

The Experiences of African American Male Commercial Sex Workers At-Risk for HIV: Accessing Outreach Services

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Jones, J.L., Rasch, R.F.R., MacMaster, S.A., Adams, S.M., Cooper, R.L. (2009). The Experiences of African American Male Commercial Sex Workers At-Risk for HIV: Accessing Outreach Services. *Journal of Gay & Lesbian Social Services*, 21(2-3), 282 - 293. doi: 10.1080/10538720902772238.

This is an Accepted Manuscript of an article published by Taylor & Francis Group in *Journal of Gay & Lesbian Social Services* on 23 Apr 2009, available online at: <http://www.tandfonline.com/10.1080/10538720902772238>.

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Abstract:

Due to the lack of education and the stigma attached to HIV testing, African American men are less likely to seek outreach services; therefore they are often unaware of their HIV status. Stigmatization of homosexuality in communities of color may also influence the availability of HIV/AIDS education and services; compounded with the fact that access to appropriate health care may be limited in these communities. While infection rates among African American men having sex with men (MSM) are well documented, research on effective interventions is not, and is particularly limited for these men who are substance users and participate in the sex trade for drugs. This article explores and documents the experiences of African American MSM in a southeastern metropolitan city who are involved in the commercial sex trade, and presents the results of a focus-group investigation conducted specifically to gain input about accessing outreach services.

Keywords: African American | HIV testing | commercial sex workers

Article:

INTRODUCTION

Since 1991, HIV infection among African American men 25–44 years old has been the leading cause of death for members of this group. While 12% of the U.S. population is African American, half of the new HIV infections reported in the United States are among African Americans. Data reported to the CDC through 2006 suggest that the leading cause of HIV infection among African American men is sexual contact with other men (CDC, 2006). While

the overall disproportionate rates of HIV/AIDS for African Americans are well documented, the same trend also exists for men who have sex with men (MSM). The proportion of African American MSM with AIDS diagnosed during 2001–2004 was at 39% (CDC, 2006).

Due to the lack of education and the stigma attached to HIV testing, African American men are less likely to seek outreach services; therefore they are often unaware of their HIV status (CDC, 2002; Malebranche, 2003). Stigmatization of homosexuality in communities of color may also influence the availability of HIV/AIDS education and services; compounded with the fact that access to appropriate health care is limited in these communities. While infection rates among African American MSM are well documented, research on effective interventions is not, and it is particularly limited for these men who are substance users (Plant, 1990; Siedman, Sterk-Elifson, & Aral, 1994), and participate in the sex trade for drugs. Because of the dual status of African American men who are also MSM, the need for culturally relevant and culturally competent programs (Crawford, Allison, Zamboni, & Soto, 2002; Kennamer, Honnold, Bradford, & Hendricks, 2000; Malebranche, 2003), is important in developing accessible outreach services. Furthermore, such programs should address specific issues related to MSM who participate in the sex trade.

This article explores and documents the experiences of African American MSM in a southeastern metropolitan city that are involved in the commercial sex trade and their perceptions regarding seeking and accessing outreach services.

HIV/AIDS AND MALE COMMERCIAL SEX WORKERS

Traditional HIV/AIDS outreach to MSM has relied primarily on social networks and venues where MSM individuals congregate (gay bars and other targeted businesses, festivals, parades, etc.) to deliver face-to-face outreach and educational materials. These interventions have helped to facilitate a change in community norms around sexual practices within the gay community (CDC, 2002). However, these service delivery modes may not reach all potential MSM. Male commercial sex workers, in particular, are less likely to be reached by traditional prevention messages (Goldbaum, Perdue, & Woliski, 1998; Weber et al., 2001). Despite the fact that most male commercial sex workers identify themselves as being either homosexual or bisexual with predominantly male clients, (Jones et al., 1998; Weber et al., 2001), men involved in the sex trade are less likely to live within the mainstream gay community than other MSM. These men often do not have access to the same resources as other MSM due to stigmatization and issues of poverty and/or race (De Graaf, Vanwesenbeeck, Van Zessen, Straver, & Visser, 1994; Stephens, Braithwaite, Lubin, Carn, & Colbert, 2000; Weber et al., 2001). HIV/AIDS outreach programs and related research geared towards this population may also be limited due to the perception that commercial sex workers as a population are a threat to society and therefore only studied in the context of passing HIV to “normal clients” instead of being a group worthy of interventions themselves (Browne & Minichiello, 1996).

