



Understanding HIV risks of chronic drug-using men who have sex with men

F. RHODES,¹ S. DEREN,² M. M. WOOD,¹ M. G. SHEDLIN,³
R. G. CARLSON,⁴ E. Y. LAMBERT,⁵ L. M. KOCHEMS,³
M. J. STARK,⁶ R. S. FALCK,⁴ L. WRIGHT-DEAGÜERO,⁷ B. WEIR,⁶
L. COTTLER,⁸ K. M. ROURKE,⁸ & R. T. TROTTER II⁹

¹California State University, Long Beach, ²National Development and Research Institutes, Inc.,
³Sociomedical Resource Associates, Inc., ⁴Wright State University, ⁵National Institute on Drug
Abuse, ⁶Multnomah County Health Department, Oregon Health Division, ⁷Centers for Disease
Control and Prevention, ⁸Washington University in St Louis & ⁹Northern Arizona University,
USA

Abstract Focus groups and individual structured interviews were conducted in six cities with 98 predominantly street-recruited men who had a recent history of smoking crack or injecting drugs and who reported having had sex with other men (MSM) in the past year. Twenty-six focus groups explored the cultural and social context of participants' drug use and sexual activity and addressed outreach and HIV prevention issues pertinent to this population. Narrative summaries developed from verbatim focus group transcripts identified seven themes: (a) sexual orientation and gender identity; (b) interactions within and between MSM networks; (c) drug use, sexual activity and personal relationships; (d) HIV transmission bridges; (e) preferred HIV information sources; (f) HIV knowledge, prevention practices and risk behaviours; and (g) availability of HIV and drug-related services. Of the 98 MSM drug users, 42% identified publicly as gay or homosexual; 35% identified publicly, but only 21% privately, as heterosexual. A total of 51% had one or more female sex partners in the past year. There was a high frequency of unprotected sex in conjunction with drug use and a distinct preference for having sex when high. For most participants, drug use rather than sexual orientation formed the core of personal identity. Participants reported associating primarily with other drug users, usually MSM, and had limited contact with people who did not use drugs and the mainstream gay community. Participants' sexual and drug-injecting activities were judged to be a bridge for transmission of HIV to both people who used drugs and those who did not.

Introduction

Men who have sex with men (MSM) currently account for nearly half of all newly diagnosed cases of AIDS (Centers for Disease Control and Prevention [CDC], 1995). MSM who use illicit drugs are especially likely to become HIV-infected for several reasons. First, those who inject drugs can be at increased risk of HIV infection if they use injection paraphernalia that

Address for correspondence: Fen Rhodes PhD, California State University, Long Beach, Center for Behavioral Research and Services, 1090 Atlantic Avenue, Long Beach, CA 90813, USA. Tel: (562) 495 2330; Fax: (562) 983 1421; E-mail: frhodes@csulb.edu

has been used by someone else. Secondly, both injecting and non-injecting drug use are associated with high-risk sexual behaviour, either as a result of increased libido caused by specific drugs such as crack cocaine and methamphetamine or through bartering of sex for drugs or money (Deren *et al.*, 1996a, b). Finally, because of the high prevalence of HIV, both in injection drug users (IDUs) and MSM, each unsafe sexual or drug injection experience carries a heightened probability of disease transmission.

The specific elevated risks of MSM drug users have been documented in a number of studies. In a study of MSM enrolled in drug treatment compared with MSM from the general community, a higher percentage of those in drug treatment reported engaging in unprotected insertive or receptive anal sex (Paul *et al.*, 1993). Similar results have been reported by other investigators for unprotected sex and other risk behaviours, including frequency of sexual activity and trading sex for drugs or money (Battjes, 1994; Gorman *et al.*, 1995; Myers *et al.*, 1992; Ostrow, 1994; Peterson *et al.*, 1992). There is also some evidence that MSM IDUs are more likely to engage in high-risk injection practices than are heterosexual IDUs. In a large study of Baltimore IDUs, homosexual and bisexual men were reported as more likely to inject drugs in a shooting gallery (Celentano *et al.*, 1991) and to shoot up with used injection equipment (Mandell, *et al.*, 1994) than were heterosexual men. Not all studies have supported these findings, however. In an Australian study, for example, sexual orientation was not related to injection behaviour and was inconsistently related to sexual risks (Ross *et al.*, 1992).

A number of studies have reported that a substantial percentage of MSM drug users are behaviourally bisexual (Gorman *et al.*, 1995; Lewis & Watters, 1994; Myers *et al.*, 1992; Peterson *et al.*, 1992; Seidman *et al.*, 1994). The sexual and drug-injection activities of men who have sex both with men and women may serve as a bridge for the transmission of HIV (and other infections) to and from a variety of other populations, including heterosexual women who do not use drugs (and their children through vertical transmission), gay and bisexual men who do not use drugs through sexual activity, drug-using heterosexual men through needle or other paraphernalia sharing and drug-using women through needle or other paraphernalia sharing and sexual activity. Additionally, the activities of MSM drug users who are exclusively homosexual may serve as a bridge for infection to and from men who do not use drugs.

Although relatively little has been documented concerning MSM drug users, drug use may take place in a number of subcultures and contexts, and the characteristics of MSM drug users and their interactions with one another may differ significantly from group to group (Gorman *et al.*, 1995; Waldorf, 1994). These differences have major implications for gaining access to and designing HIV risk interventions for such individuals. In addition, MSM have reported using a variety of injected and non-injected drugs, including crack and other cocaine, methamphetamine and heroin (Waldorf, 1994). In the western United States methamphetamine (speed) seems to be the drug of choice of many, if not most, MSM drug users (Gorman *et al.*, 1995). Increased levels of high-risk sex among MSM have been associated with the use of cocaine, especially crack, and methamphetamine, owing in large part to their disinhibiting effects combined with their reported enhancement of libido and sexual experience (Institute of Medicine, 1994; Käll, 1992; Käll & Nilsson, 1995). Types of drugs, drug-use patterns, cultural context and group interactions may be factors in determining risk behaviours and the normative practices of specific MSM groups and networks, as they are in heterosexual groups. At present, however, little research speaks directly to these issues.

