gathers data on transgender people results in a great deal of missing information. The U.S. Census does not include an option for people to indicate a transgender identity. This is extremely problematic, as the Census largely determines the funding of government programs aimed at populations with the greatest need. In the Census's current form, transgender people do not exist. Thus public health officials are left to speculate on their exact number, their average annual income, and how many are raising children, among other things. This creates a huge challenge for transgender advocates to obtain the necessary funding for programs aimed at advancing their well-being, as there are little to no data to identify their needs and support strategies to meet them.

What do we know about HIV and the transgender community?

Recently, California has begun formally documenting health trends among its transgender residents. As of 2002, the state began recording “male-to-female” and “female-to-male” as gender reporting options in publicly funded HIV counseling sites. In 2003, the California Department of Health Services released data that revealed that transgender clients had much higher rates of HIV diagnoses (6.3%) than clients of other high-risk categories. This includes men who have sex with men (4.2%) and partners of people with HIV (4.8%).

The California data provided much-needed insight into the relationship between HIV and the transgender population, proving that the issue needs greater attention. Still, while California is the most populous state in the U.S., it does not provide a complete picture of the HIV epidemic among transgender people across the U.S.

In 2007, the CDC conducted a meta-analysis of 29 studies focusing on transgender women and five studies focusing on transgender men, to estimate the prevalence of HIV. This meta-analysis reported findings similar to those in previous literature: transgender people are disproportionately affected by HIV. Specifically, it revealed that 28% of transgender women studied tested positive for HIV.

Even more alarming are the rates of HIV among transgender people of color. The 2003 California data showed that HIV diagnoses among African-American transgender clients, at 29%, were significantly higher than among all other racial groups. The CDC's meta-analysis echoed these data, reporting that among transgender African-American women, 56% tested positive for HIV. This was dramatically higher than the rate of HIV-positive white transgender women (17%).

Studies highlighting rates of HIV among transgender men are even more rare, but what research does exist points to low rates of HIV among this population. Because there is no reliable estimate of the size of the transgender population, however, it may be that the actual rate of HIV infection among both transgender men and women may be even higher than reported.

Why are transgender people at higher risk for HIV?

Discrimination plays a big role in the challenges transgender people face, which in turn makes them highly vulnerable to HIV over the course of their lives. Many transgender people experience discrimination early in life, within their families. Violence, emotional abuse, and rejection from family members leave them without the emotional and financial support that often help young people establish stability in adulthood.

Various studies point to transphobia and homophobia as barriers to transgender people successfully obtaining education, employment, social services, and housing. Lack of family and institutional support pushes transgender people to the margins of the formal economy. This is particularly burdensome to transgender people of color, who face additional discrimination based on their race or ethnicity. As a consequence, they often are exposed to stressful environments, experience

A 2007 CDC study reported that 42% of transgender women participated in sex work. Of these women, 39% engaged in unprotected receptive anal intercourse.

social isolation, and participate in behavior that places their health and safety at risk.

Limited employment options may force transgender people to turn to the street as a source of income. Many turn to “survival crimes” such as sex work, drug sales, and theft. The 2007 CDC study reported that

42% of transgender women participated in sex work. Of these women, 39% engaged in unprotected receptive anal intercourse. This rate was even higher among all transgender women in the study (44%). Further, 39% of transgender women in the study reported sex while drunk or high.

Since health care is strongly tied to employment in the U.S., many transgender people have difficulty obtaining hormone treatments through legitimate health care facilities, with the CDC reporting that half of transgender people lack health insurance. As a result, many turn to the street for hormones, with 34% reporting nonmedical sources for hormones. Additionally, 25% reported injecting silicone. The high rate of transgender people injecting hormones and silicone raises serious concerns about their exposure to HIV through the use of non-sterilized injection equipment.

How do HIV medications interact with hormone therapy?