Commercial sex workers as a group have historically faced a great deal of societal stigmatization and have had limited access to health care resources (Browne & Minichiello, 1996; Dobinson, 1992). Male sex workers may face even more covert prejudice than female sex workers due to perceived gender roles (Plant, 1990). According to Browne and Minichiello (1996), to identify oneself as a male sex worker servicing men, a man becomes subject to the socio-sexual and political discourses which stereotype masculinity and stigmatize prostitution. To further complicate this issue, “to be a male commercial sex worker and African American often means that the individual faces more discrimination and less access to resources” (Stephens, et al., 2000, p. 3).

HIV/AIDS AND AFRICAN AMERICAN MSM COMMERCIAL SEX WORKERS WHO USE CRACK COCAINE

African American MSM commercial sex workers already face racial discrimination and increased stigmatization due to sexual orientation and occupational choices, many also turn to drugs as a way of coping with tensions between sexual feelings and attractions, and societal mores (Browne & Minichiello, 1996; Dolezal, Carballo-Diequez, Nieves-Rosa, & Diaz, 2000; Malebranche, 2003; Stueve et al., 2002), while other MSM who use crack cocaine may enter the sex trade to fund their addiction (Inciardi, et al., 1991; Jones et al., 1998). Drug use, specifically crack cocaine use, may increase the risk of contracting HIV, as crack users are more likely to have sex with other substance injectors and people who are HIV positive (Browne & Minichiello, 1996; Jones et al., 1998). Similar to other MSM, African American MSM sex workers who work while under the influence of crack may be less careful in using protection and in the selection of partners (Browne & Minichiello, 1996; De Graaf et al., 1994; Inciardi, et al., 1991; Jones et al., 1998; Siedman, Sterk-Elifson, & Aral, 1994; Stueve et al., 2002; Weber et al., 2001). Crack cocaine users are more likely to have multiple sexual partners and are also less likely to wear a condom during sexual acts (Bowser & Word, 1993; Waldorf & Lauderback, 1992; Weber, et al., 2001).

EFFECTIVENESS OF OUTREACH SERVICES TO THE POPULATION

There are few documented outreach services that specifically target African American male commercial sex workers who use crack cocaine (Weber, et al., 2001; Stephens, et al., 2000). Targeting this group of men requires sensitive outreach that is specific to their needs. The research literature on MSM indicate that crack cocaine-using commercial sex workers are indeed willing to participate in HIV programs and are willing to modify behaviors (Edlin, Faruque, McCoy, & Word, 1995; Jones et al., 1998), and the ability to effectively outreach to this specific group of men as a way to gain their input and information that may prove very useful in the recruitment and delivery of service is crucial. For example, a private not-for-profit faith-based organization in Nashville, TN, conducted a one-time focus group with African American male commercial sex workers to gain their input about accessing outreach services. The information shared during the process, captured via field notes, indicates that the men, while skeptical about

the nature of their involvement in this process, were willing to take the risk in talking about accessing outreach services. A condition stipulated by the African American men before agreeing to participate in the focus group was that no women and no heterosexuals were to be in the drop-in center at the time of the focus group. The following was revealed:

“When we drove up to the building I thought police cars would be there; I thought this was some kind of a bust or set up,” stated one of the men. Others specifically asked upon entering the building, “Who is in the building?” “No women allowed!?! No heterosexuals!?”

Again, this willingness to take a risk to share their input about accessing outreach services is consistent with the literature, and should not be overlooked when conceptualizing services for this population. Another critical part of the process that cannot be overlooked was found in the van ride returning to the streets where the men talked openly about the “real stuff” specific to their experience as an African American male sex worker. They spoke very candidly about the details of their sexual encounters, describing the type of sexual activities negotiated between clients. For example, higher prices are charged for Caucasians than African Americans; the stereotypic perception being that white people have more money than African Americans. The men also discussed information regarding HIV risk reduction, as they perceive it. For example, one man stated, “During sexual intercourse I use ‘the pull out’ before you have an orgasm, or should I say ‘cum?’” indicating that he used withdrawal as a method of reducing his risk of HIV infection. Condom use was discussed, as was the means in which it is negotiated with customers. The men stated that the decision to use a condom or not was usually left to the customer's preference. Collectively, the men were adamant about not participating in any abusive treatment between each other or the customer.