Sexual orientation and gender identity also contribute to the diversity of MSM drug users and should be considered in understanding this population from the perspective of

developing access mechanisms and planning effective interventions. The drug use and sexual activity of MSM in different contexts may have different meanings depending upon self-identification as gay, bisexual or heterosexual and gender identity as male, female or transgender. A further influence on risk behaviour is related to the high degree of social or economic marginalization that characterizes MSM who are chronic drug users (Ostrow, 1994). People who are unemployed and homeless are likely to be especially difficult to reach, requiring tailored access strategies and intervention approaches, including participation and follow-up incentives, that differ markedly from the strategies and approaches that are likely to be successful with people who are employed and have relatively stable living situations. Similarly, MSM drug users who are gay-identified and maintain a connection to the larger gay community may require different contact and recruiting approaches than do people who may identify themselves as gay but who are isolated from the larger gay community.

Because homosexual activity and drug use, as well as the illegal activities associated with drug use, are stigmatizing behaviours, MSM drug users can be said to represent what Watters & Biernacki (1989; Watters, 1993) have termed a hidden population, whose members are difficult to reach and who require specific outreach strategies. In the NIDA CA studies, for example, only 2% of 4,100 males enrolled during one 16-month period reported having male sexual partners (Battjes, 1994). Although this finding may be partly an artefact of under-reporting, it is more likely that the outreach strategies, because they did not target MSM drug users explicitly, were not reaching important segments of the MSM drug user population.

To clarify some of the issues relating to the context and dynamics of HIV transmission among MSM drug users and their implications for developing effective HIV prevention interventions, individual structured interviews and focus groups were conducted with MSM drug users in six cities. Focus groups addressed the cultural and social context of drug use and sexual activity among MSM as well as HIV prevention needs.

Methods

Study sites

The study was conducted at five NIDA CA sites that were identified as having significant numbers of MSM among their research participants: Columbus-Dayton, Ohio (considered one site); Long Beach, California; New York (East Harlem), New York; Portland, Oregon; and St Louis, Missouri. Activities for the MSM focus-group study were co-ordinated by NIDA CA programme staff at each study site, with guidance from agency staff at NIDA and the CDC.

Participant eligibility

To be eligible for the study, individuals had to self-identify as biological males and to report having had sex of any type with another male in the past year. In addition, they must have reported injecting drugs or smoking crack within the past 30 days or to have been previously enrolled in the local site's NIDA CA programme. Eligibility requirements for the NIDA CA programme included drug injection or crack use in the past 30 days prior to enrollment, not being in formal drug treatment in the past 30 days and being at least 18 years of age.

Recruitment and screening

Participants were recruited between October and December 1995 through contact with former participants in the NIDA CA programme, direct community outreach and chain-re-

ferral. The degree of emphasis placed on each approach varied across sites and reflected local conditions.

At each site recruitment was conducted by experienced outreach workers, who recruited prospective study participants at street hangouts, cruising sites, drop-in centres and homeless shelters. Men considered potentially eligible were screened by outreach staff, and those who appeared qualified were informed about the study and offered an interview appointment. They were also asked to refer eligible friends or acquaintances who might be interested in the study.

Former NIDA study participants who had identified themselves as gay, homosexual or bisexual, or had reported engaging in sex with other men, were contacted by telephone or in person and told that they might be eligible for a special study of sexual and drug practices requiring an individual interview and a group discussion with other MSM.

Structured interview

A structured interview lasting approximately 45 minutes was conducted with study recruits one or more days prior to focus-group participation. The interview verified study eligibility; obtained basic demographic data; and elicited quantitative information regarding drug use in the past 30 days, number of male and female sex partners and sex-trading activity in the past year, public and private sexual identity, gender identity, current personal and sexual relationships and HIV testing history. Informed consent for participation in the individual interview and subsequent focus groups was obtained prior to the interview session. All interviewees received a \$10–20 remuneration regardless of their final study eligibility and were referred for HIV testing as appropriate. Interviews were conducted with a total of 144 eligible MSM drug users, of whom 98 attended focus groups.

Focus groups

Rationale. The use of focus groups for HIV/AIDS and drug abuse research has been described by Shedlin & Schreiber (1995), who considered the technique 'uniquely effective in obtaining information from hard-to-reach populations' (p. 154). Focus groups provide a powerful tool for the rapid exploration of phenomena whose dimensions and relationships are not extensively developed or fully understood (Stewart & Shamdasani, 1990). The focus group yields emic data that are particularly well suited to the generation of hypotheses and the identification of issues for future research. The technique was deemed particularly appropriate to increase the current limited knowledge and understanding of the personal imperatives and social interactions of MSM drug users in the context of HIV prevention.

Procedure. Twenty-six focus groups were conducted with MSM drug users. At each site, three initial focus groups explored the cultural and social context in which drug use and sexual activity by MSM drug users take place. Two follow-up focus groups were conducted with selected members of these groups to address pertinent outreach and HIV prevention issues[1]. Men were assigned to the initial focus groups based on sexual identity, drug type, age and sex trading as reported in the structured interview. The three initial focus groups at each site comprised men who: (a) identified as gay or homosexual, (b) identified as bisexual or heterosexual, and (c) represented subgroups of special interest at each site, e.g. transgenders in New York, young injectors in Portland and methamphetamine-using non-gay-identified hustlers in Long Beach. A total of 98 MSM drug users participated in the

initial focus groups, and 75 participated in a follow-up group. There were four to eight men in each group, with a total of 22 group participants in Columbus-Dayton, 21 in Long Beach, 22 in New York, 18 in Portland and 15 in St Louis.

The topics explored in the initial focus groups were (a) patterns of drug use and sexual activity; (b) personal identity as related to sexual activity and drug use; (c) relationships between drug use, sexual activity and sexual identity; (d) interactions with other drug users, MSM and non-MSM; (e) interactions with other MSM, gay and non-gay; and (f) relationships to the mainstream gay community. The second set of focus-group sessions addressed HIV prevention issues, including (a) HIV knowledge and misconceptions, (b) prevention practices and barriers, (c) availability of services, (d) credible information sources and (e) programme recommendations.