Despite the high numbers of transgender people using hormone therapy, both through medical and nonmedical sources, little is known about the interactions and potential toxicities of hormones and HIV medications. There have been no major studies of the interaction between the two, and what is known about people with HIV taking hormone therapy and HIV medications at the same time has come from studies of menopausal women taking hormone replacement therapy to minimize the effects of menopause.

Studies show that some HIV drugs can decrease or increase the levels of hormones in the blood. Further, estrogen can cause reduced levels of some HIV drugs and put one at risk for viral rebound or drug resistance. Further research is necessary to observe any potentially harmful interactions among transgender people, as well as any side effects from long-term use of both hormone therapy and HIV medications.

Where to go from here?

Currently, there is no evidence-based HIV intervention tailored for transgender people. There is an urgent need to better understand the social and behavioral factors underlying their risk behaviors if we are to prevent more HIV infections in this population. Special efforts must be made to ensure that transgender people are involved in the design of HIV prevention efforts, to ensure a comprehensive and effective strategy.

HIV clinical trials should include transgender people in order to understand the effects of new medications on hormone therapies. These trials should also include transgender youth and seniors.

Lastly, public health agencies should advocate for education on transgender issues to minimize the physical and mental health disparities they face. This includes encouraging schools and families to foster positive identities among transgender youth. ■

Raquel Sapién is Chair of the National Advisory Board of the Center of Excellence for Transgender Health.

Robert Valadéz is a Policy Analyst in the Public Policy Department of GMHC.



The Trials of Transition

by Regine Singleton

When I became HIV-positive at 16, I hadn't ever seen any outreach or education about HIV for transgender people. I always said I would never get HIV – I thought I was invincible.

At that time I wasn't paying attention to what was going on in the world. We slept all day and ran the streets all night. No one was using condoms.

I've made it to the age of 37 because I have had my mother's support from day one. She helped me get out of the crazy lifestyle I was living. We have a connection and a bond that will never go away. She understands what I go through because she works in the medical field. She has always been there – telling me to take my medicine, talk to my doctor, and take care of myself.

One of my partners gave me the virus. I didn't know he was HIV positive. I thought he was someone I could trust, but I found out that he knew he was positive and didn't tell me. There needs to be more education that can reach young people, information featuring trans women talking about their experiences, about growing up, and about staying safe.

I have been living in the same neighborhood in Brooklyn for twenty years, and it can be really hard. People are always trying to figure me out. I have tried to communicate with people in the neighborhood, and at least make some friends, but once they found out I was trans and positive, it was a whole different story. I was always either being used or threatened, and I had rocks and bottles thrown at me.

Now, people have gotten more used to me. I told them I am not going to move away because of my gender or my status. I always wanted to live there, so I am not going to leave. It is still really rough, though.

I spend so much time explaining myself to doctors and to the greater community. I feel like I shouldn't

need to explain myself, either being trans or being positive. It's hard to be accepted and to find a doctor who will be open. I have to constantly build a relationship with people to get the services I need, because if I don't do it myself no one will do it for me.

When I told my doctor that I am transgender, he was shocked. He said to me, "You look like a woman, you act like a woman – did you have surgeries?" He really didn't understand. The fact that I am a woman is not connected to whether or not I choose to change my body. I had to stop taking my hormones because they interfere with my HIV medications, but I am still a woman. It took some time and explaining, but he accepted me as I am, and now I feel comfortable with him.

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There are so many challenges for trans women, especially if they have HIV. A lot of us don't have family. If a trans woman transitions at an early age, most of the time her family disowns her. There is a lack of education in the community because so many women don't have the support of their family anymore and have to go out in the world and be on the street or live with friends. Most of them are not in school and don't have jobs, but they still have to pay their bills. This means that working the street is often the only way to make ends meet.



It can be hard for trans women to get jobs because of discrimination. Some of them don't see it, but I do. When I'm in an interview, I get looks. They analyze me up and down – they don't try to hide it. They're like, "You're trans," and I'm like, "Yeah," and they sneak a look! At my job now, they like that I am confident in who I am. They like that I am open and honest and talk to them about my HIV status, and I feel comfortable there.

