

# what are homeless people's HIV prevention needs?

## what is the impact of homelessness and HIV?

The number of homeless Americans has increased dramatically since the 1980s. It has been estimated that 13.5 million adults in the US (7.4%) have been homeless at some time during their lives, with 5.7 million adults homeless in the past five years.<sup>1</sup>

*In the past, many homeless people were former mental patients. Today, "those without housing look disconcertingly similar to those with roofs over their heads."<sup>2</sup> However, homelessness often occurs in combination with chronic mental illness, substance abuse, and unsafe sexual behavior—all factors that heighten the risk of HIV infection. AIDS cases have increased among crack users and injection drug users (IDUs) and people of color—groups that have been traditionally over represented among the homeless.*

Homeless people suffer higher rates of many diseases, including HIV, than the general population. A survey of 16 US cities showed a median HIV seroprevalence of 3.4% for homeless adults,<sup>3</sup> compared to less than 1% for the general adult population. In other studies, homeless mentally ill men in New York City, NY had a 19.4% prevalence<sup>4</sup> and in San Francisco, CA homeless adults had a 8.5% rate of HIV infection.<sup>5</sup> For homeless youth across the US, median HIV seroprevalence was 2.3%.<sup>3</sup>

## what puts a homeless person at risk?

A survey of homeless adults entering a storefront medical clinic found that 69% were at risk for HIV infection from either 1) unprotected sex with multiple partners, 2) injection drug use, 3) sex with an IDU partner, or 4) exchanging unprotected sex for money or drugs. Almost half (45%) reported at least two risk factors combined, and one fourth (26%) reported three or more risk factors.<sup>6</sup>

*Having multiple sex partners is a risk for HIV, but it may be almost impossible for homeless people to form safe or stable intimate relationships due to drug use, mental illness, violence or transient living situations. A study of homeless women found that 91% were exposed to battery, 56% to rape.<sup>7</sup> Homeless people, especially women and youth, may engage in survival sex—exchanging sex for housing, food, money or drugs.*

Substance use can facilitate HIV risks such as forgetting to use condoms, sharing needles with other IDUs, or exchanging sex for drugs. In a survey of homeless adults in St. Louis, MO, 40% of men and 23% of women reported drug abuse; and 62% of men and 17% of women reported alcohol abuse.<sup>8</sup>

## what are barriers to prevention?

Homeless populations have been labeled as "hard to reach," but because they are often living and working on the street, they are one of the most visible populations in the US. The biggest barrier to reaching homeless populations is not finding them, but forming trusting relationships and making consistent contact over time to help promote behavior change. Another misperception is that homeless people cannot be followed. A project at a men's shelter had a 95% follow-up rate 6 months after the intervention.<sup>9</sup>

*Institutional barriers and settings can restrict HIV prevention activities. Most homeless shelters provide communal sleeping and bathing, and are therefore single sex, which discourages stable heterosexual relationships.<sup>10</sup> Staffing at shelters is often only adequate to provide basic needs, and shelters may be reluctant to allow outside HIV prevention programs to talk explicitly about sex and drugs because those activities are forbidden in the shelter. For homeless people living on the street, a lack of private space for counseling and education around sensitive matters can also be a barrier.*

## Says who?

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## what's being done?

**S**ex, Games and Videotapes” is a program for homeless mentally ill men in a New York City, NY shelter that is built around activities central to shelter life: competitive games, storytelling, and watching videos. For many of these men sex is conducted in public spaces, revolves around drug use, and must be conducted quickly. One component of the program is a competition to see which man can put a condom on a banana fastest (without tearing the condom)—this teaches important skills for using a condom quickly. The program allows for sex issues to be brought up in a non-judgmental way. This program reduced sexual risk behavior threefold.<sup>11</sup>

*In San Francisco, CA, HIV tests were offered to homeless people at shelters, food lines and parks, and HIV-positive people were given referrals to early intervention.<sup>5</sup> Another testing program was linked to specialized case management to help respond to multiple clients' needs such as access to primary care, substance abuse treatment, and mental health services. Case managers were able to maintain contact and build relationships with drug using clients, many of whom were HIV-infected or mentally ill.<sup>12</sup>*

A pilot program for homeless women in New York City, NY, some of whom engage in survival sex and are victims of rape and abuse, provides methods of protection women can use in the most difficult circumstances. The women are given Advantage 24 (a time-release Nonoxynol-9 gel) and female condoms, and then learn to use these on a regular basis. As methods they can control, these provide a base for empowerment.<sup>13</sup>

*The Teen Peer Outreach-Street Work Project in San Diego, CA, trained teen peer educators to provide HIV prevention education and case management to homeless youth. Food, clothes and shelter information were provided, as well as HIV educational messages. The project found a need for, and subsequently worked to develop, educational materials for homeless youth with low literacy levels.<sup>14</sup>*

A successful program for homeless and drug addicted Latina women in Los Angeles, CA, found little difference between women who attended a traditional AIDS education program, and a longer, culturally sensitive program that emphasized problem solving, risk reduction and self-esteem. Shorter, generalized programs may be adequate for addressing more basic needs of impoverished populations.<sup>15</sup>

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## what needs to be done?

**W**e can learn a lot about HIV prevention for homeless populations by looking at prevention and treatment of tuberculosis (TB) in this population. To successfully treat TB, people need to be housed, fed, and ensured access to clinical care. More attention and funding has been given to TB among homeless people in the last decade because of the risk of infection spreading to the general population. HIV prevention deserves equal dedication and support.

*Nontraditional programs are needed that engage homeless populations at every place they access basic services, such as soup kitchens, shelters, hotels, and clinics. Staff who work in these settings should be trained in HIV prevention education. Group interventions that have worked in certain settings need to be disseminated and replicated in various institutions. Prevention services must have realistic expectations for change, and must give homeless people concrete goals that they can accomplish.*

It is difficult to conduct HIV prevention without tackling the bigger issue of homelessness. In 1981, the federal government spent \$30 billion on subsidizing low-cost housing; by 1988 that figure had dropped below \$7 billion. To stem the tide of the epidemics of homelessness, drug abuse, and AIDS among others, adequate housing, jobs, schools, transportation, day care, nutrition and health care for all is imperative.<sup>2</sup>

*A comprehensive HIV prevention strategy uses a variety of elements to protect as many people at risk for HIV as possible. As one of the most vulnerable populations in our society, the homeless need support, respect, protection and continued prevention efforts.*

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