FACTORS RELATED TO HIV INFECTION AMONG MEN WHO HAVE SEX WITH MEN IN NORTHERN CALIFORNIA

William F. Morefield
B.A., California State University, Sacramento, 2001

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FACTORS RELATED TO HIV INFECTION AMONG MEN WHO HAVE SEX WITH MEN IN NORTHERN CALIFORNIA

A Project

By

William F. Morefield

Approved by:

_______________________________________, Committee Chair
Santos Torres, Jr., Ed.D.

Date: ___________________________
Student: William F. Morefield

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Division of Social Work
Abstract

of

FACTORS RELATED TO HIV INFECTION AMONG MEN WHO HAVE SEX WITH MEN IN NORTHERN CALIFORNIA

by

William F. Morefield

This project was undertaken to explore and understand why men who have sex with men continue to be the largest total population of total HIV/AIDS infections and the highest rate of annual new infections. Men who have sex with men include men who self-identify as gay, bisexual, or as straight, but who engage in sex with other men, while keeping this practice a secretive or private behavior. The goal of this research was to discover underlying factors that cause this population to have the highest rate of new annual infections. Despite the knowledge of how HIV is spread, infections continue to occur among this population, and at increased rates among minority and young men. This researcher conducted interviews with professionals who work directly with patients living with HIV/AIDS. Findings included that HIV/AIDS is viewed as a chronic illness, not a fatal disease and that some men disregard safer-sex practices for reasons including a sense of inevitability of infection and because they love their infected partner.

____________________________________, Committee Chair
Santos Torres, Jr., Ed.D.

____________________________________
Date

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PREFACE

This author recognizes that his status as a person living with HIV affected the scope of this project and its specific limitation to the population of men who become infected through sexual contact with other men. This specific population was selected as this writer is a member of this population and this was how this writer was infected.

HIV does not discriminate based on gender, age, sexual orientation, sexual practice, or cultural heritage. HIV is a human pandemic, not a gay disease.
ACKNOWLEDGMENTS

To my family for your support and unconditional love through the years: My father Gary and my sister Tina and my aunt Sharon; Rudy, Kayla, Richard and Daniel, the best niece and nephews an uncle could ask for. Aunt Diane, for never giving up and tracking me down after all those years. My cousins and their spouses.

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Alice Lewis and Beth Tkacik, supervisors and friends, who convinced me to return to school and helped me through personal and professional issues, I would not be here today without your love and support. Donelle Anderson, for teaching me more about boundaries, self-respect and how to avoid negativity.

Last but not least, my pets: Bandit, Bonkers and Titan for keeping me sane.
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Chapter 1

THE PROBLEM

Introduction

This writer grew up during the start of the AIDS epidemic and witnessed firsthand the conflict that it created among families, communities, and a nation. Since this writer identified as gay at a very early age, he saw this epidemic from a personal view. In its early years, AIDS was seen as a gay disease and was viewed by some as a punishment against gay men.

AIDS was seen as a gay disease because it emerged first in cities where there were larger populations of gay men such as Los Angeles, San Francisco, and New York City. Outside of these areas, very little coverage published in newspapers or aired on television news. Most early coverage was limited to gay media such as the *Bay Area Reporter* in San Francisco, small reports in newspapers and scientific journals or in reports from the Centers for Disease Control.

The other primary factor that led to the lack of coverage of the growing epidemic was that other than gay men, the other population that was being heavily affected by this disease were intravenous drug users. Both of these groups were deemed as less than “Respectable” by the federal government and the majority of Americans. As a result, through the early years of the epidemic, it was believed that the emerging epidemic would remain in these affected groups (Fauci, 1999).

It took several years before the federal government under President Ronald Reagan began to view the growing epidemic as a serious national threat. The media,
when it did cover the disease, used early accepted terms of the time such as “gay cancer”
when referring to symptoms of the disease.

Popular entertainment did not touch the subject, even though many of the men
who were dying were contributors to the industry. The first major film to cover the
subject, *An Early Frost*, aired on NBC on November 11, 1985. The film starred Aiden
Quinn as a gay man who returns to his family to reveal that he is gay and living with
AIDS. The movie was the highest rated program the night it aired and won four Emmy
Awards.

This writer has witnessed firsthand the pain of living with this disease, the
mistreatment from an intolerant community and the rapid painful death it caused.
Through the first 30 years of this disease, medical science has made advances in the
treatment of the disease. In the early years, patients survived as little as a few months to
a few years. Now, with medications that keep the virus under control, patients thrive and
survive for years and decades; what used to be a death sentence, is now viewed by some
as a chronic condition.

This writer has chosen to research the topic of why men who have sex with men
are again the highest population of newly infected individuals every year. It is the goal of
this project to examine the different factors that relate to HIV infections among this
population so that it might be possible to better address these issues.

This writer holds a personal interest in this subject because he has been living
with this disease for over three years. The ultimate goal of this project is to better
understand the reasons behind the constant level of HIV infection among this population
so as to better advocate for those living with the condition; educate those who are not infected and help them to keep from becoming infected, and eliminate the disease within this writer’s lifetime.

**Background of the Problem**

In the later part of the 1970s, doctors in Denmark, Belgium and Germany began to see patients who were fighting immune system destroying infections that were killing the patients quicker than the doctors could treat the numerous infections (Shilts, 1987). These early cases had little in common with each other: there were gay men, women and children from Africa, a Danish physician working in Zaire, and a Portuguese taxicab driver who had spent time serving in the navy in Angola. Common amongst all the cases were that usually harmless infections, such as Pneumocystis Carinii, were not harmless to these patients. These small infections were destroying the patients from the inside and leading to their rapid and painful deaths. Two other links soon emerged. First, several of the early deaths were among people who had spent time in Sub-Saharan Africa. Secondly, among the gay men, there was a person in common: Gaetan Dugas who was an international flight attendant who has become known as Patient Zero (Shilts, 1987).

Between October 1980 and May 1981, five separate cases of Pneumocystis Carinii pneumonia, or PCP, were diagnosed in Los Angeles, California (Centers for Disease Control and Prevention, 1981). All five cases were men who identified as gay and by May, two of them had died. That these five men, who prior to these hospitalizations had all been healthy, were diagnosed with an infection that was previously found predominantly in immunosuppressed patients led the CDC to an initial
belief that these infections were tied to the patients, “Homosexual lifestyle or disease acquired through sexual contact.”

As a result of these early United States cases only being found in gay men, scientists coined the title Gay-Related Immune-Deficiency diseases, or GRID (Shilts, 1987), to refer to this newly emerging epidemic beginning its spread through the country and the world. With the current presidential administration of Ronald Reagan, a conservative Republican, the government agencies that should have been heavily investigating this emerging scourge, were largely ignoring it. The CDC was being overwhelmed with new cases of Kaposi’s sarcoma and other HIV related infections, and there was insufficient funding to adequately research these cases. Dr. Edward Brandt, Assistant Secretary for Health, requested help from the National Cancer Institute, National Institute for Allergy and Infectious Diseases, or NIAID, and the National Institute on Drug Abuse. The Directors of these agencies ignored the request for weeks.

During the early years of the epidemic, researchers found what was causing the infections. A virus not previously found in humans, which was transmitted through bodily fluids such as blood and semen, was discovered which led to scientists naming the two forms of the disease Human Immunodeficiency Virus, or HIV and Acquired Immune Deficiency Syndrome, or AIDS. Despite the new evidence that this was not a “gay disease”, as it was still being dismissed as, the Reagan administration continued to largely ignore the pending devastation. AIDS was still being seen by a majority of American society as a disease that was only infecting gay men and intravenous drug
users, which led some more conservative groups to view it as a punishment from God for deviant behaviors.

Even after the disease began to appear in other populations, such as people receiving blood transfusions during surgery, hemophiliacs being treated with Factor VIII, and heterosexuals, it was still being ignored. Author Randy Shilts, who covered the early years of the disease for the San Francisco Chronicle and later wrote the groundbreaking book *And the Band Played On: Politics, People and the AIDS Epidemic*, cited the disclosure by actor Rock Hudson that he had AIDS as the moment that began the change in response to the disease.

As gay men were the first group to be devastated by this disease, they were also the first to respond. In 1982, Nathan Fain, Larry Kramer, Larry Mass, Paul Popham, Paul Rapoport, and Edmund White officially created the Gay Men’s Health Crisis, GMHC, to provide support, services, and educational outreach to try to stop the spread of GRID. Over the nearly thirty years of the disease, GMHC has evolved with disease and is the longest constant HIV/AIDS service provider in the nation and currently serves any person affected by the disease, regardless of sexual orientation or gender.

Larry Kramer, one of the original founders of the GMHC left the group in frustration that it was not politically active enough in the fight against the disease. During a March 10, 1987 speech at New York's Lesbian and Gay Community Center, Kramer cajoled the audience to break out of its AIDS apathy and fight back against the government to get the medical services, medicine and response that was needed (Roshan, 2002). Two days later, the first chapter of AIDS Coalition to Unleash Power, ACT-UP,
was launched. Essentially an anarchist group of people living with HIV/AIDS, as well as their allies, ACT-UP protested against government inaction and demonstrated publicly against what it believed to be powers that were preventing education and treatment from reaching the general public.

As HIV/AIDS began to spread from just gay men and began to affect other at risk groups, it still retained a stigma due to the lack of knowledge about how it was transmitted. Ryan White, a young hemophiliac who was infected by contaminated blood products, became a national image of courage amid tragedy. Ryan sought to be a normal teenager and attend school (http://www.ryanwhite.com/pages/story.html). After a long battle, with the school and in the courts, Ryan won the right to go to school but was still mistreated by other students. Ryan and his family moved to another town where Ryan was openly welcomed into a new high school. Even while attending school, Ryan took time to be a spokesperson for the fight against HIV/AIDS as well as against the intolerance that all people living with the disease were facing, regardless of how they were infected. Ryan died at the age of 18 on April 8, 1990, but remains a key figure in the fight against AIDS more then twenty years after his death. The Ryan White CARE Act was passed in 1990 by the United States Congress and continues today as the leading government-spending program for those continuing to live with the disease.

There were two turnings point in how HIV/AIDS was perceived occurred when celebrities began taking public stances in support of education and increased government action. Elizabeth Taylor was perhaps the earliest and most visible advocate regarding the disease, revealing that she had lost friends to the disease. Taylor became one of the first
celebrities to donate money to research into the disease and soon became the “face” of amfAR, the American Foundation for AIDS Research, which was created following the merger of the AIDS Medical Foundation and the National AIDS Research Foundation in September 1985 (http://www.amfar.org/page.aspx?id=4616, 2010). To reflect the global impact of HIV/AIDS, the organization later changed its name to The Foundation for AIDS Research.

The second turning point occurred in stages as celebrities disclosed they were HIV positive or living with AIDS. On July 25, 1985, after weeks of speculation, Rock Hudson revealed that he was dying of AIDS, and stated he had been infected by tainted blood used in transfusions during a heart bypass surgery. Other celebrities and athletes who have openly disclosed their HIV status include Olympic champion Greg Louganis, and Eazy-E of the music group N.W.A. The biggest revelation occurred on November 7, 1991 when professional basketball player Earvin “Magic” Johnson retired from the NBA and announced he was HIV positive.