For trans women, facing so many challenges can lead to neglecting their health. If they are doing sex work in the evening, they don't have time to go to the doctor in

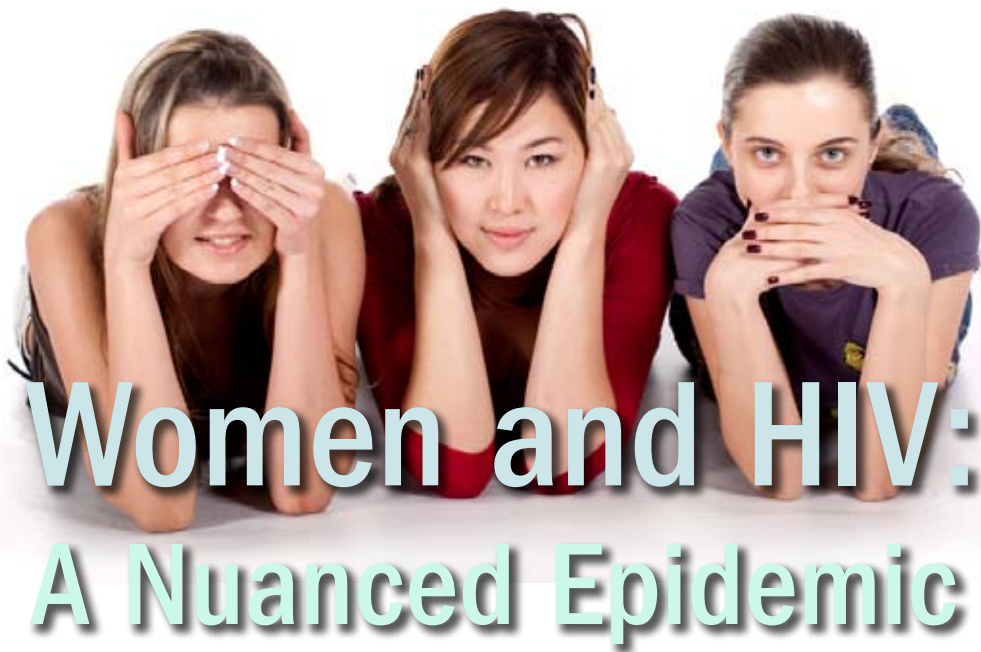
In the community there is so little support. It's just so much competition. So many of the young women are into the Ball scene, and it has damaged a lot of these kids. It's no longer fun. It's all just competition. They end up wanting to beat each other up, kill each other, over nothing.

the morning. I walk through the Village at night and see so many young transgender women using drugs, doing sex work, and having unprotected sex. Some of these women are not really thinking about their health. It's about that dollar and keeping it moving. They're starting at the age of 12, and it's dangerous. I was there. I remember staying out all night, drinking, getting high. It was a party every night and it was scary.

In the community there is so little support. It's just so much competition. So many of the young women are into the Ball scene, and it has damaged a lot of these kids. It's no longer fun. It's all just competition. They end up wanting to beat each other up, kill each other, over nothing. The community will put you down, and that's really hard for your self-esteem if you don't have anyone in your corner.

It can be so hard to get the right kind of support. Disclosing being HIV positive to a partner is difficult. You don't know how they are going to react, and how they will deal with you being positive. Once you tell a partner you are positive, sometimes things can change in the relationship. I have gone through that with partners who damaged my self-esteem. Domestic violence is also a huge issue for trans women in those situations.

