

## **SECTION 6: PEOPLE AT INCREASED RISK THROUGH HETEROSEXUAL TRANSMISSION**

Related information elsewhere in the Comprehensive Plan:

*Appendix 1: Epidemiological Profile*

*Section 8: Priority Interventions*

### **Defining the Population**

The Vermont Community Planning Group (CPG) has chosen to define and prioritize at-risk populations first and foremost by behavioral categories. These categories are based on the behaviors known to transmit HIV from an infected partner to another person: injection drug use (specifically, needle sharing) and sexual interaction (specifically, those sexual behaviors that may allow entry of virus into the bloodstream – oral, anal and vaginal sex).

The category “people at increased risk for HIV infection or transmission through heterosexual contact” does not exclusively refer to people who self-identify as heterosexual. The behaviors that put people at risk exist independently of sexual identity. Likewise, the recommendations within this section, at the most basic level, attempt to capture a behavioral category, not a demographic one.

At the same time, however, HIV prevention work is often appropriately predicated upon reaching people within defined communities and on targeting groups as specifically as possible. The Vermont CPG has a working definition for the category of “People at increased risk through heterosexual contact” and recommends that highest funding priority for HIV prevention programs targeting this group be given to programs addressing the prevention needs of the following:

Men, Women and Youth\* who:

- are partners of people who are HIV+
- are partners of people who are injection drug users
- are partners of men who have sex with men
- are people of color  
(including people who are Black/African American, Hispanic/Latino/Latina, Asian/Pacific Islander, American Indian/Alaska Native, and other people of color);
- report sexually transmitted infections (STIs) and/or unwanted pregnancy
- are incarcerated/juvenile offenders
- are homeless

Women and Youth\* who:

- are dealing with, or have a history of violence or abuse  
(including domestic violence, rape, emotional or physical abuse);
- seek treatment for substance abuse;
- live at or below the poverty line;
- are dealing with mental illness;
- are sex workers and/or trade sex for resources.

Youth\* who are:

- runaway, “throwaway,” emancipated, abandoned, medically indigent, in foster or SRS care, out of school, and/or otherwise disconnected from traditional systems
- developmentally disabled

\*For the purposes of this document, Youth are defined as ages 13-24.

**Note on Youth:**

*Where youth at increased risk are noted, the Vermont Community Planning Group recommends that Department of Health prevention funding be prioritized for programs that take place in non-school settings only. In-school HIV/AIDS education and prevention receives dedicated funds through the Vermont Department of Education.*

**Special Issue: Women Who Have Sex With Women**

Women who have sex with women is a category often left aside when determining HIV prevention priorities. Part of this may well be due to epidemiological evidence; women who have sex with women represent a significantly smaller portion of U.S. AIDS cases than do people defined by other behavioral categories. However, it is also quite possible that women who have sex with women are sometimes forgotten in the prevention planning process, or left out for no better reason than a lack of an appropriate “place” within defined high-priority categories.

Whatever the reason, it remains true that women who have sex with women are indeed at risk for HIV infection and should not remain invisible in this process. In addition to female/female sex, women who have sex with women may also be at risk as sexual partners of users of injection drugs; of men who have sex with men; or of heterosexual males at increased risk.

Programs targeting women at increased risk will inevitably be in a position to deliver prevention messages to lesbians, bisexual women, and other women who have sex with women. The Vermont CPG feels that it is appropriate, if somewhat incongruous, to recommend within this section that programs targeting women at increased risk be mindful and inclusive of women who have sex with women, when planning and delivering print materials, prevention messages, and educational efforts, such as skills building and negotiation for safer sex.

### **Women at Increased Risk: Related Issues**

In the minds of much of the American and Vermont public, HIV remains an epidemic of men, especially gay and drug-using men. As the epidemic has grown and expanded to affect new populations, original public perceptions of AIDS have been slow to change.

Heterosexual sex with a man identified as infected with or at risk for HIV and sharing of injection drug equipment together account for nearly 83% of reported AIDS diagnoses among women in Vermont. The women at most imminent risk for HIV in Vermont are those who share needles themselves or those who are the sexual partners of men with HIV, especially men who inject drugs.