To reach a younger generation of people who were heavily impacted by media culture, MTV began airing a new series called The Real World, which followed several young people from around the United States who lived together in a house and had cameras following their every move. Pedro Zamora, a Cuban-American youth who was open about being gay and being HIV positive, who had become an AIDS education activist, auditioned for and was cast in the show. Reaching a nationwide, and international audience, Pedro brought his story and activism to people his age, and in the Latino community, to show a face of HIV that they could identify with.
Today, there is no population that is unaffected or unscathed by this disease. As the epidemic of the early 1980’s has evolved into a pandemic according to Dr. Anthony Fauci (Fauci, 1999), there has been an alarming change in infection rates among gay men. Hall et al. (2008), used back-calculation techniques and found that the period from 1977 to 1985 saw the highest annual new infection rates for all populations, with the highest point coming in 1984 and 1985 with approximately 130,000 new infections per year. New infection rates dropped between 1986 and 1996 to a low of approximately 49,000 new infections annually. The later part of the 1990’s saw a new peak of approximately 58,000 annual new infections and has since held steady at about 55,000 new infections through the latest period studied, between 2003 and 2006. All the above figures refer to total new infections, not broken down into sub-populations.

The most alarming statistic in these figures is that, after a decline of infection rates among men who have sex with men during the later part of the 1980s and early 1990s, the rates have been steadily rising since then. More then half of all annual infections continue to be accounted for by men who have sex with men. Once again, this population is the single largest group affected by the HIV/AIDS pandemic, though by no means is it the only group.

Though HIV/AIDS is a global issue, this thesis will focus only on the impact of the disease on the Northern California region, particularly El Dorado, Placer, Sacramento and Yolo Counties. Although San Francisco was one of the first cities to be devastated by the disease, and it continues to be at the forefront of services to those living with and
affected by it, as well as attempting to stem the rate of new infections, it is not being covered in this project.

**Statement of the Problem**

As the above statistics indicate, gay men and men who have sex with men are the largest population that makes up new annual infections. There is a need to educate those already infected and living with the disease, and those not yet infected, to prevent new infections and eliminate this pandemic.

**Purpose of the Study**

The purpose of this study is to explore factors that are leading to a consistent rate of new HIV infections among the population of men who have sex with men. Thirty years into the pandemic and with no cure or vaccine in sight, more than 58,000 new infections occur every year. Knowledge of the factors that lead men to becoming infected is the only effective way to combat these new infections. Although women are not directly covered in this study, they will be directly affected due to one area of research relating to men who participate in Down Low sexual activity with other men. These men may become infected, not get tested, and then pass on the disease to their unsuspecting female partners.

**Theoretical Framework**

This research will be conducted under the auspices of two forms of theory. The first theory will be Lev Vygotsky’s Sociocultural Theory (Qin & Comstock, 2005), which, though emphasizing the development of children, can be extrapolated to the factor of HIV infections, which in many cases, play back to childhood issues. Sociocultural
theory defined that “All higher cognitive processes develop out of interactions with others in the sociocultural contexts of social interaction.” By exploring how and why men willingly engage in unsafe sexual activities, and from whom they have learned these practices, it may be possible to counteract them in other groups.

The second theory is Relational-Cultural Theory, or RCT. As cited in Comstock and Qin (2005), Jordan and Hardling defined that,

RCT emphasizes health, growth and courage, and points to a new understanding of human and individual strength: strength in relationship, not strength in isolation. Isolation is seen as the source of most suffering, while the process of creating mutual empathy and mutual empowerment is seen as the route out of isolation.

One of the major tenets of RCT is that isolation and shame impact development of humans. For many minority men who acknowledge their sexuality, to themselves or others, they are exposed to cultural conflict due to conflicting views. This conflict leads many minority men to participate in high-risk sexual activities, which is directly shown in higher total number and percentages of HIV infection (CDC, 2007).

**Definition of Terms**

**AIDS**: Acquired Immune Deficiency Syndrome. AIDS is not a disease in itself, but is a diagnosis based on clinically defined standards of less than 200 CD4 cells or the diagnosis of one or more opportunistic infections.

**AIDS-Defining Opportunistic Illnesses**: A diagnostic list of approximately twenty-two infections that a person with HIV is more susceptible to due to a repressed
immune system. Once one of these illnesses is diagnosed, the person is considered to have AIDS instead of HIV. Certain illnesses, such as Kaposi’s sarcoma, are not exclusive to patients infected with HIV.

**Bareback:** Anal sex without the use of condoms.

**Bisexual:** A label used to identify men who are romantically and/or sexually involved with other men, as well as women.

**Bug Chaser/Chasing:** A person who is HIV negative who purposely seeks out HIV infection by engaging in unprotected sex, often with identified positive men.

**Comorbid:** A term used when multiple diagnoses occur in a patient. These can be medical diagnoses such as Diabetes and High Blood Pressure, or mental health diagnoses such as depression and substance abuse, or a combination of medical and mental health conditions.

**CD4 Helper Cells:** A specific type of white blood cell that fights off infections. A person with lower CD4 levels is more at risk for infections that cannot be fought off.

**Down Low:** Phrase used to refer to men who may identify as straight, but who participate in sexual activities, often high-risk behaviors, with other men. An expression more commonly used by African-American and Hispanic men, it is now being used among other racial and cultural groups.

**Epidemic:** Affecting many persons at the same time, and spreading from person to person in a locality where the disease is not permanently prevalent.
**Gay:** A commonly used identifier to identify men in same-sex relationships or sexual activities. The clinical term of homosexual is not commonly used in research or in general discussion.

**Gift Giver/Giving:** A person who is HIV positive and seeks out negative partners.

**HAART:** Highly Active Anti-Retroviral Therapy is a treatment combination of three drugs that work together to stop the viral process in infected cells and to stop creation of new virus in the body. Fully suppresses HIV to undetectable levels and restore immune system function.

**HIV:** Human Immunodeficiency Virus. The virus that infects the human body through contact with contaminated bodily fluids through unprotected sexual contact, intravenous drug use and in other ways. HIV breaks down the immune system of the body, eventually leading to a diagnosis of AIDS.

**Latino:** This author, to refer to men of Spanish, Mexican or other Latin backgrounds, will use the term Latino. The research uses terms such as Hispanic and Latino to refer to these cultural backgrounds, as well as further in-group labels such as Chicano or Mexican-American.

**Men who have sex with men:** A grouping of identification that can include gay men, bisexual men, as well as men who identify as straight, but who engage in sexual activities with other men. This writer will use either the full title, or the abbreviation MSM interchangeably throughout the writing.
**Pandemic:** Prevalent throughout an entire country, continent, or the whole world; epidemic over a large area.

**Pneumocystis Carinii pneumonia:** A severe illness found in people with HIV that is caused by a germ called *Pneumocystis carinii*. Most people infected with this germ do not get pneumonia because their immune systems are strong enough to suppress it.

**Stealth:** A subset of gift givers, an infected individual who does not reveal their serostatus and seek to infect their partners.

**Seroconversion:** Converting from HIV negative to HIV positive.

**Serostatus:** State of being infected with HIV or being uninfected.

**Straight:** A commonly used title to identify men who are romantically and/or sexually involved with women. The clinical term heterosexual is rarely used in academic research and in common reference.

**Assumptions**

The following assumptions are made regarding this research:

1. Men know how HIV is transmitted.
2. Patients are honest with service providers about how they became infected.
3. Patients are honest with service providers about their sexual practices following infection.
4. Most men who become infected are unaware of the full impact and ramifications that living with HIV/AIDS can include.
5. Some who are not infected view the disease as a chronic condition instead of a fatal illness.
Justification

This writer believes that this project can be of use to HIV/AIDS educators by helping to reformat the educational model that is currently being used in schools and mental health programs. By directly addressing issues that are discovered as direct links to infection, it might be possible to prevent new infections. One of the most at risk groups are teenage males who engage in unprotected sexual activities with other teenagers and older men. Some of these males may not be ready to self-identify as gay and may be putting themselves and others at risk of spreading infections.

According to the National Association of Social Workers Code of Ethics, one major role of social workers is to promote the, “Dignity and worth of the person” (NASW, 2008). The role of the social worker is to,

Treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients’ socially responsible self-determination. Social workers seek to enhance clients’ capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients’ interests and the broader society’s interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Social Work professionals can take the lead in combating the HIV/AIDS pandemic by working with both infected and non-infected individuals. Working with clients living with the disease, social workers can help them to address their concerns,
and to help them explore their role in this epidemic. Positive clients can become educators, taking a hands-on role in teaching people about the true impact that HIV has on their lives. Finally, they need to be educated about how their behaviors put others at risk and hold them accountable for these actions. People who are not yet infected, but who are at risk, also need to be directly addressed by informing them of what the true cost of HIV/AIDS are, what problems they will deal with, and the ramifications of being infected are.

Due to its original emergence among drug users and men who were sexually active with other men, its extremely high fatality rates, and rapid progression from diagnosis to death, HIV/AIDS received a slow response from federal, state, and local governments, the media and people not immediately or directly affected by it. As a result, “AIDS, perhaps more than any other example in the twentieth century, highlights the significance that social meanings has on the social response to illness” (Conrad, 1997). Nearly thirty years after the first cases emerged in the United States, this stigmatization of HIV/AIDS, and those who live with the diseases, still continues to impact personal, community and government response.

**Limitations**

This project has several inherent limitations in its approach that are related to the narrow focus of its intent. This project is only pertaining to infections among men who have sex with men, and is therefore not going to be including women, intravenous drug users, or other groups that do not fit into this population.
Secondly, this project is only addressing the communities of Northern California, with a primary emphasis on El Dorado, Placer, Sacramento and Yolo Counties. As a result, other areas outside of this region will not be covered. This limitation is acceptable to this author as most factors can be extrapolated from one area to others and are not geographically limited.

Summary

From its global emergence in the late 1970s through the early years of the 1980s, HIV/AIDS was a disease that struck groups in the United States who were viewed as deserving of the disease as a punishment. As a result of this view, early response to the growing epidemic occurred primarily from the population it was most decimating, gay men. Early groups such as the Gay Men’s Health Crisis and ACT-UP served those affected by the disease and fought for increased response and support from the United States government.

When the disease began to be observed in other populations, such as blood transfusion recipients and straight men and women, the federal government began to seriously respond to what had become a pandemic. President Ronald Reagan largely ignored the disease and it was not until 1987, six years after the first reported United States cases that he spoke publicly about the disease. Public reaction and response to the disease began to change when new faces of the disease, such as Rock Hudson and Ryan White emerged to change the view of whom HIV/AIDS was affecting.

The scientific community had taken the early lead in tracking the disease and discovering how it was transmitted, creating the change from it being identified as Gay
Related Immune Deficiency to the more accurate Human Immunodeficiency Virus. However, the scientific community was hampered by lack of federal funding and by fighting between the scientists over who should get credit for the discovery of the virus. Through advocacy and government response, the fight against the disease began to turn. During the later part of the 1980s, rates of new infections declined and held at lower levels through the middle 1990s. Unfortunately, this decline ended and over the last fifteen years, rates of new infections have seen increases among all populations and continue to occur at an approximate rate of 57,000 new infections annually. Though the disease affects all populations, it continues to impact men who have sex with men, and primarily minority men among this population, at levels that are exponentially higher then their total population in the United States. It is the goal of this research to identify certain factors that lead to this dramatic and disproportionate dichotomy of infection statistics.

The next chapter is a summary of research into the HIV/AIDS pandemic. This information covers the history of the disease from its first days to today, statistics on who is infected and at what rates, what factors are leading to the continuing level of new infections, and finally the role and affect that government response has had on the infection levels and those living with the disease.
Chapter 2

REVIEW OF THE LITERATURE

There is substantial professional and academic research on the topic of HIV/AIDS among the select population of men who have sex with men. This research covers a multitude of topics, not all of which are included in this project. For the purposes of this project, the writer limited his research investigation to the following areas: (1) Historical background; (2) Overall MSM infection prevalence; (3) MSM subgroup infection prevalence; (4) Infection factors and, (5) Government response and policy.