We really need to have more support for these young trans women in the community, in families, and through outreach and education. There needs to be more peace and love for these girls. ■



Women and HIV: A Nuanced Epidemic

“Fighting HIV/AIDS in America and around the world will require more than just fighting the virus, it will require a broader effort to make life more just and equitable.” Barack Obama, July 2010

by Naina Khanna

In the U.S., women account for a quarter of the HIV epidemic. Globally, however, they make up half of all people living with HIV, and they experience the effects of the epidemic in many ways, whether HIV-positive themselves or as primary caretakers in families and communities affected by HIV. According to 2006 CDC estimates, there are nearly 300,000 women living with HIV in the U.S. Over the last 30 years, the epidemic’s toll on women has worsened and now appears to have stalled at a stubbornly high level. In 1985, women represented 8% of HIV infections each year in the U.S. By 2006, that had more than tripled, to 27%.

The HIV epidemic among women in the U.S. largely affects women of color, low-income women, and women with dependents. Over 80% of women living with HIV in the U.S. are women of color. While African-American women make up about 12% of the U.S. female population, a shocking 66% of new AIDS diagnoses among women in 2006 were African-American. Latinas represented 16% and Caucasian

women 17% of new diagnoses in that same year, though they are 13% and 68% of U.S. women, respectively.

The rate of HIV infections among black women is nearly 15 times as high as that of white women, and nearly four times that of Latinas. According to the HIV Cost and Services Utilization Study, 64% of women

The truth is, we do know which women are most likely to acquire HIV. All women may be at risk, but low-income women – especially black and Latina women in major urban areas with high HIV rates – have a much greater risk of HIV infection.

with HIV receiving medical care had annual incomes under \$10,000, compared with 41% of men. And the overwhelming majority of women with HIV in the study had children in their homes. This is drastically different from men with HIV.

For many HIV-positive women, their diagnosis has been a sentence to a lifetime of poverty as a result of complicated

health insurance programs, employment discrimination, and income requirements for benefits such as housing and HIV medications. Women carry a heavy burden of family responsibility, and factors such as poverty, homelessness, and racial discrimination add to the burden and contribute to their vulnerability to HIV infection. Once a woman is diagnosed, these factors may have a negative effect on her quality of care and can lead to poor health outcomes.

How do women get HIV?

The CDC reports that 72% of U.S. women who acquired HIV in 2006 did so through heterosexual contact, and another 26% through injection drug use. In August 2008, the CDC published new data estimating HIV incidence. A striking 57% of new HIV infections were among men who have sex with men (MSM), including MSM who also injected drugs. Another 31% were from to “high-risk heterosexual contact.” But what exactly is “high-risk heterosexual contact”? The CDC defines it as intercourse with someone known to have HIV or at high risk for HIV. But the majority of women who acquired HIV didn’t know the HIV status of their partners or didn’t know their male partners were at risk for HIV.

The CDC published another estimate of HIV incidence in 2010, finding that the rate of HIV infection among MSM was

more than 44 times that of other men, and more than 40 times that of women. These statistics are shocking, and call for an appropriate response. But comparing MSM to all women in the U.S. is misleading, since there is no way of knowing how many women are actually having “high-risk heterosexual contact.” Thus, there is no way to determine how likely it is for

them to acquire HIV and no way of knowing the trends of the epidemic among them. To understand these trends, we need a better understanding of the number of women truly at risk for HIV.

A CDC study released in July 2010 showed that among heterosexuals in low-income urban areas, poverty was the major factor driving HIV infection. In fact, people in the study living below the poverty line had double the risk for HIV than those living above it. Prevalence for both groups in these low-income areas was far higher than the national average. The study further concluded that “in epicenter cities such as Washington, DC and New York City, rates of heterosexual transmission among low-income populations are enough to sustain an epidemic independently of populations traditionally considered to be at higher risk [defined in the CDC’s press release as sex workers and MSM].”

Lifting As We Climb: Women of Color, Wealth, and America’s Future, a report released by the Insight Center earlier this year, documented enormous economic differences between black, Latina and white women in the U.S. According to the report, “single black and [Latina] women have one penny of wealth for every dollar of wealth owned by their male counterparts and a tiny fraction of a penny for every dollar of wealth owned by white women.” Excluding cars, single black women have a median wealth of \$100 and Latina women \$120, while the median wealth of single white women is \$41,500. This is partially due to lack of economic opportunity, housing and food insecurity, limited social mobility, and the fact that in the U.S., health care is largely tied to employment. Thus, women living in poverty (largely black and Latina women) are most vulnerable to poor health outcomes overall and have less access to health care, including HIV prevention.