A guide listing topics, transitions and probes was developed by site investigators and group moderators in collaboration with NIDA and CDC staff. Groups were co-facilitated by two experienced moderators, who met after each focus group to compare and summarize their observations and impressions. Groups lasted approximately 90 minutes; food and beverages were provided. Participants were paid \$20–40 for each focus group. Sessions were audio-taped and verbatim transcripts were produced.

Analytical approach. A summary of each site's focus groups was prepared by local investigators. These summaries synthesized the experience of each site, informed by the perspective of the site's moderators and investigators. Site summaries were the primary data source for a secondary cross-site analysis of common themes. Summaries were supplemented by topic-coded transcripts, which served as a source of illustrative quotations of key concepts[2]. The frameworks of narrative 'thick description' (Geertz, 1973) and grounded-theory interpretation (Glaser & Strauss, 1967) guided the qualitative analysis.

A common format for the site summaries was developed collaboratively by study investigators in co-operation with NIDA and CDC staff following collection of focus-group data. Site summaries were organized by seven themes, reflecting the structure defined in the focus group guide and our emerging understanding of key issues for this population. The following topics were addressed: (a) sexual orientation and gender identity; (b) interactions within and between MSM groups; (c) drug use, sexual activity and personal identity; (d) HIV transmission bridges; (e) sources and impact of HIV information; (f) HIV knowledge, prevention practices and risk behaviours; and (g) availability of HIV and drug-related services and gaps in service. Site summaries were based on focus-group transcripts and audio-tapes, augmented by moderator notes. Investigators categorized the content of each focus group session according to the taxonomy above, identifying normative as well as unique or unusual behaviours and beliefs, and characterizing the heterogeneity and the variability of participants' responses. Quotations from participants were included whenever possible to illustrate key assertions and interpretations.

Results

Table 1 presents demographic and other characteristics of participants from the structured interview. Thirty-eight per cent of the 98 men who attended focus groups had previously participated in the NIDA CA programme (0–50% across the five sites). There was no significant difference between former NIDA CA participants and new recruits on any characteristic except age (mean = 37.7 versus 34.0, $p = 0.007$). This was largely accounted for by a higher percentage of newly recruited participants below age 25 (14% versus 6%),

Table 1. *Characteristics of focus-group participants (N = 98)*

Characteristic	% ^a
Ethnicity	
African American	56
White	29
Hispanic	9
Asian, Pacific Islander, Native American	0
Other	6
Age (years)	
18–24	8
25–34	31
35–44	50
45–55	11
Male biological sex	100
Self-identified gender	
Male	86
Female	6
Transgender	5
Other, unsure	3
NIDA study participant	38
Drug use past 30 days^b	
Smoked crack or injected drugs	96
Smoked crack	77
Injected any drug	37
Injected cocaine alone	10
Injected heroin alone	18
Injected heroin + cocaine (speedball)	11
Injected methamphetamine (speed)	16
Private sexual identity/orientation	
Gay	20
Homosexual	23
Bisexual	27
Heterosexual	21
Other, unsure	9
Public sexual identity/orientation	
Gay	28
Homosexual	13
Bisexual	16
Heterosexual	35
Other, unsure	8
Current sexual relationship	
Primary male partner	20
Primary female partner	11
Steady male partner	36
Steady female partner	28
Steady male and female partners	10
No primary or steady partner	47
Number of sex partners past year^c	
1 + male partners	100
5 + male partners	43
10 + male partners	32
1 + female partners	52
5 + female partners	24
10 + female partners	11
Provided sex for drugs or money past year	51
HIV testing history	
Ever tested	93
HIV positive (of 91 tested)	16

^a Based on *N* of 98 except as noted otherwise. ^b Drug-use categories are not mutually exclusive. ^c Median number of male partners = 4; median number of female partners = 1.

reflecting the specific focus on youth at the Portland site. Anecdotal information obtained during the focus groups suggested that most participants were unemployed. Most seemed to have transient living situations, and a substantial number said they were living on the street. Focus-group participants ($n = 98$) differed from no-shows ($n = 36$) in two respects: participants were older than no-shows (mean age = 36.2 versus 33.3, $p = 0.036$), and a larger percentage identified as gay or homosexual (41% versus 20%, $p = 0.037$). Structured interview findings from the full sample of 144 participants are reported elsewhere (Deren *et al.*, 1996b).

Drug use, sexual activity and personal identity

Ninety-six per cent of focus-group participants reported drug use during the past month. The remaining 4% were previous NIDA programme participants with a history of recent drug use. Detailed drug use information is presented in Table 1. Drug use patterns differed markedly by site, reflecting in part site-specific recruitment priorities. Among participants, drug injection prevalence was 22% in Columbus-Dayton, 48% in Long Beach, 27% in New York, 78% in Portland and 0% in St Louis. The percentage of men who injected speedball[3] was considerably higher in New York (83%) than in Columbus-Dayton (33%), Long Beach (20%) or Portland (14%). The prevalence of methamphetamine injection was higher in Long Beach (90%) and Portland (43%), where methamphetamine users were a recruitment priority, compared with New York (17%) and Columbus-Dayton (0%). The percentage of participants who were crack smokers was similar across sites except for Portland: Columbus-Dayton, 90%; Long Beach, 86%; New York, 82%; Portland, 28%; and St Louis, 100%.

Focus-group discussion pointed to a strong linkage between drug use and sexual activity. As a New York participant put it, 'We know when we do get high ... we need dick.' Crack cocaine and methamphetamine were described as increasing sexual desire or enhancing the sexual experience, resulting in increased frequency of sexual activity and number of sex partners. The following comments are illustrative:

Once a person starts smoking crack ... he'll do anything. (New York)

When I take a big blast of cocaine and I see anybody—a woman, a man, whatever—and I'm horny. Whew! (Long Beach)

Speed has a way of like crossing lines. It's like you can bring somebody to do something under the influence of speed, say sexually wise, that they otherwise wouldn't do ... It makes a craving. (Long Beach)

Once you hit that [crack] pipe ... your inhibitions, they're on the floor. And you'd be surprised at some of the things that'd go through your mind ... sexually. (Columbus-Dayton)

Although participants acknowledged that crack and methamphetamine do not result in increased libido in all people on all occasions, there was strong general consensus that this was true for most people on most occasions and that 'certain types of drugs ... seems to bring ... out the sexual appetite' (New York). However, some participants questioned the assertion that once high, most men will readily engage in homosexual behaviour regardless of their stated sexual preference. In the words of one New York participant, 'A drug can only induce [sexually] what is in the person, so you cannot blame it all on the drug.'