Historical Background

Beginning in October 1980, doctors in Los Angeles and New York began to treat patients that all self-identified as sexually active gay men who were found to be infected with illnesses and infections that had previously been rare occurrences. The Los Angeles cases, five men, two of whom died by May 1981, were each found to be infected with Pneumocystis carinii pneumonia, or PCP, (CDC, 1981). The New York patients were battling a rare form of skin cancer known as Kaposi’s sarcoma, which, according to the American Cancer Society, had previously been seen primarily in, “Elderly people of Mediterranean, Eastern European, and Middle Eastern heritage” (2006). The Centers for Disease Control elaborated that, “Pneumocystis pneumonia in the United States is almost exclusively limited to severely immunosuppressed patients.”

Infection rates and resulting deaths exploded exponentially. In San Francisco, the first eight cases and two deaths were reported in August 1981. Less then two years later in mid 1983, there were 249 cases and 72 deaths, increases of 3100% and 3600% during
this period. By the following year, the numbers increased to 550 cases and 213 deaths, increases of over 200% and nearly 300% respectively (Disman, 2003).

Though these were the first reported cases in the United States, doctors in other countries had been observing these same medical cases since the later part of the 1970s. Dr. Jan Gerstoft of Denmark had worked with two gay male patients by September of 1980, both of whom were dying as result of Pneumocystis infections. Dr. Grethe Rask, a Danish researcher working in Zaire, a concert violinist in Germany, a woman and her daughter from Kinshasa, Zaire, and a Portuguese cab driver in Paris, had all died of similar infections between 1977 and 1980 (Shilts, 1987). None of these people had any connections to each other, but all died of a previously treatable form of pneumonia.

Recent research into the origins of Human Immunodeficiency Virus, or HIV, has revealed that the virus has been present in the human population for much longer then previously believed. Preserved tissue samples indicated that HIV was present, “In the former Belgian Congo in 1959, in Haiti by 1966 and possibly in the U.S. as early as 1969,” (Soares, 2009). Further analysis placed the first outbreak of HIV in Cameroon in 1908, indicating that it has been present for more then a century among the human population.

The 1969 occurrence in the United States was announced in 1987 by scientists who revealed results of testing on tissue from a patient identified only as Robert R. (Gorman, Dorfman, Kramer, 1987). Robert, a sixteen year old African-American died on May 15, 1969 of what his doctors identified at the time as a shutting down of his immune system. His autopsy found Kaposi’s sarcoma lesions over his body and in his rectum and
on his anus. At the time, no explanation for the cause of the immune system shutdown or the lesions could be determined. Tulane University virologist Robert Garry who tested the preserved tissue samples stated, "There's no question that the tissue was positive for AIDS." Results of the test showed that the blood sample reacted to all nine markers used in the highly sensitive Western blot test for AIDS antibodies.

California tracking of HIV/AIDS has changed during the three decades the pandemic has been devastating the state. In March 1983, the state began confidential reporting, by patient name, of AIDS cases. HIV reporting did not begin until July 1, 2002 with non-name coding and then changed to named reporting on April 17, 2006 (California Department of Public Health, Office of AIDS, 2009).

Despite the deaths of thousands of people in the United States and across the globe, government response was reactionary instead of preventative. After learning how the growing epidemic was spreading, San Francisco began shutting down local businesses such as clubs, bars and bathhouses frequented by men and that allowed for discrete and anonymous sexual activity. After the business owners and patrons fought back, San Francisco allowed the businesses to stay open under the provision that businesses provide condoms and promote safer-sex practices (Shilts, 1987).

**Overall MSM Infection Prevalence**

By 2007, more then one million documented cases of AIDS had been reported to the CDC. These figures, though alarming, are not fully accurate as they only represent figures reported by 34 states and five dependent areas of the United States. The CDC estimated that these figures are approximately 66% of total figures (CDC, 2007).
The CDC estimated that 40,000 people were newly diagnosed annually with HIV in the United States (CDC, 2008). Using reported figures from 22 states which have name-based HIV reporting in place, Hall et.al. (2008) found that the actual figures were in excess of 56,000 new diagnoses for the same time. Furthermore, using the CDC figures of annual incidence reporting, the researchers determined that figures had also been underestimated. However, despite a rise of overall infection rates in the late 1990s, the rates have dropped and held steady since 2002 at an estimated 55,000. As of June 2007, more than 1.2 million people aged 13 or higher had been diagnosed with HIV and/or AIDS.

Despite a drop in infection rates in the late 1980s and early 1990s, infection rates among MSM have been consistently on the rise since the early 1990s. MSM continue to represent more than half (53%) of all infections. Back calculated using the researchers methodology, MSM made up 56% of infections in the 2003-2006 yearly intervals.

California was one of the first states to be impacted by the emergence of the HIV/AIDS pandemic, and continues to be one of the highest impacted areas. As of April 30, 2009, there were approximately 36,412 cumulative HIV infections and 153,901 AIDS diagnoses since 1983 (California Department of Public Health, Office of AIDS, 2009).

Northern California consists of thirty-three counties, including El Dorado, Placer, Sacramento, and Yolo. As of April 30, 2009, there are currently 3,390 people living with HIV out of a total 3,409 diagnosed patients in Northern California. For the same region, there have been cumulative totals of 15,610 patients diagnosed with AIDS since 1983 and there are currently 6,958 people living with AIDS in the region (California Department of
Public Health, Office of AIDS, 2009). The cumulative deaths of AIDS patients in the twenty-five years of tracking in this region are 8,652, or 55.4%.

These figures are potentially lower than actual true figures. Reporting errors are possible, as according to this report, Alpine County has never reported any HIV or AIDS diagnoses or deaths. Similarly indicative of potential under-reporting, Mono County has reported no HIV diagnoses, but has reported a total of five AIDS diagnoses and three deaths.

These figures are for all instances of HIV/AIDS diagnoses, and are not separated into distinct subgroups of infection types. It should also be reflected that if a person is diagnosed with AIDS, and had previously been diagnosed with HIV, the tracking is affected accordingly, meaning that the cumulative HIV figure drops and the AIDS figure increases. Similarly, in cases were a patient has never been diagnosed with HIV, but receives an initial diagnosis of AIDS, the HIV statistic is not affected, only the statistic for AIDS diagnoses. Finally, once a diagnosis of AIDS is made, as a result of CD4 counts under 200 or the diagnoses of specific opportunistic infections known as AIDS Defining Illnesses, even with treatment, the patient is never considered HIV positive again; they are classified as living with AIDS. Northern California has two counties, Sacramento and Contra Costa, among the ten counties most impacted by HIV and AIDS statewide.

As of October 31, 2008, the greater Sacramento area, consisting of El Dorado, Placer, Sacramento, and Yolo Counties had a total of 533 MSM living with HIV and 2,535 MSM living with AIDS. El Dorado County has twenty HIV positive MSM and
119 MSM living with AIDS. Placer County has eight HIV positive MSM and 90 living with AIDS. Sacramento County has 494 HIV positive MSM and 2,209 MSM living with AIDS. Yolo County has eleven HIV positive MSM and 117 MSM living with AIDS (areyouthedifference.org).

**MSM Subgroup Infection Prevalence**

Nationally, white MSM made up approximately 48%, or 121,702, of all estimated MSM HIV incidences in 2007 (CDC, 2008). In California, white men account for 12,851 cumulative infections, or nearly 54% of total MSM infections. According to the United States Census Bureau, persons who identify as white make up 79.8% of the United States population and 76.6% of the California population. Through April 30, 2009, white MSM made up 35% (12,851) of all reported HIV cases (36,412) and 42% (64,376) of all AIDS diagnoses (153,901) in California.

The two largest minority groups in the United States, Latinos and African-Americans make up 15% and 13% of the population, respectively. These two populations are being affected disproportionately in regards to HIV/AIDS infections. Latinos account for approximately 16%, or 41,866, of all MSM HIV/AIDS infections while African-American men account for approximately 34%, or 84,965, of all MSM infections. The approximately 2% remaining of infections among MSM are spread between American Indian/Alaska Native, Asian, and Native Hawaiian/Pacific Islander. California’s population is made up of 37% Latino and 7% African-American. Among MSM HIV diagnoses, 18% are Latino and 9% African-American. AIDS diagnoses among these populations are 15% Latino and 8% African-American.
All the figures cited for national, state and local infection rates must be viewed as estimates only and not exact rates. For the national figures reported by the CDC, estimates only include 34 states and five dependent areas that have participated in the name-based reporting database run by the CDC. Furthermore, not all figures include those people, MSM included, who are living with either HIV or AIDS who have not been diagnosed or have not been tested. Lastly, these figures for MSM do not include a separated group, MSM and IDU, or intravenous drug users. All reporting, from county levels to the CDC, use these two separate classifications to clarify between sexual transmission (MSM only) and infections transmitted related to drug use (MSM and IDU).

Between 2004 and 2007, new annual diagnoses in children under 13 and all persons between 30 and 39 decreased, while infection rates held steady in ages 13 and 14. All other age ranges between 15 to 29 and 40 and above, saw increases in this same period.

Amongst white MSM, the highest rates of new infections occurred among men between 30 and 39 (4,670, or 35%) followed by men between 40 and 49 (3,740 or 28%). Amongst both African-American and Latino MSM, the largest rates of new infections occurred in the age ranges of men between 13 and 29. For African-Americans, the rate was 5,220, or 52%, while among Latino men the rate was 2,300, or 43%. Among all ages and races, African-American MSM between 13 and 29 had the highest rate of new annual infections (CDC, 2008).

Minority youth who identify as MSM were at higher risk according to CDC figures compiled during the Young Men’s Survey, conducted by the CDC between 1994
and 1998. The CDC found that 14% of African-American and 7% of Hispanic youth aged 15-22 were HIV positive (CDC, 2008).

CDC figures from 2004 showed that among all new HIV infections, 4,883 people between the ages of 13 and 24 were newly diagnosed with either HIV or AIDS, representing 13% of all newly diagnosed infections (CDC, 2008). The report also found that 5.1% of all AIDS diagnoses in 2004 were for young people and that there was a 42% increase of young people living with AIDS between 2000 and 2004.

Historically, younger men have been among the largest groups of new infections. Rosenberg and Biggar (1998) traced infection rates of age cohorts of 18-22 in January 1983, January 1988, and January 1993. The prevalence of infection rates among men doubled between 1983 and 1988 and then decreased by 27% between 1988 and 1993. The researchers pointed out that by 1993, a larger portion of young men were reporting infections resulting from heterosexual contact, one in three of young male infections, compared to one in seven of men in the general male HIV infected population, approximately 33% compared to 14%. Harper (2007) reported that between 1999 and 2003, HIV infection rates among young males increased, whereas infection rates for young women declined during the same period.

**Infection Factors**

Youth are participating in sexual activity at younger ages, represented by reporting that 47% of high-school students have had sexual intercourse (CDC, 2008). Of this amount, 7.4% reported first sexual activity prior to the age of 13. For youth who identify as MSM in their responses, 55% of the 5,589 who responded revealed that they
did not disclose their sexual attraction to others. The CDC noted that among these youth who are not open, there is less likelihood of HIV testing, thus increasing their risk of not knowing their serostatus.

Burke and Owen reported that early research into same-sex domestic violence, hereinafter referred to as SSDV, indicated that between 42 to 79% of men in same-sex relationships have experienced some form of domestic violence (2006). Among the types of violence reported were negative men who were intentionally infected with HIV by positive partners to prevent the partner from leaving. Other HIV related forms of abuse were denial of medical attention, medication, and threats of not only outing the partner for their sexual orientation, but also about their HIV status. Victims of domestic violence often display signs of poor self-esteem, depression and self-blame as a result of the abuse.

