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HIV Prevention Needs of Sex-Trading Injection Drug–Using Black Men Who Have Sex With Both Men and Women

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Abstract

This study examined HIV prevention program needs from the perspective of injection drug–using men who have sex with both men and women involved in sex trade. Focus groups were conducted involving an exploratory sample ($N = 105$) of men who met the following parameters: African American, injection drug–using behavior, men who have sex with men and women, and men who frequent parks and other areas for sex trade in Baltimore City and surrounding areas, aged between 18 and 40 years. Data suggest that an HIV prevention program is needed that includes a safe space specifically for the IDU-MSM/W sex-trade community, comprehensive services including treatment for substance abuse and job assistance, and methods for improving HIV-prevention, such as communication skills to increase condom use during sex. These findings provide a better understanding of a population for which little is known, and identifies HIV prevention program needs for the IDU-MSM/W community involved in sex trade.

Keywords

HIV prevention; sexuality; drug abuse; MSM/W; IDU; sex trade

As of 2007, a paucity of research exists that explores factors that may be useful for developing HIV prevention programs targeted toward sex-trading injection drug–using men who have sex with both men and women (IDU-MSM/W). For the purpose of this study, IDU-MSM/W refers to injection drug using men who have sex with both men and women, and who trade sex for drugs and/or money to purchase drugs. Many studies of HIV infection that included injection drug users (IDUs), since 1991, have focused on whether injection or sexual risk factors, or both, were associated with HIV seroconversion, and have not included sexually transmitted diseases (STDs; Bluthenthal, Kral, Erringer, & Edlin, 1999; Kral, Bluthenthal, Lorvick, & Gee, 2001; Longshore, Bluthenthal, & Stein, 2001). Others have examined risk factors among IDUs (Kral, Bluthenthal, Erringer, Lorvick, & Edlin, 1999; McFarland, Kellog, Dilley, & Katz, 1997; Dushay, Singer, Weeks, Rohena, & Gruber, 2001), and explored the relationship between self-reported sexual orientation and behavior among IDUs (Pathela et al., 2006; Washington et al., 2006).

At the end of 2005 (the most recent year for which statistics are available), an estimated 217,323 men who have sex with men (MSM) in the United States were living with AIDS, representing 67% of all men and 52% of all people living with AIDS (Centers for Disease Control [CDC], 2007). In the United States, MSM are still the group at greatest risk: 72% of

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people diagnosed with AIDS in the United States in 2002 were MSM. In addition, MSM make up the largest group of new HIV cases in men (45%), compared with IV drug users who are not MSM (11%), men who have sex with women (9%), and MSM who inject drugs (3%; CDC, 2007). Little is known about IDU-MSM/W involved in sex trade, a subpopulation of the MSM community. Additionally, evidence exists across numerous surveillance studies that despite HIV/STD prevention efforts, African American IDUs and MSM are still disproportionately affected and infected by HIV and other STDs (Celentano et al., 1991; CDC, 2000; de Luise, Blank, Brown, & Rubin, 2002; Strathdee et al., 1998). According to Pathela, Blank, Seil, and Schillinger (2006), results from a study conducted in New York City suggested that MSM who exclusively had sex with men and self-identified as heterosexual were more likely than their gay-identified counterparts to be an ethnic-minority, foreign-born, had only one sex partner within the last year, yet they were less likely to have been tested for HIV, and less likely to have used a condom during their last sexual encounter.