The truth is, we do know which women are most likely to acquire HIV. All women may be at risk, but low-income women – especially black and Latina women in major urban areas with high HIV rates – have a much greater risk of HIV infection. If the same women are experiencing challenges with mental

health, substance use, domestic violence, or homelessness, or have incarcerated partners, they are at even greater likelihood of acquiring HIV. These factors contribute to a woman’s HIV risk independently of her personal risk behavior.

Yet prevention efforts to date have failed to intervene with an understanding of which women are most at risk and which interventions would truly make a life-changing difference. Efforts need to move away from solely asking women to use condoms, and to focus on upholding their rights to mental, physical, and emotional wellness, and their safety, self-sufficiency, and equality.



Prevention: Follow the Money

Many women are never offered an HIV test. The National Women and AIDS Collective has documented numerous instances of women being discouraged from taking, or being flat-out denied, an HIV test. This is true even when HIV testing was medically indicated. This may be because reimbursement rates for testing individuals vary depending on perceived risk, and risk is defined by behavior. The lack of data collected on factors that influence a woman’s risk – other than her number of partners and drug use – limit HIV prevention planning and resource allocation. The current model targets resources by demographics and individ-

ual risk behavior. It is rare for prevention planning to incorporate income level, health care access, housing stability, or mental health concerns – all factors shown to correlate with HIV vulnerability. HIV-related stigma and fears of criminalization for nondisclosure or transmission make it even less likely that people would seek out an HIV test

There are promising signs, however, that prevention and resource targeting are moving in new directions that may better identify women at risk for HIV. One such mechanism is the Dynamic Prioritization Model being tested by New York City’s HIV Prevention Planning Group. The

model targets prevention resources using a combination of local epidemiology, risk behavior, and socioeconomic and other data. The Maryland Department of Health is also using innovative measures to identify women at risk. This includes utilizing data on homelessness and income, and mapping geographic areas with high rates of HIV to best target HIV prevention and testing resources.

Addressing HIV prevention in a comprehensive way, including biomedical, behavioral, and social interventions, will improve efforts among women. A critical component of this is the understanding that prevention and care must be integrated. Women are whole beings, and services should reflect that.

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Health Care and Health Outcomes

Women with HIV face poor health outcomes, and studies show that African-American women in particular receive substandard medical care. The Women's Interagency HIV Study found that African-American women taking HIV medications were less likely to achieve an undetectable viral load and more likely to die than other women with HIV. According to the investigators, "White women had more favorable responses to HAART. The poorer responses to HAART found in African-American and Latina women, however, were explained largely by HAART discontinuation . . . and depression." Studies show that women of color with HIV are more likely to be depressed but less likely to be offered treatment for depression than white women. Women of color with HIV are also less likely to be offered HIV medications.

In addition to barriers presented by the cost of health care, women of color report a lack of trust in the medical system. Peer-based and culturally relevant programs have been shown to increase retention in care and HIV treatment adherence.

Reproductive justice is also an integral part of HIV care, especially for women. The majority of women interact with family planning services in some way every year. Each one of these interactions is an opportunity for HIV education, screening, and care. They are also opportunities for screening for HIV risk factors, which may include domestic violence, substance use, housing instability, and mental health challenges. Yet insufficient funding results in poor service delivery, so the majority of women are never even asked if they want an HIV test. By the same token, HIV-positive women report distressingly few conversations with their health care providers about whether they are hoping or planning to have children. One study in Canada showed that 31% of women with HIV engaged in such a conversation. Of these women, 61% brought up the subject themselves.