There is a subculture within the MSM population of HIV negative men who seek out specifically serodiscordant men. These men are known as bug chasers, referring to intentionally seeking out HIV infection. Very little research has been conducted into proving the existence of this group. Moskowitz and Roloff (2007) studied 300 profiles from an Internet site designed for men who sought unprotected anal intercourse, UAI, or barebacking. Research indicated that 14% of gay men identified as barebackers. To identify the bareback subculture of bug chasing, researchers split 300 samples into separate groups, of equal number, of men who identified as either barebacker or bug chaser and examined each profiles identifications which included the serostatus’ of the person and the partners they sought, and the requirement for condom use. The research clearly authenticated that bug chasers do exist as a specific sub-culture.
The same authors further explored whether bug chasers could be considered to be sexually addicted (2007). They examined four popular beliefs about the explanations of bug chasing: A sense of belonging in an HIV positive brotherhood; the diabetes metaphor of HIV being livable and virtually a meaningless hindrance; a backlash against safe-sex education; and finally, that many men believe infection is inevitable and they should just do it and be in control. The authors then looked at the defined levels of sexual addiction: Victimless sexual behavior; deviant sexual behaviors, and victimizing sexual behaviors. Using a similar study system as their other bug chasing research, the researchers found a positive, yet non-binding, connection between sexual addiction and the bug-chasing phenomenon.

Carballo-Diéguez and Bauermeister (2004) identified three major indicating factors regarding why some men engage in bug chasing,

Perceptions of risk are also influenced by the improved medical management of HIV with highly active antiretroviral therapy; a sense of burnout among people who have tried for a long time to adhere to safer-sex guidelines; and the erotization of HIV through ad images of persons living with HIV who are portrayed as healthy, virile, and physically fit individuals.

Gauthier and Forsyth (1999) compiled information about men who engaged in bug chasing and gift giving from web sites, e-mail groups, and other online sources. In analyzing the hundreds of profiles, they identified four categories of men who, while not currently infected with HIV, actively seek to become infected. The first category is entitled “Fear and Relief” and includes men who view infection as inevitable and thus
seek to control how it happens so they can move on with their lives. “Risk Taking as Eroticism” is a group where men eroticize the act of being infected and, “Perceive heightened sexual satisfaction derived from high-risk sexual encounters wherein they, ‘flirt with death’.”

Their third category is “Loneliness and Group Solidarity” in which men who are HIV negative view themselves as being either left behind by friends and lovers who have become positive. As a result, they become lonely and in order to resolve this loneliness, they choose to seroconvert and join the perceived brotherhood of men who are HIV positive or living with AIDS. The final category is “Political Actions” and consists of men who view unprotected sex and intentional conversion as an act of rebellion against sexual authority. One underlying factor that connects all four of these categories is the view that HIV is no longer a fatal disease, but instead a chronic illness which can be managed with medications, equating HIV/AIDS to the same status as Diabetes.

Another study was done to examine the real occurrence of seropositive men who have UAI with steady male partners who are serodiscordant or of unknown status. Denning and Campsmith collated interviews with MSM who were HIV positive or living with AIDS in eleven states and one city (2005). Specifically covering men who knew their status for the previous year, the researchers had a pool of 674 participants. Their results showed that 144 (21%) of the respondents had participated in UAI in the previous year. Further, 81 of these men, or 56%, reported either total insertive, or both insertive and receptive, UAI.
Another study supplied contrasting information regarding sexual activities of HIV positive men. Tewksbury (1995) interviewed 54 men, 48 of who identified themselves as gay, regarding changes in sexual activity following their diagnoses. 26% of the respondents reported a cessation of sexual activity. The researcher further broke this down and reported that 45% men who identified as having AIDS reported cessation, opposed to only 20% of those who were asymptotically HIV positive. In exploring reasons for change and/or cessation, respondents cited concern for male partners; effects of losing a partner to the disease; physical factors, including medication side-effects; and a loss of self-esteem related to the stigma of HIV/AIDS and physical changes, such as wasting or Kaposi’s Sarcoma. The researcher also found a small percentage of respondents who stated a belief that it was their partner’s responsibility, not their own, to protect themselves against infection. Finally, Tewksbury found that 13% of the respondents believed a partner intentionally infected them, and very few in this group express negative reactions toward the partner, citing personal responsibility.

As local and national statistics have shown, African-American men are the largest rate of new annual infections among the MSM population. Research has found that for many African-American men, sex and sexuality are viewed as distinct representations of their masculinity (Duck, 2009). The men who believe their sex and sexuality proclaim their masculinity are more likely to avoid information that would inhibit their sexual behavior such as being tested for HIV. The same research also shows that these men are more likely to not use condoms with sexual partners, regardless of the partner’s gender. Some men are tested, but either do not get their results or are not likely to disclose their
status to partners. According to CARES (2009), “While African Americans make up less than 7% of the population in Sacramento County, 22% of the patients at CARES are African American. Even more alarming is that 40% of the women at CARES with HIV/AIDS are African American.”

The other conflict to the ideal of masculinity is having sex with other men. For men across multiple ethnic ranges, some participate in sexual activities with other men on what is referred to as the Down Low, which means among other things, “In a clandestine or sneaky manner,” (Gonzalez, 2007). Those men who participate in down low, same-sex activities do not identify as gay or bisexual; they identify as straight.

**Government Response and Policy**

There are many areas in which the response to HIV infection and prevention are lacking. Harper (2007) cited six separate examinations into current HIV prevention programs aimed at youth. All six examinations found that the vast majority of programs were specifically aimed at heterosexual youth. This material cannot simply be translated to work for gay and bisexual youth, but must address group specific issues relating to the reasons behind high risk behavior in gay and bisexual male youth, including, “Psychological, social and structural factors,” (p. 807).

Anthony Fauci, head of the National Institute of Allergy and Infectious Diseases (NIAID), and a long-time expert on the AIDS pandemic, wrote that, “HIV infection in adults is entirely preventable by behavior modification,” (Fauci, 1999). To assist in this modification, Dr. Fauci cited education, condom promotion and provision, drug-abuse
treatment and needle and syringe exchange programs for intravenous drug users as a few ways to eliminate HIV infection.

The policy of the United States government regarding HIV prevention also shows a lack of adequate response to the rising levels of HIV infection, in MSM populations and in all populations (Cahill, 2008). The President’s Emergency Plan for AIDS Relief (PEPFAR) requires that all countries receiving funding from the United States have a national AIDS strategy, yet the United States does not have one of its own. In regards to funding, only four percent of national HIV/AIDS funding is spent on prevention. Additionally, a majority of the money spent on prevention has been directed between 2001 and 2008 toward abstinence only programs, which do not adequately address the realities that more adolescents are having sex and are doing so at earlier ages. The federal government has opposed needle and syringe exchange programs for IV drug users despite programs in New York reducing HIV infection rates among IV drug users by 78% between 1990 and 2002.

Abstinence only education programs were federally supported as early as 1981 under President Ronald Reagan and the Adolescent Family Life Act. In 1996, these programs were enhanced and expanded by Congress and President William Clinton. Expansions in 1996 included shifting federal funding to programs that were abstinence exclusive, prohibited distribution of condoms and other contraceptive devices to youth in schools, and began the process of allowing federal funds to be allocated to faith-based organizations. Programs created included Section 510 of the Social Security Act in 1996, part of welfare reform, and Community-Based Abstinence Education (CBAE) projects in
2000. CBAE bypassed state government approval processes and, both it and Section 510, prohibited, “Disseminating information on contraceptive services, sexual orientation, gender identity, and other aspects of human sexuality,” (Santelli, 2006). Section 510 contained eight definitions of what abstinence-only education is. Those definitions, taken directly from the Social Security Act, read,

(2) For purposes of this section, the term “abstinence education” means an educational or motivational program which—

(A) Has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity.

(B) Teaches abstinence from sexual activity outside marriage as the expected standard for all school age children.

(C) Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems.

(D) Teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity.

(E) Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.

(F) Teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society.

(G) Teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances.
(H) Teaches the importance of attaining self-sufficiency before engaging in sexual activity.

These rules all have in common that, without saying specifically, the federal government is promoting only sex between a man and woman, and only in the context of marriage. This policy ignores the reality that teenagers may be struggling with their sexuality, engaging in sexual activities regardless of the teachings, and in doing so, without easy access to contraceptives, often having unprotected sex. The fact that abstinence only education has failed can be seen in the fact that HIV infections have been on the rise in youth between the ages of 15 and 19, predominantly among males.

In 1983, following the early cases of the emerging disease, the CDC reported that the United States Public Health Service had recommended, among other actions,

As a temporary measure, members of groups at increased risk for AIDS should refrain from donating plasma and/or blood. This recommendation includes all individuals belonging to such groups, even though many individuals are at little risk of AIDS. Centers collecting plasma and/or blood should inform potential donors of this recommendation. The Food and Drug Administration (FDA) is preparing new recommendations for manufacturers of plasma derivatives and for establishments collecting plasma or blood. This is an interim measure to protect recipients of blood products and blood until specific laboratory tests are available.

The temporary measure remains in affect almost thirty years later, despite advances in testing for HIV antibodies. The American Red Cross has several restrictions against donations from populations determined to be at risk for exposure to HIV/AIDS
among them, “Are a male who has had sexual contact with another male, even once, since 1977” (http://www.redcrossblood.org/donating-blood/eligibility-requirements/eligibility-criteria-alphabetical-listing).

In 1987, the United States began a prohibition against any person infected with HIV/AIDS to travel from another country to the United States. The prohibition was implemented under the policy of the United States Public Health Service, which had for decades maintained a list of "dangerous and contagious diseases," (www.AIDS.org) that excluded persons from entering the country for public-health reasons.

In June 1987, the Public Health Service, or PHS, under pressure from President Ronald Reagan, added AIDS to this list. The PHS acquiesced to the pressure but stated that the exclusion was not, “Based on any new scientific knowledge and that AIDS is not spread by casual contact which is the usual public concept of contagious,” (www.AIDS.org). The following month, Senator Jesse Helms introduced, and the Senate unanimously passed, the Helms Amendment, which added HIV to this list.

After issues surrounding a 1989 HIV/AIDS conference in San Francisco, organizers of the June 1990 Sixth International Conference on AIDS, also being held in San Francisco, spent a year working with the government to create special waivers to allow travel by those living with HIV/AIDS who were also experts in the field. Despite the collaboration, and due to the complex issues around the waivers and the travel ban, over 70 AIDS, medical, and government organizations, including the International Red Cross, the British Medical Association, and the European Parliament, boycotted the meeting. Harvard University, which was scheduled to host the 1992 conference,
announced that it would withdraw its sponsorship, unless the travel ban was eased or eliminated. Between the 1990 conference and 2010, no international conference of the epidemic has been held in the United States due to the travel ban.

On January 23, 1991, the CDC published its intention to remove all diseases from the exclusion list, except for active cases of Tuberculosis, in the Federal Register. After the intention was made public, a thirty-day period for public feedback was opened. Conservative groups began a grassroots campaign to organize its followers to oppose removing the restrictions. One group, C.W.tian Action Network of Forest, Virginia sent mailers to its members that started with the message,

Are there not enough homosexuals with AIDS in the United States that we now need to import more? That's exactly what's happening -- more homosexuals, more AIDS, more death being brought to the United States -- thanks to the liberals within the Department of Health and Human Services. (www.AIDS.org).

This and other campaigns, as well as an opposition letter signed by 67 Republican Representatives, led to a delay of the implementation of the changes. Also involved in blocking the change was the Department of Justice, who had no authority to be involved, as the Immigration Reform Act of 1990, Section VI, Exclusion and Deportation granted sole authority to the Secretary of Health and Human Services to implement any changes to this list.