The impact of HIV/AIDS on African American IDU-MSM/W has been greater for some U.S. metropolitan cities (CDC, 2004). For example, African Americans represent 27.9% of the population in the state of Maryland (U.S. Census Bureau, 2001), yet African Americans represent 79.5% of reported AIDS cases in the state of Maryland (CDC, 2003a). A similar disparity exists for the largest city in the state of Maryland: African Americans represented 64.3% of the population in the city of Baltimore, but represented 88% of all reported AIDS cases in the city of Baltimore (CDC, 2003a). Furthermore, intravenous drug use has directly and indirectly accounted for more than one third (36%) of AIDS cases in the United States since the epidemic began (CDC, 2003a). However, in the state of Maryland, IDUs accounted for more than half (53%) of AIDS cases. IDU-associated AIDS cases continue to be an important public health issue. Reports on IDU-associated AIDS cases in the United States and Maryland among MSM in the United States, respectively, accounted for 13% and 3% (CDC, 2003a).

There have been significant medical diagnostic and management advances and improved treatment for people living with HIV since the epidemic began, particularly new antiretroviral agents. However, STDs and HIV infection among MSM/W and IDUs remain an important issue, particularly for the African American community.

Courtenay-Quirk, Wolitski, Hoff, and Parsons (2003) reported that HIV-seropositive African American MSM had higher interest in programs focusing on safer sex and serostatus disclosure as compared with their White counterparts. Since the beginning of the HIV epidemic, numerous quantitative and qualitative studies have examined MSM/W and the different sexual and drug-use patterns of these men compared with homosexual men (CDC, 2003b; Chu, Peterman, Doll, Buehler, & Curan, 1992; Crawford, Allison, Zamboni, & Soto, 2002; Peterson et al., 1992; Stokes, McKiman, Doll, & Burzette, 1996). However, these studies are limited in providing data concerning the HIV prevention needs specific to the IDU-MSM/W sex-tradecommunity. No study has explored specifically HIV prevention for the African American IDU-MSM/W sex-trade community (Johnson et al., 2005). The MSM/W who are IDU involved in sex trade pose a double concern when engaging in unprotected sex for both their male and female sex partners. Likewise, they put themselves at risk for sexually transmitted infections.

The IDU-MSM/W who are on the “down low” (men who do not self-identify as homosexual; however, secretly have sex with other men) may be ashamed and stigmatized for participating in sex with another male, and may subsequently participate in sexual encounters with other men in secret, despite having sex with women. Limited data exist for IDU-MSM/W involved in sex trade concerning HIV prevention needs for this

subpopulation. Despite previous research that suggests that MSM/W are more likely to practice safer sex than self-identified homosexual men (Peterson et al., 1992), these studies have provided minimal information about the subpopulation, IDU-MSM/W involved in sex trade. Hence, research is needed that explores prevention needs for IDU-MSM/W, a population involved in high-risk behaviors that are primary and secondary transmission categories (CDC AIDS Community Demonstration Projects Research Group, 1999; CDC, 2007). These men, who are at an increased risk of HIV exposure being IDUs involved in sex trade, require expanded and targeted HIV prevention programs that focus solely on their needs.

To this end, research is needed that explores the needs of the IDU-MSM/W, involved in sex-trade community, directly from the viewpoint of the participants. The purpose of this study was to explore the following questions: (a) What kinds of information and materials would be important to include in an HIV prevention program developed for IDU-MSM/W? (b)What issues do IDU-MSM/W perceive to be crucial that need to be addressed in an effort to motivate and increase safer sex practices among them and their male and female sex partners? (c) What is the feasibility of involving recovering IDU-MSM/W as peer educators to take messages to the street as a means of delivering an HIV education intervention to active IDU-MSM/W?

Method

Research Design

The study's methodology was reviewed and approved by the Morgan State University Institutional Review Board. Additionally, the sample ($n = 105$) was selected considering the following criteria: African American, IDU behavior, MSM/W, and men who frequent parks and other areas for sex trade in Baltimore City and surrounding areas, aged between 18 and 40 years.