For many years, the primary fight of women affected by HIV has been to secure high-quality and nondiscriminatory pregnancy planning, fertility assistance, and

access to reproductive technologies that protect women from HIV. Recent research by the U.S. Positive Women's Network indicates that HIV-positive women's sexual and reproductive rights are routinely violated. Respondents report alarmingly high levels of stigma and discrimination in reproductive health care settings, resulting in coerced abortions and forced sterilizations.

The Women's Interagency HIV Study found that African-American women taking HIV medications were less likely to achieve an undetectable viral load and more likely to die than other women with HIV.

A battle is also being fought on a related issue: the right for all women to receive safe abortion services, independent of income level. For the first time this year, the International AIDS Conference program included a panel on HIV, unwanted pregnancy, and abortion. This conversation must continue with a focus on the sexual and reproductive rights of women with HIV.

Next Steps

The first-ever National HIV/AIDS Strategy, released in July 2010, discusses the extent of the HIV crisis among black and Latina women. The next step should be targeted initiatives to address the prevention, care, support, and anti-stigma needs of black and Latina women. These should be developed with input and decision-making from all stakeholders, including HIV-positive women from those communities and the people who work with them.

HIV stigma and discrimination create barriers to testing and quality care, and must be dealt with effectively and compassionately. The U.S. must end criminalization of people living with and vulnerable to HIV. This includes sex workers, drug users, LGBT individuals, and people of color, especially black men and women.

As HIV becomes a chronic, manageable condition, it becomes increasingly necessary to understand the psychological and emotional effects of a longterm diagnosis. Individuals "manage" their HIV differently. There are little data, for example, on what choices women in heterosexual sero-different relationships – in which both partners' HIV status is known – make about risk reduction. Additionally, we do not know how reproductive desires and relationship expectations influence their choices.

Additional research and increased investment are needed to find HIV prevention technologies like microbicides that are controlled by women, and which offer a range of conception options. Research design should utilize teams of medical researchers working together with behavioral scientists, sociologists, and community members, including people with HIV.

Community-level interventions will have to incorporate a variety of policy, cultural, and economic changes, including syringe exchange programs, comprehensive sexuality education, effective re-entry programs for formerly incarcerated individuals, and improved targeting of resources to social and sexual networks where HIV prevalence is high. These interventions must be more accessible, and HIV testing and care must be made more acceptable to the general community by addressing HIV-related stigma.

Finally, addressing the HIV epidemic among women in the U.S. requires that the human rights and dignity of all people are upheld through economic justice, ending racial discrimination and homophobia, and challenging gender norms and sexist practices. ■

Naina Khanna is Director of Policy and Community Organizing at the U.S. Positive Women's Network's Women's Organized to Respond to Life-threatening Diseases (WORLD).

Report from Vienna: Progress and Challenges

In July 2010, over 20,000 AIDS activists, researchers, care providers, and people living with HIV from across the globe gathered in Vienna for the XVIII International AIDS Conference. This convening provided a place to exchange views on the profound challenges of fighting the HIV epidemic around the world. Presenters and participants shared a range of local and international work, including prevention interventions, treatment advances, medical and behavioral research, advocacy, social marketing campaigns, and organizing initiatives.

The goal of achieving universal access to treatment remains paramount. The conference was dominated by scientific findings that support the belief that if existing programs were scaled up to meet the needs of the 33 million people living with HIV, the epidemic could be significantly blunted. Of those infected with HIV worldwide, half are women, and in 2008, young people between 15 to 24 years old accounted for 40% of all new HIV infections.

With three new HIV infections for every person gaining access to treatment, access to scientific and medical advancements in treatment is vital. A bold prevention effort will begin this year in which people are given HIV treatment immediately after testing positive rather than waiting until their immune system declines. The five-year study could significantly reduce transmission.

In his plenary speech, former U.S. President Bill Clinton noted, “Too much is spent on studies and reports that sit on shelves. Every dollar we waste today puts a life at risk. It is time...to spend the money more wisely and to deliver health care in a better and more timely way. South Africa has shown remarkable leadership this year. They’re now trying to test tens of millions of South Africans and more than double the numbers on treatment over the next few years.”