Drugs and sex were also linked in a transactional sense in that having sex with men served as a mechanism for obtaining drugs or money to buy drugs. The possession of drugs, in turn, was described as a means of attracting desirable sex partners, both male and female. Thus, an invitation to share drugs often carried an expectation to have sex: 'They say, "Look, hey, I got this amount of drugs, you know. Can we smoke it all? Can I give you some head or this and that?" And if you want the drug, you say, "Okay"' (New York). Another New York man noted that, in some instances, what seemed to be an attempt to procure drugs disguised a sexual agenda: 'You can be standing on the corner, [and] somebody comes up to you and tells you ... "You know where to get something?" And all the time they really want to ... take you with them.'

Some non-gay participants stated that they provided sex to mainstream gay men [4] for drugs or money. The attitude toward such encounters was mixed—some individuals felt preyed upon by gay men who pay for sex: 'Most of 'em are assholes; most of 'em got diseases. They don't give a damn about you, your dick, or what you gonna do with the money' (Long Beach). Others were of the opinion that gay men who pay for sex are simply lonely, noting that they sometimes offer non-gay hustlers a meal, a shower and a place to stay for the night. One non-gay participant described how his own feelings about gay men had changed:

Before, when I'd have sex with guys, I was always hustling. You know what I mean? But after a while I tell you what, I started seeing that some of these people [gay men] actually cared about me, and that started becoming more fulfilling than the money.
(Long Beach)

Participants, except the few who reported only occasional use of drugs, agreed that their drug habit was the primary focus of their lives and, as such, was perhaps the central element of their personal identity. For most, using drugs and supporting that habit was their foremost priority. Everything else, including sexual activity and sexual preference, was secondary. Participants in one of the New York focus groups were quick to reply affirmatively when asked whether 'the drug is more important than your [sexual] identification'. In the words of a St Louis participant, 'If you're using [drugs], it doesn't make that much difference [about sexual orientation]—it doesn't make any difference.'

Sexual orientation

Table 1 summarizes participants' self-described sexual identity/orientation obtained during the structured interview. Approximately half identified as either gay or homosexual (43% publicly, 41% privately). While there was substantial agreement in the private versus public sexual orientation reported by participants ($\kappa = 0.51$, $p < 0.001$), relatively more men identified themselves publicly as heterosexual than did privately (35% versus 21%). Also, 27% identified privately as bisexual, but only 16% did so publicly.

Many, if not most, focus-group participants displayed a high degree of comfort and openness in discussing their sexual orientation and their same-sex behaviour. This openness was more characteristic of self-identified gay, homosexual and transgendered men than it was of bisexual and heterosexual men. Thus, men who identified as bisexual or heterosexual, but who were behaviourally bisexual, tended to avoid talking directly about their same-sex experiences, tended to justify and rationalize their homosexual activity and expressed dissatisfaction with traditional sexual-orientation labels. Gay- and homosexual-identified participants, on the other hand, were frank about their homosexual activities and were comfortable in applying specific sexual-orientation labels. Individuals who described themselves as trans-

genders were also candid in discussing their sexual activities, but they did not consider the labels 'gay' or 'bisexual' or 'straight' to be adequate descriptors of sexual orientation. Among gay- and homosexual-identified participants, there seemed to be a general, although not exclusive, preference for the term 'gay' over 'homosexual'. One Columbus-Dayton participant who identified himself as homosexual said, 'For some reason I just don't like the term "gay" ... I like to have the in-the-face comment that I am "homosexual".'

Typical of participants who identified themselves as gay or homosexual were comments reflecting comfort, and lack of ambiguity regarding their sexual orientation, such as:

I'm letting them know that I'm gay and this is me, and accept me for who I am or not. (New York)

I'm not ashamed of it [being gay] because I don't care who sees me with who ... That's me, I'm doing my life ... I ain't ashamed of what I do. (St Louis)

In marked contrast were the statements of non-gay men:

I'm straight ... [though] sometimes you might dip around. (Columbus-Dayton)

If you go out there and do something for money, that doesn't make you a homosexual, because you don't do it that often. (St Louis)

You get so twisted [when you use drugs] that you end up just crossing the lines ... and it doesn't matter whether it's a woman or a man. (Long Beach)

We're not gay; we're not bisexual ... we're kind of out there doing what we got to do ... we don't discriminate [men or women]. (Long Beach)

I don't label myself as any one of the categories ... I just consider myself to be me, and whatever works, works. (Columbus-Dayton)

MSM youth, gay as well as non-gay, seemed somewhat less open than older participants about their sexual orientation and sexual practices in interactions with those they perceived might not be gay-friendly. A younger street-based participant from the Portland area said, 'No, [my friends don't know that I have sex with men] 'cause I keep my sexuality private. I'm not going to tell anybody about it.'

Gender identity

Although most of the participants reported their gender as male during the structured interview, 11% reported transgender or female and 3% reported some other gender designation (Table 1). Of the 14 individuals who reported gender other than male, 12 were from three sites: Columbus-Dayton, New York and St Louis. In New York, which had a special focus on gender-identity, male-to-female transgenders saw themselves as distinctly separate from other MSM drug users regardless of sexual orientation. They perceived themselves as disapproved of and discriminated against by gays and non-gays alike and felt marginalized with respect to the gay community. These feelings are evident in the following comment:

You know ... it's like you're no longer a part of the gay community, but then again you're no longer part of the heterosexual community, so then you have to make up your own community, and this is where the transgender comes out.