Four trained research assistants (RAs) recruited IDU-MSM/W who were recruited in parks, and inner-city streets/ blocks (referred to as, "the beat," among locals) known for sex trade, and who consented to participate and attend a focus group session at a location convenient to the area in which they were recruited. The RAs were social work graduate students with at least 2 years experience working with the IDU-MSM or MSM/W population. As a safety precaution, RAs did recruitment in pairs. In addition, the RAs were trained to introduce the study and the criteria (i.e., an IDU-MSM/W who trades sex for drugs or money) that must be met to participant in the study. Then, RAs asked potential participants, "Are you, or do you know someone who may be, interested in participating in this study?" Those participants who met the criteria were given further information regarding focus group sessions (e.g., available dates, times, locations).

The participants who reported having used any nonprescription substances within 12 hours of attending the focus group were not allowed to participate. Qualitative methods were used to provide an in-depth examination of the perspective of IDU-MSM/W on topics and issues of interest for HIV prevention programs among IDU-MSM/W, factors that would motivate participants to attend HIV prevention/ education workshops, and the feasibility of recovering IDU-MSM/W serving as peer educators to encourage safer sex practices and drug prevention among IDU-MSM/W. The perspective of IDU-MSM/W would likely produce useful information for the purpose of developing an HIV prevention program that involves recovering IDU-MSM/W as peer educators in an effort to increase the attendance of practicing IDU-MSM/W at HIV prevention programs, increase safer sex practices, and condom use between IDU-MSM/W and their male and female sexual partners.

Data-Collection Method

This study integrated two major components. The first was a self-report survey administered to IDU-MSM/W concerning race, age, education, marital status, drug using behavior, and HIV status. Second, 11 focus groups were conducted involving IDU-MSM/W.

Focus groups were selected because of their usefulness as a powerful means to evaluate services and/or test new ideas, and because focus groups are an excellent way of involving community members in developing an intervention (Dudley, 2005). The focus groups were conducted in settings comfortable for the participants (community centers near the areas most frequented by IDU-MSM/W). All participants were involved in the discussions. Because the sessions were a one-time occurrence, a few brief ground rules were enforced to sustain participation: respect others when they are talking; speak from your own experience instead of generalizing ("I" instead of "they," "we," and "you"); do not be afraid to respectfully challenge one another by asking questions, but refrain from personal attacks—focus on ideas; participate to the fullest of your ability—community growth depends on the inclusion of every individual voice; instead of invalidating someone else's story with your own spin on his experience, share your own story and experience; the goal is not to agree—it is about hearing and exploring divergent perspectives; and be conscious of body language and nonverbal responses—they can be as disrespectful as words.

The focus group included approximately 8 to 10 participants per group. Focus group sessions were between 60 and 95 minutes (average time was 80 minutes). Research assistants were trained by the principal investigator to moderate the focus group sessions. The moderator used a semistructured script that included the following: (a) What are some needs for improving HIV prevention programs that may be useful for you, (b) What are some services you think would be useful in an HIV prevention program, (c) What are some reasons you may not have used a condom when involved in trading sex for drugs or money, and (d) What are your thoughts about receiving HIV education from MSM/W who have a past history of trading sex for drugs or money? The sessions were recorded using an audiorecorder. Participants were provided with refreshments. In general, the agenda included welcome, review of goal of the meeting, review of ground rules, survey administration, discussion, questions and answers, and wrap up.

Coding and Analysis

Focus group interviews were recorded and transcribed by a Washington, DC based professional transcription service. Two trained qualitative researchers coded the data by repeatedly reviewing the participants' recorded responses (i.e., transcripts), and several categories were identified. Central to the procedures of qualitative research are the selection of a core category and relating all major categories both to it and to each other (Strauss & Corbin, 1998; Washington, 2002). After identifying major categories, process notes were developed, participants' responses were compared using Cohen's kappa, and central themes relayed through the participants' responses were identified. Cohen's kappa revealed a significant measure of agreement ($\kappa = .781$, $p \leq .01$) for the degree to which the two reviewers' codes were applied to the data. The goal was to allow patterns and common issues shared among the participants concerning HIV prevention program needs, motivation to increase condom usage, and the feasibility of including recovering IDU-MSM/W as peer educators to deliver HIV prevention messages to active IDU-MSM/W. This method of "emerging" analysis is referred to as the naturalistic inquiry or constructivist paradigm.