After this failed attempt to remove the ban on travel in 1991, President Bill Clinton attempted to eliminate the ban in the first year of his presidency, but failed to do so. Changes to this policy during its 22 year existence included adding provisions that
granted international persons living with HIV/AIDS, who had either a spouse or child who is a U.S. citizen or lawful permanent resident, the right to seek legal permanent residence in the country (Cahill, 2008). This policy only applied to heterosexuals who had opposite-sex spouses, thus endorsing a discriminatory double standard to gay men who might be infected, but in a relationship with a United States citizen.

During the 2008 Presidential election, candidates Barack Obama and John McCain were sent surveys by the GMHC that covered, among other topics, repealing the travel ban. Senator McCain declined to complete the survey, while Senator Obama announced his support for repealing the ban.

On October 30, 2009, President Obama reauthorized the Ryan White CARE Act, which ensured continued funding for HIV/AIDS medications. At the same time, he announced that, per the CDC decision, the ban on travel of all persons with HIV/AIDS to enter the United States would be lifted ("You’re Welcome,” 2009). On November 2, 2009, the Federal Register printed the new directives from the CDC that stated that HIV/AIDS was not a threat to the United States population for transmission through casual contact, and,

As a result of this final rule, aliens will no longer be inadmissible into the United States based solely on the ground they are infected with HIV, and they will not be required to undergo HIV testing as part of the required medical examination for U.S. immigration. (p. 56547).

This policy went into effect on January 4, 2010.
In 2006, San Francisco began a program that directly addresses teenagers in ways they are familiar with. In response to rising rates of sexually transmitted infections among teenagers, the San Francisco Department of Public Health collaborated with Internet Sexuality Information Services, Inc., ISIS-Inc., to create a text-messaging service that teenagers could privately access through their cellular phone service. The city implemented this program after a survey found that 85% of youth between 12 and 24 owned cellular phones. The program, SEXINFO, was launched in April 2006 following distribution of informational material such as posters, bus shelter advertisements, internet banner ads and coverage by local and national television and print media. Between April and October, more then 4,500 responses were received, of which 2,500 led to requests for further information (Levine, McCright, Dobkin, Woodruff, & Klausner, 2008).

Users of the service could request information on any of ten topics, and the four most requested topics were on condom breakage, STDs, pregnancy, and HIV. In addition to information on the specific topics, names of youth oriented medical and social services, their address and hours of service were sent in the text message. To make the program specific to the target population, the automated text messages were written in popular Internet shorthand. The message sent out about condom breakage reads, “U may be at risk 4 STDs + prgnancy S.E. Clinic, Keith at ArmstrongSt, 415-671-7000 M-F8-5, W8-12, City Clinic 356 7th St 415-487-5500 MWF 8-4 TuTh 1-4” (http://m.sextext.org/Info.aspx). This message translates to, “You may be at risk for STDs and pregnancy.”
**Gaps in the Literature**

The research into the existence of bug chasing was problematic, as the researchers explained, due to the fact that there were no human participants, only profiles. This research method does not take into account that some online profiles are made up to receive attention, as opposed to hearing from truly self-identified and practicing bug chasers. In their further research, linking bug chasing and addiction, the researchers cited the lack of research into the other side of the topic, men known as gift givers who knowingly and willingly attempt to infect serodiscordant men. The research done by Gauthier and Forsyth had the same limitations, as they only accessed online profiles on sites of interest to men who possibly engage in bareback sex and bug chasing. Furthermore, though their categories might be considered useful, they portray the men who created these profiles as “Deviant” and throughout the paper pathologize the men. Unlike Moskowitz and Roloff, Gauthier and Forsyth do not acknowledge that these profiles are possibly only established as fantasy or role-playing tools that do not lead to real world sexual behavior.

Tewksbury (1995) cited a limited availability of respondents due to the, “Structural and personal difficulties social service providers face in assisting researchers.” However, in more recent years and research, due to more specific reporting by states, this information has become more readily available. Despite this improvement, only 40 of the 50 states in the United States report HIV diagnoses to the CDC, which, until the research by Hill et.al. led to under representation of the true amount of annual HIV infection rates.
Summary

The research shows that despite the knowledge known about HIV and AIDS, infection rates continue at an alarming rate of nearly 56,000 per year in the United States. Taking into account that as many as one-fourth this amount are also HIV infected, without being aware of it, that is nearly 70,000 new HIV infections annually. The groups being hardest hit are minority men, primarily African-American and Latino, and youth who participate in sexual activity with other men.

There are many factors that are causing the HIV infection rates to stay at a high steady level year after year. Men of all ages continue to practice unprotected sex whether for the belief of increased pleasure, they are pressured to by their partners, a false belief that their partner is safe because they do not look sick, or because of beliefs of religious nature or that condoms impede their masculinity. No matter the reason, these men are putting themselves and their partners, as well as other partners who the person may be with, at risk of HIV and other sexually transmitted infections.

Among youth, males are having sex with other men, usually who are older than them and who convince the youth to not use condoms. For the younger men, this practice allows for acceptance and exploration of their sexuality in such a way that others in their peer group may not find out. However, these same young men who may be struggling with their sexual identity, may also be having sex with female peers, and not using condoms, thus possibly spreading infections to these young women and any other partners that may be involved. The other cause of not using condoms in this age group is that schools have been required to teach abstinence only sexual education. These
programs do not include teaching students about safer-sex practices, condom availability, or discussion regarding any type of sexuality aside from male-female partnering. There is also an unwritten message in abstinence only teaching that sex is only penile-vaginal intercourse and as a result, more youth are engaging in oral and anal sex, to avoid losing their virginity.

Perhaps the most disturbing factors that have emerged are the subpopulations of gay men who identify as bug chasers who actively seek to become infected with HIV/AIDS and who actively seek to infect men who are not HIV positive. The group of gift givers can be further split into those who spread HIV to willing partners and those who either do not reveal their status or lie about it and attempt to stealth infect men who are not seeking the infection.

No matter the factors, whether substance use, not using condoms for whatever reason, lack of safer-sex education in school, or avoiding being tested for HIV, they need to be directly addressed before HIV prevention can become effective. Dr. Fauci of NIAID stated it concisely, “Unless methods of prevention, with or without a vaccine, are successful, the worst of the global pandemic will occur in the 21st century.”

The next chapter will discuss the methodology used by the researcher in the completion of this project. Included in this section is information on how the research was designed, conducted and tabulated, information on the experts who participated in the interviews, and what limitations this researcher faced in the process to complete the study, that might be similar to other limitations faced by prior researchers and how this might be amended for future studies.
Chapter 3

METHODS

Design of Research

This project was conducted using qualitative methods, which provides the benefit of allowing for a deeper and more precise understanding of personal knowledge and experiences. By using qualitative methods through the conducting of interviews with professionals who work with the population of people living with HIV/AIDS, it will provide real world support to data discovered during the review of the literature. Furthermore, it may provide additional information that may not have been covered in other academic and professional research.

The researcher conducted interviews with people who possess personal experience and professional expertise in the field of HIV infections among the MSM population. All interviews were semi-structured, consisting of questions predetermined by the researcher and additional questions based on information provided by the subjects, to obtain a greater breadth of information, experiences, and statistical data.

Human Subjects Approval Process

This research project was originally designed to include a survey that would be completed by men living with HIV/AIDS who became infected through sexual activity with other men. The survey was designed by this researcher to cover the respondent’s sexual practices before and after they were diagnosed. When this research proposal was presented to the Human Subjects Committee of the Social Work Division, it was accepted as an “At-Risk” study. The committee determined that those living with HIV are a
population that requires higher levels of research protection due to the stigma that still surrounds HIV/AIDS today.

Based on the recommendation of the committee, this researcher changed his focus to service providers who work directly with patients living with the disease. After resubmitting to the committee, the new research proposal was accepted as a no risk study. Each participant signed Consent to Participate in Research forms (see Appendix A) that were approved by the committee. The interviews consisted of two types of questions: questions that were specific to each participant, and questions that each participant was asked. These questions are listed in Appendices B through E.

Participant Information

This researcher conducted interviews with four professionals who have first hand knowledge of factors that lead to individual infections. Furthermore, they have knowledge of the unrealized impact that infection has on the patient. The subjects who participated in the interviews will be identified throughout the remainder of this project by either their initials or by their coinciding participant number.

Participant number one, identified as E.T., is an RN, MSN and FNP-C and is the Nursing Manager at CARES. In her professional role, E.T. works directly with clinic patients and has hands-on knowledge of why men who have sex with men continue to be the highest impacted group of new annual HIV infections. E.T. began working in the HIV field while volunteering at the San Francisco AIDS Foundation Hotline and returned to school to get a nursing degree because, “It was too hard to just watch and do nothing” as friends became sick and died of HIV/AIDS
Participant number two, identified as M.E., is a MS and RD and is the Registered Dietician at CARES and works with approximately 500 of the clients that the agency serves, which total over 2000. In her role, M.E. helps clients to improve their diet and enhance their nutrition knowledge to help them deal with not only their HIV/AIDS status, but as well as other diseases and conditions that the clients may face such as Diabetes, multiple forms of Hepatitis and conditions that may be ancillary to their primary diseases such as kidney function. While she was doing a hospital internship in the early years of the epidemic, Margie saw first hand how a patient with AIDS was mistreated and ignored by nurses and doctors. She took it upon herself to take the patient his food and talked with him. After receiving her degree and working in different positions, Margie took a position with U.C. Davis Medical Center and then at CARES to work with those affected by HIV to help them learn how diet and nutrition can positively affect their health and help them to improve their immune system.

Participant number three, identified as P.P. is the Clinical Pharmacist for CARES and works with the multi-disciplinary team to ensure safety of medicine interactions for clients. P.P. also works directly with clients to help them deal with medicine regimen adherence and reactions. P.P. did not seek a position in the HIV field as a result of personal experience. Instead, she took the position to seek out a new professional challenge in a field that she did not have any experience in and reported that she has loved the challenges that emerge on a regular basis.

Participant number four, identified as C.W., is a Licensed Marriage and Family Counselor who has worked at CARES for approximately nine months. His primary work
is with individuals, couples, and working in the Alcohol and Other Drug (AOD) program. C.W. stated that his primary professional interest was to work with gay men and he began working at CARES since he knew he would be working with that specific population.

The information compiled in this project was gathered during interviews with professionals who work, in various areas of expertise, with patients living with HIV/AIDS. Due to these different areas of knowledge, the interview questions were specifically tailored to each subject.

All interviews began with gathering information regarding each subject’s professional background. The interviews then moved into areas that were tailored specifically to each subject. For example, information about the medical aspects of HIV was received from E.T. while information regarding costs of and amount of medications taken was received from P.P.

**Data Collection Process**

The data for this project was gathered during the interviews with professionals who work with patients living with HIV/AIDS. All interviews were conducted at the CARES clinic, in each subject’s office for their convenience and comfort. The interviews were semi-structured, consisting of questions that the researcher created before the interview and questions that were used to expand on information provided in responses by the subject.

Each subject gave verbal consent to the interview being recorded by the researcher using a digital audio recorder. Following the completion of each interview,
the audio file was transferred to the researcher’s personal computer and was then transcribed, by the writer, into text files.

**Limitations**

The primary limitation of this project was that the only participants were professionals who work with men living with HIV/AIDS, and not men who are living with the disease. This population only has the information provided to them by their patients. If this researched had been allowed to include men living with the disease, more specific information might have been found. This researcher acknowledges this limitation exists throughout a majority of research on this topic as HIV/AIDS continues to have a stigma attached to it as do those who are living with the disease. This population, regardless of gender, sexual orientation, mode of infection or health status is considered to be an At-Risk population. California State University, Sacramento defines At-Risk as the probability or magnitude that participation could cause, “Possible harm (physical, psychological, social, or economic),” (2009).