HIV risk-behaviours and barriers to risk reduction

Participants reported that HIV risk-behaviours were commonplace in their experience and that of MSM drug users of their acquaintance. This was especially true of sexual behaviour, but it was also true of behaviour related to drug injection. The men described a variety of situational and personal obstacles to effective risk reduction.

Sexual risks. Participants in all cities stated that they engaged routinely in high-risk sexual practices, including unprotected anal sex (both insertive and receptive), oral sex and vaginal sex. In addition, a substantial majority of participants reported having a variety of casual sex partners, many of whom were members of populations with high rates of HIV infection.

Condom use was reported as a problem: some men did not use condoms at all or not for certain types of sex or with certain partners, and others tried to use condoms consistently but were unable to do so. Individual perspectives on condom use differed. Some of the men took no personal responsibility for condom use but did not object if their partners wanted to use condoms: 'I've never had to put one on, I guess it's because I'm always on the bottom, so whatever he wants to do, I don't care. [He uses a condom] if he wants to, I mean, you know, shit, I'm going to OD on heroin anyway, you know what I'm saying?' (Columbus-Dayton). A few participants stated that they had not used condoms in the past and had no intention of starting: 'Believe me, I don't use condoms; I'm never gonna use condoms' (New York). Others said that they used condoms sometimes but were simply not motivated to do so all the time: 'I'll get in these moods where ... I make 'em use it, you know. Then I get in these ... moods where I don't care ... where ... I find it more convenient not to use them' (Columbus-Dayton). Condoms were reported to be used more often for anal and vaginal sex and less frequently for oral sex, as expressed by one Columbus-Dayton man: 'With me, if ... you give 'em head, okay ... fuck the condom. But if they want up in you, then they want to put a condom on.'

Several barriers to consistent condom use were mentioned, but chief among them was drug use and the disinhibiting effects on libido, which reduced personal control and attenuated motivation to use condoms. Participants were quite explicit:

The drug ... sets you up so that you don't go the course ... as far as rubbers and those kind of things, they go out the window. (New York)

People often when they take a hit, or when they slamming or whatever, the practice of safe sex just goes basically out the window ... That good intention is just vanished. It's gone. (Long Beach)

Besides the attenuating effects of drugs on personal motivation to use condoms, other barriers to condom use, mentioned or implied, were (a) the belief that certain sexual activities such as oral sex and withdrawal before ejaculation entail little or no HIV risk; (b) a fatalistic life perspective that reduces the perceived importance of protective health behaviour; (c) the perception of sex traders that customers do not want to use condoms; (d) the belief that condoms are unnecessary if one's sex partners are 'clean'; (e) the belief that condoms are unnecessary with main, steady or other non-anonymous sex partners; (f) the perception that condoms are too much trouble, reduce sexual spontaneity or are otherwise unpleasant to use; and (g) not having condoms immediately available. Participants described some of these obstacles as follows:

The risks are far less of becoming HIV positive through sucking cock, especially if they don't come in your mouth. (New York)

[If] the price is right, you have to give them what they want ... They're paying for that pleasure, so you have to satisfy them. (New York)

Usually [I] just ask them if they want to use one [a condom]. If they got one, that's about it. It depends on the person, though, if they don't. If it is somebody that I've been [around] for awhile and I know them, like, maybe ... [I'll do] something. (Portland)

It's good to have protection, but ... if you ain't got it ... at the time, you ain't gonna worry about it. (St Louis)

To me, it is just I can't suck a guy if he has a rubber on. It's not natural. (Columbus-Dayton)

Injection risks. Most of the participants who injected drugs stated that as a rule they tried to avoid sharing needles or other drug injection paraphernalia. IDUs in New York and Portland had some access to free syringes through local needle exchange programmes, and in Columbus-Dayton and Portland new syringes were readily available for purchase through retail pharmacies. Pharmacy syringe sales to IDUs were restricted in Long Beach and New York. In the eyes of New York IDUs, the increased access to new syringes made possible by needle exchange programmes had made the sharing of injection equipment essentially a non-issue:

They give you all that now [needles, cookers, cotton]. No reason for you to share them anymore ... The thing you gotta worry about is sex now.

In Long Beach and Columbus-Dayton, the two sites in addition to New York and Portland with IDU participants, needle-sharing seemed to be more an issue, and there was more discussion of cleaning works with bleach. At all sites, participants viewed themselves and other MSM drug users as generally diligent about not sharing needles.

Even my lover and I, when we shot together, we bleached the rig if we only had one and cleaned it between each other. Now, we didn't use condoms when we had sex, but we ... always did our rigs. (Long Beach)

If the opportunity arose to get high, however, and they did not have a clean needle, participants agreed they would often go ahead and share. Used needles were more likely to be cleaned before sharing when bleach was immediately available, and no one was drug 'sick' (i.e. in urgent need of a drug dose):

I [shared] just because I was sick and needed some drugs, and there was no bleach around, and a friend of mine had already used it ... I hate doing it, but I have. But usually I ... use a new needle. (Portland)

Participants and other IDUs they knew did not seem to be as careful to avoid sharing drug cookers and filter cottons as they were to avoid sharing needles and syringes.

Personal relationships and group affiliations

Information about personal relationships, affiliations and interactions with others was obtained in the initial focus groups. These findings have been organized into five topics.

Relationships among MSM drug users. Gay men, transgenders and non-gay men commonly reported that they usually hung out on the street in separate groups that interacted minimally. The interactions that did occur were based on drugs rather than any perceived commonality as MSM. Although distinctions in street group membership on the basis of sexual orientation were not reported universally, they were the more common pattern. Gay and non-gay focus-group participants in Long Beach said that, although they usually remained apart on the street and seldom interacted, they were keenly aware of each other's presence and routinely observed one another's drug and sex-trading activities.

The relationships between gay and non-gay MSM drug users seemed to be characterized by a live-and-let-live attitude in combination with a moderate degree of social distance and occasional co-operation based on mutual drug needs. Both gay and transgender participants described frequent social interactions with one another and conveyed a sense of social intimacy, mutual support and group cohesiveness. Non-gay participants, by contrast, seemed to have minimal social attachments to their MSM peers and to be more isolated from one another.