Results

As shown in Table 1, the self-report questionnaire revealed that the participants were 90% African American, 10% African American of Latino decent, and the mean age was 31.6 years (standard deviation = 8). Fifty-eight percent of participants had less than a high-school diploma, whereas 42% had a high school diploma, and 6% attended college. The majority of the participants were single (84%). Likewise, the majority (59%) self-reported a known, HIV seropositive status.

The following themes emerged from an analysis of the qualitative data: Provide a safe space for IDU-MSM/W to go for HIV prevention, HIV prevention programs needed that provide job assistance and substance abuse treatment, and access to and communication about condom use are reasons IDU-MSM/W reported not using condoms.

A Safe Space

Participants suggested that an HIV prevention program that focuses solely on the needs of the IDU-MSM/W population is much needed. The responses revealed that many of the participants would prefer to attend a prevention program that provided services and a safe space for IDU-MSM/W. One participant stated,

> Nobody knows that I mess around [with men]. I go to the park on days I don't have to watch my son. I can make a few dollars in no time. The guys out there like to [give oral sex]. I always think I can't get HIV from a dude [the giver]. I have wanted to go to learn about this … no place I know of that I would feel like I can ask questions about HIV. You know, like a place with straight [heterosexual] guys who do this [sex trade] for a few dollars to get high, but don't like men like that.

Another participant stated,

> I been to the doctors 'cause I had stinging from my man-man [penis] one time … the nurse asked me questions about who I have sex with … I only told about my girlfriend, wasn't going to talk about sex with no dudes, I wanted to ask about HIV stuff, but I didn't because she [the nurse] might have thought I was gay.

Moreover, another participant stated, "I wished there was some private spot [place] to get information about HIV where people don't have to know what I do and who I have sex with."

Majority of the responses suggested that IDU-MSM/W sexual practices, drug-using behavior, and HIV risk are not mutually exclusive issues. Rather, responses suggested that prevention programs are needed that address multiple issues, such as job assistance, substance abuse treatment, and access to condoms.

Job Assistance

A participant stated,

> What I need is some help to get myself together. We all need help. I know I wouldn't be down there trying to sell [sex] if I had my own money to get high. The doctors been saying that I got bipolar and got post-traumatic stress disorder. I ain't got [nothing] but a hard time on these streets. So, what I need is some help! If they have a program with other types of stuff, like some help getting a job, and some money … I'd go right now.

Another participant stated,

> I now wished I had finished high school, I think I could have done more with my life … hard to get employment. I go down there to sell [sex] for money and then I get high [inject drugs].

Substance Abuse Treatment and Job Assistance

A participant stated,

> Some people look at us and think that we just lazy … I know I need help, but really no place to go with no money. I've been doing this since I was 15 years old. I never graduated from school, but I do work sometimes doing odd ended jobs for people around the neighborhood. I need a real job and some help getting off this.

Another participant, an IDU-MSM/W who self-identified himself as heterosexual, stated,

> I believe that for some of us [IDU-MSM/W], we [are] not gay and we have girlfriends but just don't got money for drugs—so we have sex with another dude to get money. I know for me I like to have sex with my girl—she don't want to use condoms—and me neither. So, we don't use them. My girl don't know I play [have sexual encounters] with dudes. She knows I use [drugs] but never ask where I get it [drugs] from. If I would never use drugs I would not sell myself. But … [silence].

Condom Communication and Access

Participants discussed issues that are crucial for motivating and increasing safer sex practices amongst IDU-MSM/W and their male and female sex partners. The themes that emerged regarding condom use were how to talk to one's sexual partner about the use of condoms, and access to free condoms in areas where sex trade occurs.