This research strictly limited the geographical area covered to Northern California, primarily El Dorado, Placer, Sacramento and Yolo Counties. Despite this geographical restriction, this researcher believes that this study could evolve in the future to include more areas and participants, including those living with and affected by the disease.

Finally, this researcher chose to limit the study to only address the infections of men who have sex with men as they make up the highest number of total historical infections and new annual infections. It is not the intent to convey that MSM are the only
population affected by the HIV pandemic. Future studies should include men and women who are infected through sexual contact with opposite sex partners, as well as male and female intravenous drug users who contract the disease through the use of contaminated needles.

**Summary**

This project is using quantitative research to discover if the information found during the research of existing literature could be confirmed with participant response. This researcher originally intended to use the participation of men who are living with the disease to get their specific and expert knowledge of why they became infected and whether their behavior has changed since they found out their status. Due to restrictions imposed by the Division of Social Work, this research had to be modified to only use the participation of professionals who work with people living with HIV/AIDS.

Each participant was contacted by this researcher and agreed to be interviewed. The interviews lasted between seventeen and forty-five minutes, and were conducted at each participant’s office at CARES. All subjects gave this researcher consent to be audio recorded, and these interviews were later transcribed to provide an easier way to analyze the response data.

The next chapter will integrate the information provided by the subjects into specific categories. This information will ideally match the research that was documented in the previous literature review. In addition, it is probable that new information will be revealed, based on the professional knowledge of the interview subjects. With this support and validation of preexisting data, and new information
provided, it is possible to create new tools that can be used to more effectively address the HIV/AIDS pandemic.
Chapter 4

THE PROJECT

After conducting the interviews, this researcher transcribed each interview. Once the transcriptions were completed, the content of each was analyzed so as to identify the information that was revealed during the interviews. The subjects reported some information that provided support to what was discovered in the literature. Additionally, knowledge was provided that countered certain beliefs with medical information.

Each interview consisted of questions that sought insight on each person’s credentials and experience in the field of working with HIV/AIDS. Each subject was also asked about their beliefs on the efficacy of current HIV prevention programs and they were given the opportunity to create what they believed would be a more effective way to combat the spread of new infections.

The remainder of the questions was designed to address areas of knowledge that were specific to each interviewee. For example, M.E. was asked to discuss how nutrition can improve the quality of life of a person living with HIV/AIDS, while C.W. was asked about mental health and chemical dependency issues.

Biographical Information

The following tables detail the professional training of each respondent, their role in the CARES team and why they chose to work with the HIV community (See Tables 1-4).
<table>
<thead>
<tr>
<th>Training and Role at CARES</th>
<th>Why I work in the HIV area</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Registered Nurse</td>
<td>“I became a nurse because of HIV. I was working in theater and my friends were dying of HIV. It was too hard to just watch and do nothing. I was a volunteer at the SF AIDS Foundation Hotline in the late 80’s. So in some level, I’ve been working with HIV patients ever since. I still haven’t found a cure. I made a commitment to stick with it until I find a cure”</td>
</tr>
<tr>
<td>• Master of Science in Nursing</td>
<td></td>
</tr>
<tr>
<td>• Family Nurse Practitioner - Certified.</td>
<td></td>
</tr>
<tr>
<td>• Urgent care to all patients as needed, <strong>women’s health, HIV/Diabetes/Hepatitis</strong></td>
<td></td>
</tr>
<tr>
<td>C care to panel of between 350 and 400 patients.</td>
<td></td>
</tr>
<tr>
<td>• Oversee the flow of the medical floor and the policies on the medical floor to exceed HIV Quality of Care national standards</td>
<td></td>
</tr>
</tbody>
</table>
Table 2  
*Participant #2 M.E.*

<table>
<thead>
<tr>
<th>Training and Role at CARES</th>
<th>Why I work in the HIV area</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Registered Dietician</td>
<td>“People who have HIV…by personal choice or whether it happened to them, life crosses a life changing experience when you’re diagnosed with HIV and how you’re going to live with that. The people here are more real and I enjoy working with them at that level.”</td>
</tr>
<tr>
<td>• Master in Dietetics</td>
<td></td>
</tr>
<tr>
<td>• Internship in hospital setting</td>
<td></td>
</tr>
<tr>
<td>• Trained at AIDS Project Los Angeles on HIV/AIDS Nutrition, covering work with food banks and clinical work.</td>
<td></td>
</tr>
</tbody>
</table>

Table 3  
*Participant #3 P.P.*

<table>
<thead>
<tr>
<th>Training and Role at CARES</th>
<th>Why I work in the HIV area</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Doctorate of Pharmacy, University of Pacific.</td>
<td>“I am a relational type person. In a hospital, the job is more adrenaline based and does not provide for many opportunities to directly connect with clients. I saw CARES as a family-oriented/family work team that promotes collaboration between members.”</td>
</tr>
<tr>
<td>• Post-graduate residency at UCDMC.</td>
<td></td>
</tr>
<tr>
<td>• Clinical pharmacist</td>
<td></td>
</tr>
<tr>
<td>• Direct consultation with individual clients about their medication regiment.</td>
<td></td>
</tr>
<tr>
<td>• Works with the medical and mental health staffs to help bridge the gap of knowledge about different medications that clients require.</td>
<td></td>
</tr>
</tbody>
</table>
Table 4
Participant #4 C.W.

<table>
<thead>
<tr>
<th>Training and Role at CARES</th>
<th>Why I work in the HIV area</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Master’s in Counseling</td>
<td>“I like the challenge. The spiritual and essential nature of people who’ve been down this road, it changes them. And those who have not been positively changed, I really love the challenge of working with them. And those who have been positively changed, I love the depth that that change has brought to their life and I like working with that.”</td>
</tr>
<tr>
<td>Psychology</td>
<td></td>
</tr>
<tr>
<td>● Licensed Marriage and Family Therapist</td>
<td></td>
</tr>
<tr>
<td>● Counseling and AOD services - providing individual and group counseling to patients struggling with substance abuse issues.</td>
<td></td>
</tr>
</tbody>
</table>

CARES

According to their website, CARES, the Center for AIDS Research Education Services, was established in 1989 through a partnership of UC Davis Health Systems, CHW Mercy, Sutter Health, and the county of Sacramento, and later, Kaiser Permanente. It is the largest HIV/AIDS nonprofit clinic in the Sacramento region and serves clients from all over the Central Valley who need testing, clinic services and counseling.

Currently, CARES serves more then 2,000 people each year with comprehensive services that care for the whole person, including a women’s clinic, dental services, on-site pharmacy, and behavioral health services such as counseling and nutrition education.
The Center also provides free and anonymous walk-in rapid testing services. In 2008, CARES performed nearly 1,000 rapid HIV tests, as broken down in Table 5 (CARES, 2009).

Table 5
HIV Testing Results 2008

<table>
<thead>
<tr>
<th>Testing Location</th>
<th>Total Tests Administered</th>
<th>Positive Test Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop-in testing at CARES</td>
<td>392</td>
<td>43</td>
</tr>
<tr>
<td>Community Testing</td>
<td>550</td>
<td>0</td>
</tr>
<tr>
<td>National HIV Testing Day</td>
<td>55</td>
<td>0</td>
</tr>
</tbody>
</table>

The largest population by age at CARES are patients between 45 and 64 (see Table 6), while whites make up largest group based on racial backgrounds (see Table 7), and MSM is the predominant infection mode for clients are MSM (see Table 8) (CARES, 2009.)

Table 6
Patients by Age 2008

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-24</td>
<td>54</td>
</tr>
<tr>
<td>25-44</td>
<td>891</td>
</tr>
<tr>
<td>45-64</td>
<td>1,005</td>
</tr>
<tr>
<td>65 and over</td>
<td>31</td>
</tr>
</tbody>
</table>
Table 7

*Patients by Race 2008*

<table>
<thead>
<tr>
<th>Race</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>311</td>
</tr>
<tr>
<td>Amer. Indian or Alaska Native</td>
<td>31</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>39</td>
</tr>
<tr>
<td>Black/African American</td>
<td>428</td>
</tr>
<tr>
<td>White</td>
<td>1,047</td>
</tr>
<tr>
<td>Not Reported</td>
<td>12</td>
</tr>
</tbody>
</table>

Table 8

*HIV Mode of Transmission 2008*

<table>
<thead>
<tr>
<th>HIV Mode of Transmission</th>
<th>Client Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men who Have Sex with Men</td>
<td>54%</td>
</tr>
<tr>
<td>Injection Drug User</td>
<td>12%</td>
</tr>
<tr>
<td>Men who Have Sex with Men &amp; Injection</td>
<td>9%</td>
</tr>
<tr>
<td>Heterosexual Contact</td>
<td>22%</td>
</tr>
<tr>
<td>Transfusion, Hemophilia</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
</tr>
</tbody>
</table>

The CARES Mission Statement is, “We transform lives through HIV/AIDS care, research and community awareness.”
Following the completion of the content analysis of all interview transcriptions, four areas of specific importance were revealed: Intentional infection; HIV viewed as a non-serious health issue; Other medical concerns; and Other factors of infection. Not all respondents provided information for all the topics.

**Intentional Infection**

E.T. and C.W. reported hearing from clients various reasons why they intentionally became infected. The one factor that all three reported hearing was the belief that HIV is not as serious an issue as it used to be. Specifically, E.T. reported hearing from MSM infected clients an, “Oh, well, it’s okay, you just take a pill and it’s no big deal” kind of attitude. C.W. reinforced this point when he revealed that clients who intentionally get infected might be in denial of the danger and he also used the phrase “It’s no big deal” when referring to the clients belief that due to antiretroviral medications, HIV is no longer a serious issue. In response to this, C.W. stated, “It’s just a little minimizing the real impacts of having the virus.” He described a pattern for some clients who had become intentionally infected, “Some of them from a vaguely suicidal kind of thing, not caring for anything, just very reckless, knowingly reckless.” His meaning was that for some clients who intentionally exposed themselves to risky behavior, they did so because they did not care about the results and willingly engaged in the reckless behavior.

E.T. disclosed the love cause that is revealed when she works with clients who were HIV negative and in a committed relationship with a partner who is positive. She
revealed that the seroconversion occurred out of love because, “I love him. He loves me.” She revealed that she asks these clients, “What is love? Can you define love?”

Another theme discovered in the research that was confirmed was inevitability of infection. E.T. stated clients have told her, “I figured I was gonna get it anyway. So what’s the big…It was gonna come.” She elaborated that there is, “This sense of helplessness that you can’t do anything to avoid it.”

**HIV: Not a Serious Health Issue**

This writer does not intend to imply that HIV is not a serious health issue. In the research, particularly in regards to intentionally becoming infected, there is an overwhelming belief among some men that HIV is no longer a serious issue when it comes to overall health. P.P. stated that she had not heard from clients that HIV is a chronic illness, but did reveal, “That is the view of providers.”

To the medical profession, HIV is now viewed as a chronic disease due to new pharmaceutical treatments. During the early years of the pandemic, most people who were diagnosed with HIV rapidly progressed to AIDS and died with in a matter of years, often no more then three to five years. The first drug treatments, using a complex combination of AZT and other drugs, required dosages to be taken throughout the day at timed intervals.

In the later part of the 1990s, a new treatment regiment was created, Highly Active Anti-Retroviral Therapy or HAART. Since the implementation of this new procedure, which combines three classes of drugs, often into a single pill, treatment for HIV has become an easier plan to follow. M.E. reinforced this change when she stated,
“The great thing is that patients are living longer, as opposed to in the 80s when we thought everyone would be dead in 10 or 5 years. Now we’re seeing people living 15-30 years post-exposure.” She went on the call this new generation of people living with HIV as “long-termers.”