Relationships with non-MSM drug users. Regardless of their sexual identity, participants seemed to interact with non-MSM drug users primarily as necessary to maintain their drug habit. Some described relationships with various drug-using women and with men who were not MSM. The basis for these relationships seemed to be drug use, and the content of interpersonal interactions was mainly drug-related.

Involvement in local gay scene. MSM drug users, including those who were gay, typically reported very limited involvement in the local gay scene [5] of each city. The existence of a mainstream gay scene was acknowledged by participants at all study sites. In some focus groups, 'gay scene' was perceived as loosely synonymous with 'gay community', and the terms were used interchangeably. In other groups, the men drew a strong distinction between the two terms with one participant maintaining that, although there may be a gay scene in his city, there was no gay community in the sense of a cohesive social organism.

A number of gay participants in Long Beach said that they were not active in the local gay scene because they did not feel accepted by members of the mainstream gay community, whom they perceived as elitist and disapproving of drug use. Gay participants at other sites said that they had gone to gay bars in the past, but they did so infrequently now because they were older, they were tired of it, or their involvement with drugs was more important to them. Most gay and transgender participants in New York reported that they were not a part of the mainstream gay scene represented by Greenwich Village. By contrast, younger participants in Portland reported being actively involved in the gay scene through two clubs [6] they visited on occasion.

As might be expected, non-gay MSM reported less direct involvement in the local gay scene than did individuals who were gay, reflecting a concern that they would be labelled gay. One non-gay participant in Long Beach asked, 'Do I really want to walk in there ... and have all my friends see me in a gay center?'

Other relationships. Most of the personal relationships and social interactions described by participants existed in the context of drug use or drug-procurement activities such as sex trading. None the less, a number of participants reported having social relationships, including relationships with family members, outside the drug scene. Also, during the

structured interview, half of all participants (53%) reported being in a current relationship with a primary or steady partner. Similar patterns were reported by gays or transgenders (47% in steady relationships, all with male partners) and by non-gays (59% in steady relationships, 83% with female partners).

Influence of ethnicity. Only limited information concerning the influence of ethnicity on MSM drug users' personal relationships, interactions and group identification emerged during the focus groups. Although ethnicity was not addressed explicitly in the focus-group protocol, the topic was spontaneously mentioned in some groups, with tangential references and limited discussion indicating ethnicity to be of peripheral importance in this sample.

HIV transmission bridges

Participants reported regular sexual and drug-related interactions between MSM drug users and a variety of other individuals and groups. In some focus groups the concept of HIV transmission bridges was not considered in specific terms, although the sexual and drug-related linkages of MSM drug users to other groups were explored in some detail. In other groups, these interactions were discussed as potential bridges for the reciprocal transmission of HIV between street-based MSM drug users and other people. Participants described themselves or other street-based MSM drug users as having linkages that carry risk for HIV transmission with the following distinct groups of individuals: (a) mainstream gay men, (b) mainstream MSM heterosexual or bisexual men, (c) female sex partners and (d) other street-based drug users who are not MSM. Sexual activity seemed to be the primary vector for HIV transmission between MSM drug users and all groups except non-MSM street-based drug users, for whom the potential vector was the sharing of drug injection equipment.

Mainstream gay men. Reported sexual interactions of participants with gay-identified men from the local gay community took place most often in the context of sex-trading, usually in public sex environments. Although not exclusively true this pattern was typical, especially for non-gay participants. Many, if not most, of these sex-trading interactions seemed to involve drug use or the exchange of drugs, in addition to money.

Heterosexual/bisexual men. Similarly, sexual interactions with non-street-based heterosexual and bisexual men also took place largely in the context of sex trading. Drugs, in addition to money, seemed less typically involved in these sex transactions than in transactions with gay men. There was a strong consensus at all sites that there is a large group of non-gay men, commonly married, who regularly cruise MSM drug-user hangouts, seeking partners for transactional sex. There was general agreement by gay and non-gay participants that these men are very closeted about their same-sex behaviour, and that they satisfy their homosexual desires largely or entirely through transactional sex:

There are men that I know that are married, happily married, OK, that love for me to put my lips on their dick. It's just that simple. They don't mess around in the gay life, in the gay community *per se*, but they have that thing about them. (Columbus-Dayton)

A lot of these people ... can have children of their own and grandchildren, but ... they still deal with [other men]. (New York)

Several gay participants expressed a preference for having sex with men who present themselves as straight. Some said they went out of their way to meet straight men, who were described as generally willing to use drugs but not heavy drug users:

Maybe they smoke a little grass or drink some beer. And they are much easier to get laid if they're [high] ... because they're pretty much closeted, you know. (Portland)

Female sex partners. As shown in Table 1, 28% of the participants stated that they had a current steady female sex partner, and 52% said they had had sex with at least one woman in the past year. A heterosexual man described his ongoing relationships with men and women:

I still am primarily heterosexual. I like my women, and ... I have a bunch of different women that I see, and ... occasionally I dip—I dip and dabble with other men. (Columbus-Dayton)

Many of the female partners of MSM were said not to use drugs and to be unaware of their partners' homosexual activities as well as their drug use. One participant objected to the behaviour of his fellow MSM in this regard:

There's a few of the guys at that park that I think should ... have their balls nailed to a wooden floor and the building set on fire because, after they're sucking and fucking gay guys who they know have AIDS and ... sharing [works] ... they go home to a young lady. (Long Beach)

Another Long Beach participant questioned the naiveté of women regarding their partners' homosexual activities: 'This one bitch was talking about how her man wasn't doing anything. Please! He was behind [that] bush ... the night before gettin' a blow job.'

Non-MSM drug users. Interactions of participants with other drug users who were not MSM seemed mostly confined to drug-related transactions and occasional sharing of injection equipment. As presented by participants, interactions with street-based non-MSM drug users were not the norm, and sex-for-drugs or sex-with-drugs activities between members of the two groups were infrequent.