Of these emerging themes, the most frequently occurring topic discussed by the respondents was that it is difficult to talk about condom use with a stranger with whom one is about to have sex with, particularly when sex trade is involved. Furthermore, the responses suggest that condom use communication is an issue. A participant, a 26-year-old IDU-MSM/W, stated,

> It's difficult to talk about using a condom—I generally try to just get or give a blow [oral sex] for a few coins [money]. It [using a condom] rarely comes up—I won't know what to say—to ask a dude to use a condom. They don't like to give oral on the plastic, they are paying to give oral on the real thing.

Another participant reflected on his sexual encounters:

> I don't ask dudes if they want it bare—I just let them suck until I am [erect], then I just [have sex with] them bare [without a condom]. I can keep an erection longer if I don't use a condom. Guys have asked me to use a condom—I tell them that I am safe and it's okay since I am safe and I can't get anything from them because I am the top. Most of the dudes just want it [sex], so they just let me do it bare. Most of the time me or them don't have a condom anyways.

Feasibility of IDU-MSM/W Peer Educators

Participants shared their perspectives concerning the feasibility of involving recovering IDU-MSM/Ws as peer educators to take messages to the street as a means of delivering an HIV education intervention to active IDU-MSM/W. A few responses indicated that a peer educator would be welcomed in their community. However, most of the responses indicated that it may not be feasible. The participants stated that a peer educator would know the venues where IDU-MSM/W frequent and would be less intimidated by the environment. Nevertheless, the responses suggest that being an IDU-MSM/W often leads to depression

and loss of self-confidence. Many of the responses revealed that IDU-MSM/W need more than just a peer educator, but also housing assistance, drug rehabilitation, mental health services, job skills, and jobs. Overall, the responses revealed that peer educators would be welcomed into the IDU-MSM/W community, but may not be the person who can reach the community in an effort to increase safer sex practices. A participant stated,

> Getting information from someone who has been sexually active with both men and women, and who has been involved with sex trade as a means of gaining drugs or money for drugs, he would know how to talk to us. But I don't think I would listen to a dude that knows where I'm coming from, and know the feelings we have about being with strangers. It would be embarrassing if this dude is now straight. He would know how tough it is trying to talk about condoms and HIV with dudes and my girl before sex, he might judge me since he clean and shit.

Another participant stated,

> I don't know—I just think a dude whose been messing around like that, doing it for money [and drugs] could not educate me better cause he [is] probably still doing the same thing. Ain't nothing wrong with these dudes, I just think a guy who like girls and let dudes suck on them or penetrate them for drugs, they might lie or say anything. People always think of us [IDU-MSM/W] as drugged up all the time, but most time we [are] not on drugs in daytime when trying to get sexed. We do sex stuff in parks in the daytime to get money to get high at night. It's a small world, so we probably would know the guy and got high with the guys who might be trying to train us.

Discussion

The data from this exploratory study were limited to the IDU-MSM/W sex-trade community in the Baltimore–Washington corridor, nonetheless, this is a first step to understanding a complex, hard-to-reach, subpopulation of the MSM/W community, and may be useful for future studies exploring HIV prevention program needs for the IDU-MSM/W sex-trade community at large. Focus groups as the method for collecting data does not allow for an exploration of extraneous variables (e.g., frequency of drug use). Notwithstanding these limitations, the data offers a snapshot of the HIV prevention needs of IDU-MSM/W involved in sex trade.

The major findings of this study were threefold. First, the data suggest that the IDU-MSM/W sex-trade community needs an HIV prevention program that provides a safe space (i.e., a place where IDU-MSM/W can get information specific to this population). A universal prevention message for all men is that proper use of a latex condom can reduce HIV risk. However, IDU-MSM/W involved in sex trade need messages that include the importance of properly using condoms to reduce HIV risk with sex-clients, and male and female sex partners, including when the IDU-MSM/W, client, or sex partner's HIV serostatus is known or unknown. Additionally, literature for this population should include HIV risk information regarding sex while using drugs, and needle sharing.