While needle-sharing by women themselves and the risk behaviors of their partners are the defining characteristics of women's HIV risk, there are other factors that increase women's vulnerability to HIV infection. These factors do not themselves constitute HIV risk, but they influence the environment in which transmission might take place and should be understood and factored into the development and implementation of HIV prevention programs for women at risk.

#### **Sexually Transmitted Infections (STIs)**

Infection with sexually transmitted diseases may enhance women's vulnerability to HIV infection. Many of these infections may damage the integrity of mucosal tissue in a woman's vagina, potentially increasing risk of HIV transmission if sexually exposed to the virus.

Besides HIV, reportable sexually transmitted infections in Vermont include chlamydia, gonorrhea, hepatitis (all strains), and syphilis, with chlamydia and gonorrhea by far the most commonly reported.

### Power/Gender-based Dynamics

Power imbalances in relationships contribute to women's risk for HIV. The challenge of expecting a male partner to wear a condom is made more difficult if a woman has reason to fear physical violence or emotional battering in her relationship. A woman who is economically dependent on her partner may feel powerless to insist on changes in sexual behaviors for fear of loss of income, housing, and other daily necessities, fears that may be enhanced if children are also affected by the potential loss of support.

At the extreme of powerlessness, sexually abused and sexually assaulted women have no control over their potential HIV risk, and are vulnerable to HIV if their abuse or assailant is HIV infected.

### Trading Sex for Resources

While there is a minimal commercial sex industry in Vermont, there is no question that this is a growing issue here. Reports of sex for money, sex for drugs, or survival sex for shelter and food (especially among young runaways) are on the rise. In July of 2004, many Vermonters were surprised by the exposure of a human trafficking operation, which brought Asian women to Vermont, where they were held against their will for sexual trade.

Women in these situations are even less likely than other women to be able to insist on protection in sexual relations, and therefore are placed in a vulnerable position for HIV transmission.

### Racism

Racism also increases vulnerability for women of color, as the double stigma of being female and of color enhances powerlessness. Racism and sexism conspire to reinforce stereotypes of women of color and their sexual roles that contribute directly to an environment of increased risk. Women of color may also be at greater risk because of the disproportionate prevalence of HIV in communities of color, increasing the statistical likelihood that they may come in contact with the virus through a sexual partner.

### Substance Use

Addictions to a variety of substances may increase women's vulnerability to HIV infection. While not universally well-documented to have a direct effect on HIV risk-taking behaviors, the widely understood disinhibiting and judgment-impairing effects of many intoxicating substances raise serious concerns for HIV prevention.

### Corrections

Women who are involved in the criminal justice system may be at particular risk as there is a great correlation with substance use and entry into the correctional system. Women in custody or on probation may be in extremely vulnerable economic and social

positions, and this lack of power may particularly enhance their risk in sexual relationships. Within correction facilities, access to clean injection equipment and latex barriers for sex is absent or severely restricted, further increasing possible HIV risk.

### Disenfranchised Populations

In addition to these factors that increase women's vulnerability to HIV infection, some groups of women are systematically disenfranchised and not necessarily reached by general HIV education and prevention efforts. Women in these categories who are also in high-risk situations may be at increased risk because they lack adequate information or skills to protect themselves.

Women who may experience this systematic disenfranchisement include: women living in poverty; women with limited literacy; very young women and older women; refugees and recent immigrants; women for whom English is not their first language; lesbians and bisexual women; women who are Deaf or hard of hearing; women who are migrant, homeless, or incarcerated; women who have developmental disabilities; and women with psychiatric disabilities. HIV prevention programs and agencies serving women should be particularly aware of the barriers to reaching these groups, including the possible gaps in HIV awareness and knowledge that may exist.

### Perceptions of Risk

Finally, it must be remembered that larger numbers of women may have some risk for HIV infection without belonging to any of the particular identifiable risk populations. Sexually active women who have sex with men (particularly young women, college students and high school students) may not be statistically likely to encounter a sexual partner with HIV, but some number of them may. Efforts to target women at imminent risk should not give the message that other women have no reason to be concerned about protection. General information campaigns should help support all HIV-negative women in maintaining their status through the adoption and maintenance of safer sex practices or deferral of sexual intercourse.