But treatment alone cannot end the epidemic. New methods of HIV prevention are necessary, especially among women and men who have sex with men (MSM), who are among the most vulnerable to infection. One of the conference’s most encouraging reports came from a vaginal microbicide study, a long sought-after prevention tool for women. The study, CAPRISA 004, reported a nearly 54% success rate in preventing HIV in women who used the microbicide as directed. This finding means there is finally scientific evidence that a vaginal gel could be effective in preventing HIV. This may provide women with a much-needed tool to take control of their own bodies and health. It must be developed further to determine whether it can also provide protection for anal intercourse.

The conference also underlined the immediate need to stop efforts to criminalize sex between consenting adults, as well as to support community-based education and advocacy

on the human rights of MSM and transgender people. Sessions stressed the need for anti-discrimination laws in relation to sexual orientation and gender identity. Continued efforts to eliminate prejudice in the general population and discriminatory treatment by health providers and local officials are vital. These behaviors marginalize those most affected by HIV and cause the epidemic to worsen. Anti-gay harassment and abuse magnify health problems and affect mental health, leading to depression, social isolation, and an array of adverse socioeconomic outcomes.

There were encouraging signs of increases in the visibility of issues facing both MSM and women. Although workshops on MSM, especially in Latin America and Africa, have increased from past conferences, it remains an issue that must be addressed by a broader range of institutions. Research on the links between criminalization of homosexuality and its effect on HIV, and on the global impact of the U.S.-based Christian Right’s anti-gay policies, were also discussed.

The issue of HIV and aging gained great recognition at the conference. Three dozen seminars, workshops, and satellites – the most ever at an international conference – were focused on the impact HIV has on older adults and those who have lived long-term with the virus. This was a welcome change from previous conferences, which had only lightly addressed this issue. A substantial proportion of people with HIV are over 50, many of whom were among the first to take HIV treatment. They are now facing a host of medical problems, social isolation, stigma, and financial worries different from and greater than their HIV-negative peers.

After co-chairing a satellite session on HIV and aging sponsored by ACRIA and the U.K.’s Terrence Higgins Trust, Dr. Gottfried Hirnschall, Director of HIV/AIDS at the World Health

Organization, said, “There have always been older people with HIV, but what is new is the numbers – that will require new public health thinking compared to the past. Aging with HIV is not just a clinical challenge, it is...a social challenge, and it’s not just confined to one part of the world versus another.” There was also a satellite session organized by San Francisco AIDS Foundation, amfAR, and GMHC, featuring Dr. Amy Justice of Yale School of Medicine, an expert in comorbidities and aging.

Ultimately, medical advancement cannot cure gender inequity, pills fail to combat homophobia, and prevention innovations do not redistribute global wealth more equally. Social change that challenges these structures is the only answer. The 2012 International AIDS Conference will be held in the U.S. for the first time, possible only because the HIV travel and immigration ban has finally been lifted – a reminder that unrelenting advocacy can lead to much-needed reform. ■



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A CALL TO ACTION

The economic crisis has left AIDS service organizations with limited funding to support necessary programming and treatment. As a result, thousands of people who were promised AIDS treatment are currently being turned away from clinics and forced onto AIDS drug waiting lists. Several ideas are circulating about how to generate the billions of dollars that are needed to meet the needs of all people affected by HIV. One idea that is gaining support is called a Financial Transactions Tax (FTT).

Around the world, banks engage in all kinds of risky gambles and make tons of money. These gambles, known as financial transactions, are untaxed. An FTT would attach a 0.5-0.005% tax on multiple financial transactions, and could raise \$400 billion a year for job creation at home, climate change, and AIDS treatment and prevention for millions worldwide.

Sign the petition asking President Obama to create a Financial Transactions Tax at: www.healthgap.org.