Second, the data suggest that IDU-MSM/W need prevention programs that include comprehensive services. Many of the IDU-MSM/W involved in sex trade need programs that address not only safer sex practices, but also the multiple issues that may be a barrier to HIV prevention, such as job assistance and drug treatment. For example, many of the IDU-MSM/W report having unprotected sex with other men for money to purchase drugs, and few report later having sex with their female counterparts without a condom; thus, this is a high risk for HIV transmission.

Third, the data suggest that communication skills/ prompts for negotiating safer sex practices with clients are important issues for IDU-MSM/W. Many of the men state that they are less-likely to use a condom with a sex-client unless the client requests it; the craving for the drug [or the need for the money to purchase the drug] is more dominant. Considering these data, HIV prevention programs for the IDU-MSM/W sex-trade community should address the multiple issues these men face, such as job assistance, substance abuse treatment, and greater access to condoms.

These findings provide a better understanding of IDU-MSM/W involved in trading sex for drugs, a population for which little is known. Moreover, the findings suggest that more education is needed that focuses specifically on high-risk behavior and HIV prevention for the IDU-MSM/W sex-trade community. The IDU-MSM/W sex-trade community need messages that are specific to their sexual practices and behaviors (e.g., if you are a man topping [inserting a penis in a man's anus] another man, you should wear a condom—topping without proper use of a latex condom puts you and your sex partner at high risk for HIV infection).

Another finding was that most IDU-MSM/Ws were not high on drugs during their daytime sex-trade activities. Contrary to what we would have hypothesized, IDU-MSM/W in this study consistently reported that they are active during the daytime hours and not under the influence of drugs. They are seeking sex trade to get money to use drugs in the late evening and/or nighttime.

Communication for most people is difficult (Troth, 2000), particularly when it is talking about HIV, safer sex, and condom use. Hence, developing prompts that help people start a conversation about HIV and safer sex may serve useful for IDU-MSM/W and others. Similarly, developing programs that offer comprehensive services (i.e., drug treatment, mental health counseling, job skills training, job referral services) may be useful for IDU-MSM/W in an effort to address not only safer sex practices, but to effect change on the core concerns (e.g., drug abuse, depression, unemployment, self-esteem issues) related to their sex-trading behavior.

Further research is needed that examines IDU-MSM/ Ws sexual practices, and explores HIV knowledge, awareness of HIV stigma, and HIV prevention communication knowledge and skills in an effort to develop an effective HIV prevention program. Additionally, research is needed to explore whether a relationship exists between HIV prevention knowledge/ awareness, HIV stigma, safer sex communication, and safer sex practices, and the effectiveness of involving MSM/W who are recovering injection drug users in an HIV prevention program developed specifically for the IDU-MSM/W sex-trade community.

The results will provide a better understanding of a population for which little is known. Moreover, the results will identify HIV prevention program needs of the IDU-MSM/W community and these data may be used to develop HIV prevention programs that focus on the needs of the IDU-MSM/W community.

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Table 1

Demographic Variables for Study Participants ($N = 105$)

Variable	Percentage (*n*)	Mean (Standard Deviation)
Race		
African American (not of Hispanic origin)	90 (94)	
African American (Hispanic origin)	10 (11)	
Education		
Less than high school	58 (61)	
High school diploma	36 (38)	
College attendance/degree	06 (06)	
Marital status		
Single	84 (88)	
Domestic partner	03 (03)	
Married	13 (14)	
HIV status		
HIV seropositive known status	27 (28)	
HIV seronegative known status	14 (15)	
HIV status unknown	59 (62)	
Injection drug use[a]		
Yes	100 (105)	
No		
Traded sex for drugs or money[a]		
Yes	100 (105)	
No		
Age (years)		31.6 (8)

[a]All participants reported injection drug–using behavior and involvement in sex trade.