## **Youth at Increased Risk: Related Issues**

*NOTE: Where youth at increased risk are noted, the Vermont Community Planning Group recommends that Department of Health prevention funding be prioritized for programs that take place in non-school settings only. In-school HIV/AIDS education and prevention receives dedicated funds through the Vermont Department of Education.*

No single program will reach or meet the needs of all at-risk youth. A variety of approaches must be developed to access different pockets of youth at risk in the community. One study notes, "Social and cultural factors, such as religion, values,

gender roles, economic conditions and individual differences must be considered in designing effective programs. Because of the differences in the culture of various adolescent groups, an effective educational program for one group may not be effective for another group.” (Yarber and Parillo, “Adolescents and Sexually Transmitted Diseases,” *Journal of School Health*, 62 [7], 1992.)

Some youth, because of their own risk-taking practices and the amount of virus present among their pool of potential sexual or needle-sharing partners, are at much more imminent risk than others. While all youth are entitled to quality HIV prevention services, HIV prevention efforts should particularly focus on the needs of youth facing an immediate and significant risk of infection. This concern particularly applies to youth from communities with a well-documented over-representation in reported AIDS data.

### Abstinence/Postponement and the Continuum of Risk Behavior

More than any other targeted population, we cannot assume that young people are or are not sexually active, or active substance users. Young people have a variety of levels of experience with these activities, and HIV prevention program design must reflect that fact.

It is important to recognize and acknowledge the choices young people make, whether they are choosing to abstain from or postpone sex or drug use; or if they are actively engaging in these behaviors. It is also important to allow for the fact that young people who are abstinent will likely choose not to remain so at some point in their lives; and some who are drug users and/or sexually active may choose to cease those behaviors and become abstinent. All of these points on the continuum of drug use and sexual activity are part of a comprehensive approach to HIV prevention. \_

### GLBTQ Youth

It is important for programs targeting youth at increased risk to take into account the HIV prevention issues specific to young people who are questioning their sexuality or who already self-identify as gay, lesbian, bisexual or transgendered. The recommendations in this sub-section, it should be noted, come under the umbrella of “people at increased risk for heterosexual transmission.” While this is in some ways an incongruity, it also is an attempt to address the artificiality of certain kinds of categorical line-drawing. Many people do not exist or self-identify within neatly drawn definitions.

An increasing number of GLBT and questioning youth have access to groups and activities focused on their needs. School-based gay-straight alliances, for example, are fairly common as compared to several years ago. However, it is also true that many of these youth are more likely to be involved with more general, out-of-school, youth-targeted programming. Consequently, it is important that such programming, where it is the channel for HIV prevention messages, be as inclusive as possible.

For many adolescents (and others coming out), experimentation and participation in sexual activity is frequently an important and powerful stage of sexual orientation integration. The presence of a significant rate of HIV in the population of men who have sex with men means these young people face an increased chance of contact with an infected partner early in their sexual activity. Information, skills, and support to reduce the risk during this experimentation period are especially important.

Gay, lesbian, bisexual, and transgendered, youth have been largely overlooked in many school-based HIV programs and in public education efforts. Our society's fear of acknowledging young people's sexuality, coupled with the pervasive homophobia in our society, makes such school and public advertising efforts fraught with controversy, and therefore rarely implemented. This invisibility only adds to the isolation of these youth, and makes many of the most widely available prevention efforts barely relevant or accessible to the population most in need.

HIV education and prevention efforts must specifically include representation of young people of all sexual orientations in their materials and curricula. These efforts should directly address the specific risk situations and prevention needs of gay, lesbian, bisexual, transgendered, and questioning youth. Such efforts should also work to create safer space for all youth by encouraging wider acceptance of young gay, lesbian, bisexual, transgendered, and questioning youth. As with other programs, GLBTQ youth must be integrally involved in the design and delivery of these programs to enhance the chances of success.

## **Men at Increased Risk: Related Issues**

In a 2000 report for World AIDS Day ("AIDS; All Men – Make A Difference"), the American Association for World Health suggested a framework for male-focused prevention:

Men should be encouraged to:

- Accept greater responsibilities for being providers of care and support for their families
- Take a greater role in helping end the spread of HIV
- Change harmful sexual stereotypes (of male dominance, women's roles, homophobia, etc.)
- Change the way they view risk taking, sexuality and violence
- Address their sexuality honestly and responsibly
- Be a positive role model for boys
- End their silence on issues of sexuality
- Support one another

These recommendations touch on risk for infection among men, as well as their role in prevention for women. Both of these are key factors when addressing HIV with this population.