HIV information and preferred information sources

Participants believed that they and most other MSM drug users possessed a high level of knowledge about HIV transmission and prevention methods and believed that they were generally well informed about sex and drug risks. One participant put it this way:

All of us got the knowledge. None of us have any business catching AIDS ... cause we [all] know what to do. (Columbus-Dayton)

In spite of a high level of general HIV knowledge, some participants indicated that they or other MSM drug users they knew were not aware or did not have a complete understanding of HIV prevention and risk issues, including injection risks associated with shared cookers and cottons, correct procedures for disinfecting syringes with bleach, possible risks associated with unprotected oral sex and certain risks of anal sex. A large percentage of participants believed that oral sex posed little significant HIV risk or posed risk only in special circumstances, as when there are cuts or sores on the penis or in the mouth. Many participants believed that the risk of HIV transmission was eliminated if ejaculation in the mouth was

avoided and did not seem to be aware of the infection risk posed by pre-ejaculate. Some participants also expressed the belief that anal sex without ejaculation carries little HIV risk. In Long Beach, a number of participants reported that many MSM drug users of their acquaintance believe that lambskin condoms, considered a relatively ineffective HIV barrier, provide good protection against HIV. The issue did not arise at other sites, and it remains uncertain how widespread this misconception may be.

The preferred institutional sources of HIV/AIDS information mentioned by participants included community health clinics and medical offices, sexually transmitted disease clinics, drug treatment programmes, HIV counselling and testing centres, gay and lesbian community centres, shelters, youth centres, street outreach programmes and needle exchange programmes. In general, the sources were viewed as essentially equal in terms of the credibility of the HIV prevention information they provided. Perceived differences among providers concerned client utilization, such as convenience of access and the attitude and service orientation of agency staff. HIV prevention providers viewed as bureaucratic, impersonal or lacking in respect or empathy for drug users or MSM were said to be avoided whenever possible.

Drug-using peers were most frequently mentioned as people the participants considered most capable of influencing their own behaviour with regard to HIV prevention. Younger participants especially looked to their peers for advice. A few older participants, on the other hand, said that they had no regard for the opinions or expectations of the people they knew, especially those who used drugs. In general, family members were not considered influential.

Current HIV and drug-treatment services and services gaps

Participants identified a wide variety of available HIV prevention and drug-treatment services. These include: (a) office-based and street-outreach HIV prevention and service programmes operated by local AIDS organizations, gay and lesbian centres, churches and other community-based organizations; (b) HIV counselling and testing services; and (c) residential and outpatient drug treatment programmes. Services offered to people with HIV/AIDS included food, housing, medical and mental health services and advocacy and referral services. The availability of drug-treatment services was not considered adequate, and the process for obtaining treatment services was commonly perceived as too bureaucratic. According to one Portland participant, 'It's like you're either going to go somewhere that's gonna help you get through it right away, or else you're going to say, "Fuck it!" and go get high.' Although sites differed in the specific types of HIV- and drug-related services mentioned by participants, there was overall agreement about the general categories of services that were available to them.

Participants identified HIV prevention services in each community that were tailored to drug users, including those provided through street outreach and drug treatment programmes, but participants were not aware of programmes or services specifically for gay and non-gay MSM drug users. Participants did not point to this as a gap in services, but focused their comments on the ways in which HIV prevention services for drug users in general might be improved, including increasing staff sensitivity to sexual orientation and homosexual behaviour.

Preferred prevention approaches

A variety of personal opinions were expressed about the best methods of reaching MSM drug users, strengthening their interest in HIV prevention and engaging them in risk reduction.

Participants made specific suggestions about ways to improve the appeal and effectiveness of HIV prevention programmes for MSM drug users. Some said that they considered brochures and other written materials as problematic because many street-based drug users have limited reading skills. One man described his reading difficulties and his preference for pictorial materials:

Look, I'm not educated or none of that. I never finished junior high, OK. For me to read something, hah! And half the people out there, they ain't educated, either. To me, when I see a picture, I remember that picture. I don't remember what's written down. (Long Beach)

Other participants emphasized the value of videos:

When they ... [showed] this video about HIV, AIDS, and gonorrhoea and syphilis and all that ... that really stuck with me more than anything else, even me reading about it ... That's why I practice right now safe sex, because of what I have seen. (Long Beach)

If I actually saw a documented case where someone went from HIV to full-blown AIDS ... that would be enough to get to me personally. (Columbus-Dayton)

There was general agreement at all sites as to the primary importance of street outreach as a means of reaching MSM drug users to provide HIV prevention information, encourage personal risk reduction and link them with intensive HIV interventions and drug-treatment programmes. Participants made the following specific suggestions for prevention approaches that would be most effective with MSM drug users: (a) night outreach, (b) outreach vehicles, (c) drop-in centres, (d) rap groups, (e) plays and skits—suggested by older as well as younger participants, (f) food—especially meals and (g) radio and TV advertising.

Participants considered it highly important that outreach workers and intervention staff be former drug users or at least indigenous members of the local community and comfortable with people who use drugs: 'A junkie can talk to a junkie; a dope addict can talk to a dope addict; a smoker can talk to a smoker' (Long Beach). Whether staff members were gay or non-gay did not seem to be relevant. Of paramount importance, however, was whether prevention staff communicated adequate warmth and respect. Similarly, female staff typically were not viewed as problematic, but rather an asset.

Just as participants did not attach singular importance to the sexual orientation of staff, they also did not see any particular benefit in establishing separate programmes for gay and non-gay men. In fact, some participants pointed out that separate programmes would create difficulties because of the implied necessity for self-labelling. Men who were not gay tended to consider the idea of separate programmes as negative; gay men more frequently viewed it as a non-issue. The importance of personal identity as a drug user is revealed in one man's comment:

I would say that a gay person [who does not use drugs] would be better off getting his information from the gay community, as the dope addicts [gay and non-gay] would get it from an outreach program within their area that they're more comfortable with. (Long Beach)

Discussion

The MSM drug users in our study were defined broadly in terms of drug use, sexual behaviour, sexual orientation, gender identity, age and ethnicity. For the most part, these

were men who smoked crack or injected heroin or speedball. Use of methamphetamine, primarily injected, was also reported, primarily by participants from the two West Coast sites. Although this was at least in part accounted for by a recruitment priority at the Long Beach site that favoured methamphetamine users, it is also consistent with the findings of Gorman *et al.* (1995) and other investigators (Eggan *et al.*, 1996; Reback, 1997) concerning a high prevalence of methamphetamine use among MSM in West Coast cities. Unfortunately, aspects of the study's methodology limit the generalizability of its findings. Specific limitations arise from the study's (a) targeted, non-random recruitment strategy and predominately street-based sampling frame; (b) small number of participants, study sites and focus groups; and (c) the focus-group method itself. The explicit focus of the study on MSM who were chronic drug users functioning in a street context prevents applying the findings to other groups of drug-using MSM, in particular gay men who are recreational drug users.