C.W. and E.T. also mentioned how people who were infected a long time ago responded to their diagnoses. C.W. revealed, “Those who were infected years ago were given a death sentence in their minds.” E.T. mentioned, “One thing I’ve noticed in people who were infected a long time ago, and told they we’re going to die and they didn’t, is they did nothing about exercise, quitting smoking, eating healthy, not drinking as much, because they thought they were going to die.”

One other belief that was detailed in this section was that some people believe HIV only involves taking a single pill. E.T. revealed that, in regards to new annual HIV infections, “The gay population, MSM, seems to be stable. I think for a while it seemed to go down, and now there seems to be this, ‘Oh, well, it’s okay. You just take a pill and its no big deal’ kind of attitude.” P.P. showed the fallacy in this attitude early in her interview by stating,

Our research by the pharmacists show that the average patient is on seven different medications, which is not seven pills a day, that’s many, many more pills spread out over the day. HIV is really a pretty small piece of the overall medication burden pie.

Later in the interview, she discussed the medication regiment for some patients, “Seven medication average means zero for some and twenty for others.” She continued
with details about one patient, “Previous patient I met with is on thirteen scheduled medications, which results in eleven pills in the morning, six pills at 4:00 in the afternoon, and then more at bedtime.”

**Other Medical Concerns**

Although HIV is still a disease that invariably breaks down the immune system, leading to infections that would normally be fought off causing AIDS, it is no longer the only major health issue facing those infected. E.T., P.P., and M.E. all indicated that the major health concerns are illnesses, side effects, and diseases secondary to HIV infection. According to P.P., there are three causes for these other medical conditions, “Some are related to HIV, some to medications, some to the increasing age of clients.”

HIV is the virus that a person is initially infected with. After infection, the virus invades healthy cells in the body, changing the genetic structure to new HIV cells. Without medication, these cells continue to replicate leading to the reduction and eventual elimination of T-Cells, which help to fight off everyday infections. The virus is kept in check by the use of medications that prevent the virus from attacking healthy cells and replicating new viruses.

There were multiple subordinate and comorbid illnesses that E.T., P.P. and M.E. talked about, that many people who become infected with HIV may not be aware they will be susceptible for. Some of these are well-known diseases, while others are side effects, of either HIV infection or medications. E.T. reported, “Maybe 30% of our patients have Hepatitis C. It’s particularly high in IV drug use, but we’re seeing it as
sexually transmitted. It complicates HIV, and it’s a tough treatment, so we deal with that a lot.” P.P. listed three causes to these

M.E. discussed issues that long-term patients have, “Although we don’t see the AIDS wasting we used too, we do see a malabsorption syndrome where people long term on medications are developing lipoatrophies, a loss of fat in certain places.” She elaborated further,

And so what happens there is the diabetes develops, the hyperlipidemia, the high triglycerides is really a system malfunction. We don’t know how much is the medications and how much is the virus, or is a combination of both. We know certain medications can trigger high glucose levels, high lipids. Medications can be switched and those effects can be fixed.

Other issues seen by M.E. include,

There is a higher risk of heart disease and other issues, aside from weight causes, that are a result of the virus and the medications wearing away on the system. Our bodies are like machines, and they’re being taxed by fighting the virus and by taking medications we wouldn’t normally take, there is going to be a long-term affect.

As was described earlier, the medication regiments for some patients can consist of up to twenty pills a day. For patients who are required to take this extreme number of pills, there are separate issues that they are susceptible to. P.P. described one issue as, “For some it’s a headache, some it’s just pop them and go. Some patients only take some of their pills, prioritizing one disease over another. Schedule is the biggest problem.”
Side effects of medications are also a complication for some patients, which P.P. separated into three sections,

Biggest complaints that lead to patients not taking their meds are nausea, vomiting, diarrhea. Secondarily, drowsiness, headache, ability to concentrate. These two levels are the highest risk to cause to stop taking meds. Beyond these, are long-term effects, such as metabolic (high blood sugar, high cholesterol) changes in body (bone mass), changes in kidney and liver function.

Dealing with the side effects of medications is done in two ways. P.P. offered that patients are encouraged to, “Stick with the prescription for four weeks to build up tolerance to side effects or to adjust to the medication. Sometimes, an additional medicine is prescribed to deal with side effects of main drug.” M.E. discussed that nutrition,

Can help them tolerate difficult medications. For example, if a client is having severe diarrhea as a result of meds, if I can help with dietary changes to remedy the side-effects, I can help them stay on their meds and stay in care.

**Other Factors of Infection**

One issue that was discussed by C.W., E.T. and P.P. during their interviews was the mental health of clients. CARES offers a full mental health program for clients, ranging from one-on-one, couples, and group therapy to psychiatric services, and Alcohol and Other Drug (AOD) Services.

P.P. identified, “Depression, bi-polar, ADHD, anxiety disorders, things like that” as a few of the mental health issues clients deal with. C.W. added, “Major psychoses.
You add substance abuse on top of that, or the impact of mental illness on someone who is using drugs or drinking. We see personality disorders.” He described a circular pattern of the role of mental health in HIV infection,

People who have struggled in life because of mental illness have behaved in ways that have put them at risk for contracting HIV. And people who have contracted HIV have experienced things as a result of that knowledge or the dangerous behaviors they were in that contribute to the development of mental illness. There’s a feeding of all that together in both ways.

C.W. discussed that for many of his gay male clients, “Many of them did it in combination of using drugs, primarily meth or other party drugs: Ecstasy, GHB, Ketamine. Some were drunk.” Meth, or Crystal Methamphetamine, is a powerful stimulant that, according to the San Francisco AIDS Foundation (2008), “Stimulates your libido as well as anything else. And crystal can increase your self-confidence and lower your inhibitions. It also enhances sensation. If one uses crystal in a sexually charged situation, the effect will be heightened.” GHB, or Gamma hydroxyl butyrate, is degreasing solvent or floor stripper mixed with drain cleaner (“What is GHB?” n.d.) and Ketamine is a powerful tranquilizer primarily used by veterinarians for surgery on felines and monkeys (Porrata, 2008), as well as alcohol, all can put people at risk of engaging in behavior that can lead to infection.

E.T. discussed clients who did not use condoms and who told her that some of the reasons they did not included, “He won’t use a condom” and complaints that, “They don’t fit. They decrease sexual pleasure.” She also stated that in the case of younger
people, “They may not know how to properly and safely put a condom on.” She also described patients who, “Didn’t know their husbands or partners were injecting or on the down low” and who, as a result,

Got infected purely as a victim situation. So there is that element to it where you think you’re doing the right thing. You don’t think you have to use a condom with your husband of thirty years or your partner of thirty years.

E.T. also discussed older citizens, male and female, “Heterosexual and homosexual, thinking when they were single, ‘AIDS wasn’t here’ and they’ve been in these long relationships. And when they’re single and start messing around, HIV pops up. We’re seeing that around the country as well.” At the other end of the age spectrum, E.T. talked about the pain she feels when younger gay men come in as patients, “I still don’t know what to do about the gay guys. It breaks my heart. These beautiful young boys come in and be completely unfazed that they are infected.”

Summary

The interviews provided ample reinforcement of what was discovered in the reviewing the literature, and also provided new sources of information regarding why HIV infection continues to occur. At the same time, the respondents did not verify all of the factors discovered in the literature.

Perhaps the two most distressing factors that were confirmed by the interviews were that there are men who intentionally become infected and that these same men believe that HIV is not a major health issue. Examples of these included responses from patients who believed that getting HIV was an inevitability and that HIV can be treated
with a single pill with no other issues. Until these thought processes are amended, not only will people who hold these beliefs continue to become infected, but they can also lead others to thinking the same thing.

Other important factors that confirmed what the literature showed is that there are some people who become infected, not of their own choice, but because they trusted their partners and allowed sex to occur without condoms. These include women in relationships with men who might be on the down low, as well as men in same-sex relationships they believe are monogamous, but in fact their partners are engaging in unprotected sex outside of the relationship.

Although it was proven that there are some men who are intentionally exposing themselves to HIV infection, none of the respondents identified these men using the titles “bug chaser” or “bug chasing.” In addition, specific ages of newly infected patients were not discussed, though E.T. did address the growing infection rates among older citizens, as well as the apparent apathy of younger gay men when they discover they are HIV positive.

In the next chapter, this researcher will bring this project to its end by discussing how the information provided by the four respondents can be used to address the HIV pandemic as it stands in 2010. Further, this researcher will discuss his ideas on what can be done to change the current prevention techniques, which are obviously failing to connect with its targeted audience. Finally, the future of research into the topic of HIV infection will be discussed and what needs to be done to make it more relevant.
Chapter 5

CONCLUSION, RECOMMENDATIONS, AND IMPLICATIONS

The interviews this researcher conducted with four people who work directly with patients affected by the HIV pandemic successfully put a human aspect to the information discovered in the research of the literature. At the same time, it also identified some areas of research that are lacking in true efficacy and which need to be improved upon.

Conclusion

With the expert participation of professionals with medical, mental health, and behavioral knowledge of patients, evidence was found to support much of the existing literature. There are patients who become infected with HIV intentionally and for various reasons including a sense of inevitability of it occurring, a feeling of love and connection to a partner who is infected and the most reported, that there is a belief that HIV is a chronic illness that can be treated with a single pill.

To counter this belief that HIV is treatable and “Not a big deal” this researcher specifically discussed health issues with each respondent. According to one respondent, P.P., service providers see HIV itself as a chronic condition, due to the long term survival rates of patients currently being treated using the HAART regimen. However, each respondent did discuss that there are illnesses, reactions to medications, and diseases that those living with HIV/AIDS are more prone to being affected by. Conditions such as diarrhea, nausea and headaches are a few of the side effects to medication. The chemical break down of the medications by the body lead to organ malfunction, which cause
effects of their own such as high blood sugar and high cholesterol, leading to more medications to treat these issues and their potential to cause Diabetes and heart disease. To counter the belief that a single pill treats HIV, P.P. revealed that the average patient at CARES is on seven different medications, which can mean taking as many as twenty pills per day. The financial burden of just these prescriptions can be almost $200 per month in insurance co-pays.

Though this researcher chose to specifically limit the topic to men who became infected through sexual contact with other men, each subject discussed other factors of infection. The use of party drugs such as crystal methamphetamine can lead users to participate in sexual behavior they might otherwise not participate in. These activities can include unprotected sex with multiple partners, decisions to not use protection with a single partner and more. There are also growing numbers of older persons becoming infected later in life due to coming out of long-term relationships where condoms were not used and that HIV/AIDS was not present before their relationships began.

**Recommendations**

Nearly a full thirty years since the first cases of HIV were seen in the United States; new infections continue to occur across all populations. It is clear from the statistics and research that prevention techniques are no longer effectively reaching populations, and as such, need to be modified to stop the spread of HIV. CARES has created a program called *Are You the Difference*, which works directly with people living with HIV to teach them new behaviors that can help them to prevent passing the disease to others. This program has been effective in reaching CARES clients and others in
Sacramento among the over 4,000 patients diagnosed and receiving care in the region. According to E.T., it is, “Estimated that there is another 2,000 patients in Sacramento who do not know they are infected.” This is the population in the region who must be reached through prevention and education.

Culture specific education needs to be implemented to reach groups that still stigmatize HIV as a gay disease. African-American and Latino men who participate in sexual activities with other men need to know the risk they are at; as are their male partners and female partners they may go home to. African-Americans are disproportionately being affected by the pandemic, in Sacramento and nationwide, as show by the statistics from CARES that African-Americans make up less then 7% of the Sacramento population, yet account for 22% of the client base at CARES. Changing the stigma and encouraging all people to be tested can reduce the spread. The disproportionate statistics for African-America and Latino men of all ages is specifically addressed in the research of (CDC, 2008; Rosenberg and Biggar, 1998; and Harper, 2008) among others.