Addressing the sexual behaviors of heterosexual women without men does not take into account gender and power imbalances and does not encourage men to take responsibility for their own health and the health of their families. Therefore, heterosexual men, in and of themselves, should be targeted for HIV prevention.

While heterosexually transmitted infection among men who have sex with women represents a small portion of the AIDS epidemic, it is important to target the need for prevention among those men who are in known high risk situations and/or engaging in specific behaviors that put both themselves and their female partners at risk.\_

### **Risk Behaviors**

HIV risk practices among men who have sex with women can include the following:

- Sexual intercourse while under the influence of drugs/alcohol
- Unprotected anal intercourse (this can include men who have sex with both men and women; men who have sex with women)
- Unprotected vaginal intercourse and unprotected oral sex
- Sex with multiple partners and sex with a partner who has multiple partners
- Sex with partners of positive/unknown HIV status
- Injection drug use *(The rise in infections from injection drug users who are heterosexual men has led to the rise among heterosexual women. This trend, in turn, puts other heterosexual men at risk because they may have sex with these HIV+ women who are users of injection drugs, or sexual partners of people who use injection drugs.)*

### **Special consideration: Men who have Sex with Men**

There is some overlap between this population and the population of men who have sex with men. Common understandings of sexual orientation or identity do not always mesh with behaviors. Some men who identify as heterosexual also have sex with men. This section is concerned with male-female (heterosexual) transmission (not to be considered synonymous with heterosexual identity or orientation). The HIV prevention needs of men who self-identify as heterosexual, but also have sex with men, are addressed in a separate section.

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### **Other considerations for programs targeting men who have sex with women:**

The following factors should be considered when creating HIV prevention programs for men who have sex with women. While each of them may not apply to *all* men at increased risk, this list represents some potential barriers to HIV prevention that providers should be prepared to address.

#### “Traditional” Roles

While the historically “traditional” role of heterosexual men as providers, husbands and fathers is in some ways outdated, it is also the reality for many people and cultures today. While HIV prevention interventions should not seek to promote gender stereotypes, it is important to meet men where they are. Awareness and prevention campaigns may very well find a higher response rate among some men if those campaigns focus not just on personal risk and health, but on the perceived larger needs of the family unit.

#### Sexual violence/Power dynamics

Men are overwhelmingly the most common perpetrators of sexual violence. This is true for anonymous assault, in cases of casual sex, and in ongoing relationships.

Men are also more often in greater control regarding condom usage with their female partners. While some female-controlled protective options are available, the male condom is still the most common and feasible preventive method for anal or vaginal intercourse.

Men should be encouraged to understand issues of power and violence, to identify the roots of these power-based dynamics and, where applicable, to deal with triggers to violence and other risk behaviors.

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#### Sexually Transmitted Infections

While there is not necessarily a “community” of heterosexual men with sexually transmitted infections, this is a population with a clear demonstration of risk behavior. Health care providers and support groups for people with specific conditions (such as herpes or hepatitis) should become active players in disseminating HIV information and prevention education.

#### HIV stigma/awareness

Many men, particularly men who identify as heterosexual and who are not injection drug users, still see HIV as a “gay” disease. Previously mentioned recommendations in this document address the value of increasing awareness around risk. Another strategy that

has shown some promise with this population is the incorporation of HIV education into a general health-focused context. Studies of young heterosexual men have shown a higher level of receptivity to sexual health models as compared to disease prevention models. By teaching men to take care of themselves and their partners, we are inherently addressing prevention -- of pregnancy and of sexually transmitted infections including HIV.

### Peers

Part of the “gay disease” stigma surrounding HIV for heterosexually-identified men is the lack of peer education for this group. As with any population, the involvement of peers is a key to effective programming. Wherever possible, men who have sex with women should be consulted in program design, and recruited and trained to deliver interventions to other men within this population.

**END OF SECTION 6:**  
**PEOPLE AT INCREASED RISK THROUGH HETEROSEXUAL TRANSMISSION**