Although the MSM drug users in our study seemed to have relatively complete, accurate information about HIV transmission and prevention methods, HIV risk-taking, especially sexual risk-taking, was common at the individual level. The non-use of condoms was nearly universal during oral sex, and condoms also were frequently not used for anal sex. This high rate of unprotected sex seemed to be a function of several factors, the most important of these being the enhancing effects on libido and sexual pleasure typically attributed to crack cocaine and methamphetamine, combined with the psychological disinhibition associated with drug use. Among MSM sex traders, the non-use of condoms was also attributed to customer preferences. The failure to use condoms for oral sex may be related in part to the relative lack of awareness of the potential HIV risks associated with oral sex. In addition, many participants' fatalistic approach to life, coupled with indications of low self-esteem, were probable contributors to their unsafe behaviour. The unfortunate outcome of this confluence of factors was that unprotected sexual activity commonly took place in conjunction with drug use, and there was a distinct preference for having sex when high.

For many, if not most, of the MSM drug users in our study, issues of sexual orientation and identity were not perceived as highly salient or, for non-gay men, as especially meaningful. This was not true for transgender individuals, however, who represented themselves as unique among MSM drug users and who were highly concerned with sexual and gender identity. Participants who identified themselves as gay or homosexual described their sexual orientation in unambiguous terms but tended not to relate to concepts of gay community or gay scene. Those who identified themselves as bisexual or heterosexual, on the other hand, tended to be ambiguous in describing their sexual orientation and commonly objected to the use of sexual-orientation labels. For all these MSM, including transgenders, the overriding personal reality was their drug use and this fact served to frame the construction of personal identity. In this group of MSM drug users, the core of personal identity was drug use. Other elements of identity, including sexual orientation, were secondary, a consistent finding in all six cities. If confirmed in later studies, this suggests that HIV risk interventions for street-based MSM who use drugs should recognize the differential personal relevance of sexual orientation for men who identify as gay or homosexual versus bisexual or heterosexual versus transgender, as well as the core importance of drug use in the construction of personal identity.

Study participants reported associating primarily with other drug-users, usually MSM, maintaining only limited contact with persons who did not use drugs. It was found that gay and non-gay MSM drug users functioned as separate social units on the street and maintained a fair degree of social distance, although occasionally the two groups interacted. Group affiliation was also determined by age: younger and older MSM drug users tended to form separate cohorts. The street-based MSM drug users in our study, including those who were

gay, tended to have few connections to local gay communities and were not a part of the local gay scene. Many gay MSM drug users reported that they felt ostracized because of their drug use by the traditional gay community and also unaccepted by gay-orientated HIV/AIDS service providers. One may speculate that a contributing factor to this perception could be the fact that nearly two-thirds of the participants in our study were ethnic minorities, whereas the mainstream gay community is almost exclusively white. The fact that the focus groups were not homogeneous with regard to ethnicity may have inhibited discussion surrounding this and other issues related to ethnicity. Although we were not able to investigate systematically the typology and multiple determinants of affiliation and social relationships among MSM drug users, such research is needed to develop an adequate understanding of this population for purposes of reducing HIV transmission.

Our evidence indicates that the sexual and drug-injecting activities described by participants in this sample, and perhaps those of MSM drug users more generally, form a bridge for transmission of HIV to other populations, including mainstream gay, heterosexual and bisexual men; the female sex partners of MSM drug users; and street-based drug users who are not MSM. These vectors of HIV transmission are bi-directional: in many cases the same populations that are at risk from MSM drug users in turn place MSM drug users at increased risk.

The need for behavioural interventions to reduce personal HIV risks in this special population is critical, especially in light of their ongoing sexual and drug-related interactions with members of other populations. Developers of interventions must recognize the heterogeneity of MSM drug users in terms of their drug use and sexual orientation, as well as the primacy of drug use in defining personal identity. The relative isolation of street-based MSM from other drug users and from the mainstream gay community must also be recognized in developing effective interventions for this population. The high attrition rate among younger and non-gay MSM in this study is indicative of the challenge before us in engaging members of this at-risk population. Extensive further research using both ethnographic and survey techniques is required to learn more about the characteristics of MSM drug users and the social context in which they function in order to effect meaningful reduction of their HIV risks.

Acknowledgements

This research was supported by grants from the National Institute on Drug Abuse (1-U01-DA-07474, 1-U01-DA-07286, 1-U01-DA-07305, 1-U01-DA-07302, 1-U01-DA-08324, 1-U01-DA-07295) and the Centers for Disease Control and Prevention (DA-0043-01).

Notes

- [1] One site conducted three follow-up focus groups and included two participants who had not attended an initial group.
- [2] Coding of transcripts was performed by three research assistants under the supervision of an experienced ethnographer; 10 content categories were used to reflect key themes expressed by participants. A standard protocol ensured accuracy and consistency of code designations in the transcript.
- [3] Although the term 'speedball' usually refers specifically to an injected mixture of heroin and cocaine, the definition used in the current study, it has been observed among New York drug users that speedballing can also mean injecting heroin in conjunction with smoking or snorting cocaine.
- [4] The inclusive term 'gay' will be used, in the absence of specific differentiation, to refer to men who identified themselves as gay or homosexual; 'non-gay' will be used to refer to bisexual- or heterosexual-identified men.
- [5] 'Gay scene' refers to the bars, clubs, gyms, gay community centres and other public venues that make up the formal and informal social institutions of the middle-class, non-street-based, local gay community.
- [6] 'Clubs' are gay bars that offer dancing and at which patrons frequently use drugs.

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