One topic that came up during the interviews was that many people no longer fear contracting HIV/AIDS. Multiple studies (Carballo-Diéguez and Bauermeister, 2004; Gauthier and Forsythe, 1999) identified that reasons for this belief include the benefits of HAART treatments, burnout towards safer-sex practices, and the portrayal in medical advertising of people living with HIV as being, “Healthy, virile, and physically fit individuals.” There is also a sense of inevitability of infection and a desire to become infected to be part of a brotherhood. The authors of both identified an undercurrent of
belief that HIV is no longer a fatal disease, but instead is a simply treated and controlled chronic condition.

To change this system of destructive thinking, publicity campaigns and posters must be updated to show that HIV is still a fatal disease and that there are still physical manifestations. E.T. discussed CARES’ *Positive Speaking* that trains positive individuals to speak to community groups and schools to educate them about the current face of HIV. While she likes the program, she did have some negative feelings as well,

We have our speakers who are very healthy and very funny and very good-looking, and it’s not really the face of HIV. They see these speakers and think, ‘It’s not that bad. He’s doing fine, he’s back in school, he’s in theater.’

She countered that students should take tours of the clinic to see the other side of the disease,

They’re not seeing my patients who are in wheelchairs, my patients who have neuropathy so severe they can’t walk. People who are dealing with treatments for Hepatitis C, treatments that are so nauseating and anemia provoking. So I think the face on the outside is still not right.”

Finally, she also had a criticism of the advertising done for HIV medications, advertising that can play into or reinforce the belief that HIV is not a major issue. Her opinion of this advertising is,

I think the advertising is terrible. If you look at HIV drug advertising, they use models, gorgeous models, that is absolute crap. This is not Flonase for your allergies. This is like a big deal. So until we take the pretty face away, which is
not to say they aren’t important, we have beautiful people who are positive, but its
giving the message that it’s not a big deal. And even though those people look
good, it’s a very big deal.

The final misconception that must be addressed is the false belief that a person
only needs to take a single pill and they will be healthy. As P.P. stated, some patients are
on a regiment of pills that can include upwards of twenty pills a day. A poster or
advertising campaign that counters the single pill myth, with a photographic display of
the total pills taken during the day, might be a beginning to countering this thinking. As
an example, this writer, prior to infection, thought it was only a single pill a day to
maintain health. However, this writer is currently on a regiment of six pills in the
morning, including a multi-vitamin and another six pills before bed at night.

Duck (2009) discussed how the impact of down low sexual behavior has on the
African-American community in regards to sexual practices of refusal to use condoms
and the spread of HIV and other sexually transmitted infection. To fully address this
issue, the stigma of HIV/AIDS needs to be directly addressed. E.T. spoke about a
woman she met who, after seeing the film Precious, and hearing a statement that a
character made about not being infected because, “He didn’t do me in the butt,” the
woman asked E.T., “So, you can’t get HIV from vaginal sex?” E.T. relayed that this kind
of question no longer surprises her, but does continue to frustrate her.

The stigma that still exists: that a person cannot get HIV because they are not gay
or do not have anal sex, needs to be addressed to each specific population group. People
need to be reeducated that HIV is not a disease that only infects gay men, that anyone can
get it if they do not follow a few simple guidelines: know their status, know their partner’s status, and practice safer sex by using condoms. Finally, all prevention and education techniques need to be addressed specifically to meet each group individually. For example, campaigns must be designed that address African-Americans, which will be separate from Latino communities, Asian communities, women, gay men, and so forth.

**Implications**

The research has clearly shown, as have the interviews, that HIV is still a relevant problem today. Social work professionals, no matter what populations they choose to work with, need to know that many of their clients are probably at risk directly or indirectly for becoming infected. By having this knowledge, social workers can help clients know their risk and support them in making healthy choices. We cannot stop the pandemic by only working with those who are already infected; we need to prevent those who are not infected from becoming so.

For the future, it is important that a researcher who seeks to continue this or a similar topic be allowed to speak with people who are living with the disease and get their expert knowledge. While talking to professionals who work with people living with HIV was beneficial in support of this project, this researcher believes that the impact would have been more beneficial if the information had come from the patients themselves. These prospective respondents can be protected in the research by not having their names revealed, conducting the research where they feel comfortable and allowing them to quit if they become uncomfortable.
Allowing the person living with the disease to provide their information would bring an honesty and greater knowledge to the research. This would provide more authentic information which can be used to create better prevention techniques to educate those who are not infected, and particularly to those who are contemplating becoming infected, that HIV is not an easy thing to cope with and to counter the, “It’s no big deal” myth. Lastly, it will provide support to, or refutation of, research that has been conducted that only used online resources.

Summary

This project has been an experience this researcher has greatly enjoyed doing and looks forward to continuing in a professional capacity. For a disease that is 100% preventable to still be infecting nearly 60,000 people in the United States every year, it is obvious that prevention messages are failing to achieve their intended goal. The reasons for infection range from what one respondent referred to as a, “Victim situation” where a person becomes infected because they trust their partner’s faithfulness, to the group of people, more often gay men, who believe that HIV is either inevitable or easily treatable and who then become intentionally infected.

Until prevention techniques are modified to address these new infection factors, the rate of infection will continue to, at best, remain stable at current yearly rates, or at worst, increase to new high levels. One benefit of increasing the efficacy of prevention techniques is that the CDC estimates that, “Every new infection prevented saves taxpayers $250,000,” (CARES, 2009.) If the current rate of approximately 57,000 new
annual infections could be reduced by just 10%, this could represent an estimated savings of over $1.4 billion taxpayer dollars.

For the future of research, human subjects guidelines need to be relaxed that would make speaking to actual people living with HIV/AIDS. This researcher was informed that this population is considered “At-Risk” by the guidelines the Division of Social Work Committee for the Protection of Human Subjects, due to the stigma of HIV/AIDS on those living with the disease. When one of the major factors that continue to contribute to the new infections is the stigma of HIV/AIDS, this is a circuitous loop that cannot be fixed. While interviewing professionals provided a great amount of insight into the pandemic, it would have been more beneficial to be able to have the knowledge of people living with the disease to provide their stories. Until such time as they are allowed to actively participate, not all the information gathered will have a feel of authenticity.

The only way that HIV can be eliminated, since there is no vaccine or cure in the near future, is to prevent new infections from occurring. Thus, education needs to be redirected to an honest and frank representation of what HIV does to the body to change people’s thinking. Seeing the blunt and perhaps even more frightening side of HIV might affect people in the same way that visually jarring anti-smoking campaigns have done. Until this happens, people will continue to put themselves, their partners, and their futures in jeopardy.
APPENDIX A

Consent to Participate in Research

(Purpose of Research) You are being asked to participate in research, which will be conducted by William Morefield, graduate student of Social Work at California State University, Sacramento, under the supervision of Dr. Santos Torres, Jr., Professor of Social Work. The purpose of the study is to understand the multiple factors that influence HIV infection rates in men who have sex with men (MSM) in the Northern California area.

(Research Procedures) You are being asked to participate in an audio-recorded interview regarding your professional background and knowledge regarding the HIV/AIDS pandemic in Sacramento, particularly in regards to men who became infected as a result of sexual contact with other men. Each interview will last approximately 30-60 minutes and will consist of between six and ten questions. With your permission, the researcher will record the interview using a digital recorder. All interviews will be transcribed by this writer and will be destroyed following publication of this research.

(Risks) This research project has been determined to be a “No Risk” study that involves no danger to the subjects. However, if at any time you feel uncomfortable, you have the right to suspend or terminate the interview without penalty. Should you request the interview be ended, this researcher will end the interview and no information obtained will be used.

If you experience any psychological discomfort during the study and feel you need help, either immediately or any time after completing the research, please contact CARES at (916) 914-6200 to speak with a mental health counselor. You may also contact the Crisis Hotline in Sacramento County at (916) 732-3637.

(Benefits) The information you provide may help social work professionals, HIV/AIDS educators and prevention professionals and future researchers to better understand why MSM is the largest group of new annual infections every year and how to better create prevention and educational materials to decrease or end these new infections.

(Confidentiality) All results obtained in this study will be confidential. Your signature on this consent form will be kept in a locked cabinet in this researcher’s home. Following completion and submission of this research, all consent forms will be destroyed using a paper shredder. All recordings of the interviews, both original and backup copies, will also be destroyed.

(Compensation) There is no compensation for this project.
(Contact Information) If you have any questions about this research, please ask now. If you have any questions at a later time, you may contact William Morefield, MSW graduate student, at (916) 213-6174, or by e-mail at wmorefield@gmail.com. You may also contact my adviser, Dr. Santos Torres Jr. by phone at (916) 278-7064 or by e-mail at torres@csus.edu.

Your participation in this research is entirely voluntary. You may decide not to participate, or to stop participating at any time without consequence. Your signature below indicates that you have read and understood this consent form and agree to participate in the research.

_____________________________________                      _______________________
Signature of Participant                                    Date

_____________________________________                      _______________________
Signature of Researcher                             Date
APPENDIX B

Interview Questions for Participant #1 E.T., RN, MSN, FNP-C

1. What is your educational background related to your profession?

2. What made you decide to work with the HIV community?

3. How long have you been working with this population?

4. What keeps you interested in working with this population?

5. What is your role in the medical team?

6. How many clients does CARES serve?

7. On average, how many people are diagnosed with HIV at CARES?

8. Are there any newly diagnosed clients who were initially diagnosed with AIDS, not HIV?

9. What are some of the reasons that you have heard, in working with male clients who became infected from other men, on why they became infected?

10. Aside from HIV, what are some of the other conditions that a person living with HIV may be affected by or infected with?

11. Do you see any problems or limitations with current HIV prevention/education programs?

12. If you could create a HIV prevention/education program, what would it encompass?
APPENDIX C

Interview Questions for Participant #2 M.E., M.S., R.D

1. What is your educational background related to your profession?

2. Why did you decide to work with the HIV/AIDS population?

3. How long have you been working with this population?

4. What keeps you interested in working with this population?

5. Have you found that nutrition is important in this population?

6. What have you found is important in working with this population?

7. What impact does HIV/AIDS have on the body from a nutrition aspect?

8. What role can nutrition play in the health of someone who is living with HIV/AIDS?

9. Do you see any shortcomings or problems with HIV prevention techniques currently being used?

10. If you could change prevention techniques, what would you do?
APPENDIX D

Interview Questions for Participant #3 P.P., Clinical Pharmacist

1. What is your educational background related to your profession?

2. What made you decide to work with the HIV community?

3. How long have you been working with this population?

4. What keeps you interested in working with this population?

5. On average, how many medications is the typical CARES patient on, for HIV and related issues?

6. For these medications, what is the typical daily regiment?

7. What are some of the side effects of these medications?

8. If those side effects occur, how are they dealt with?

9. What is the average cost of HIV medications?

10. For a person who is diagnosed with HIV, what are some of the financial hardships they may face?

11. Do you see any shortcomings or problems with HIV prevention techniques currently being used?

12. If you could change prevention techniques, what would you do?
APPENDIX E

Interview Questions for Participant #4 C.W., LMFC

1. What is your educational background related to your profession?

2. What made you decide to work with the HIV community?

3. How long have you been working with this population?

4. What keeps you interested in working with this population?

5. How many clients do you work with?

6. What are some of the mental health issues that your clients are dealing with in combination with their HIV?

7. Have your clients given reasons why they became infected?

8. Do you see any shortcomings or problems with HIV prevention techniques currently being used?

9. If you could change prevention techniques, what would you do?
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