This description of the men's experiences is crucial to the conceptual understanding of outreach services for African American male sex workers who may be at risk for HIV infection. It gives a voice to a sub-population that is often-time oppressed by the mainstream population, and moreover it provides information about a particular phenomenon that is under-studied.

SEX WORK IN NASHVILLE

Information on male sex work in Nashville was obtained from an indigenous outreach worker in this particular community who had been an active part of the community. It was through the assistance of this outreach worker that male sex workers were accessed and enrolled in the focus group discussed below. Sex work in Nashville is located in different geographic areas of the city that reflect sexual preferences; men are in one area and women are in two different areas of the city. These locations are known to potential clients as well as law enforcement. The involvement of the latter increases the risk of legal difficulties for both the sex workers and their clients as the city police department is known to periodically conduct a series of busts.

The landscape of male sex workers in Nashville demonstrates a geographical division that, in some respects, is a reflection of racial polarity but more particularly reflects the sexual tastes or

preferences among men who seek the services of male sex workers. Men involved in sex work populate a certain section and street in the city. The street is divided and inhabited by African American men in one block and Caucasian men in an adjacent block. While at first glance, it might appear that this divide is a reflection of racial segregation among MSM, focus group participants viewed this geographic division as a pragmatic “business practice” that facilitates easy access for customers who have sexual preferences for either African American or Caucasian sexual partners. The field is already narrowed and they have only to negotiate with a particular men based on more individual preferences. The men recruited for the focus group were contacted in this area of the city.

PILOTED FOCUS GROUP INVESTIGATION RELATED TO ACCESSING OUTREACH SERVICES

Given the complexity involved in designing outreach services in general, the research team concluded that the most effective way to determine what services are needed for MSM who use illegal substances, participate in the sex trade, and who are at risk for HIV, was to go directly to the source. Therefore, we conducted an exploratory investigation of this population to gain information and input from potential clients about what they would want in a program designed to facilitate their access to services. Specifically, the pilot focus group addressed the perceived need, accessibility, feasibility and marketing of outreach services.

Sample/Informants

The sampling of participants for this study was purposive; we sought men who self-identified as MSM, engaged in the commercial sex trade where sex is traded for drugs, were at-risk for HIV, and may be interested in, or previously attempted, accessing outreach services. The sample participants consisted of four African American males, all of whom self-reported engaging in sex for money or drugs. Three of the four men self-identified as homosexual or bisexual. All of the men reported a history of cocaine use. The self-reported socio-economic status of the participants indicated that the men were among a segment of the population that is poor, disenfranchised, and lacks the ability to access resources. The sample participants were selected based on availability. Two African American outreach workers from a local faith-based agency, one of whom was himself a recovering cocaine user, recruited African American men from the known commercial sex trade corner in Nashville to ride in the church van to come to the outreach center for dinner and to talk. All of the men volunteered to participate in the focus group and signed a consent form.

Procedure

The site of the focus group was a faith-based community agency that primarily provides substance abuse coordination and HIV/AIDS prevention and care services for adults. The setting for the focus group involved a family style meal where the men served themselves. Prior to eating, the participants were asked to participate in a prayer of thanks.

The group facilitator conducted structured one-on-one interviews to ascertain specific demographic information: age, substance used, and sexuality. Each participant was asked to provide a pseudo name they wished to be called for that night and advised that if they should choose not to participate in the focus group there would be no negative consequences related to them. Consent forms were signed at this time. Upon completion of this process, the participants transitioned to the table for dinner. Instructions for the focus group were given at that time: participants were informed that the information discussed is for the sole purpose of gaining input and information about their experience, and what they would want as consumers of outreach services. They were further informed that the group responses would be audio taped and the tapes would be stored in a locked file cabinet at the agency where only the research team would have access. The participants were reminded to identify themselves only by the name given for that night; advised to be honest as language did not matter; encouraged to relax and enjoy the discussion. The group lasted for approximately two hours. At the end of the group the participants were advised about confidentiality and reminded not to discuss any personal information about others shared at this meeting.

Design

Qualitative methods via focus group and field notes were used to collect and analyze data for this research. The use of qualitative methods is unique in that it allows research to be conducted in a variety of methods, all of which have reoccurring features that are “naturalistic,” and they allow the researcher to gain a holistic overview of the context understudy (Miles & Huberman, 1994). Because the researcher is able to serve as the instrument for data collection, this process often yields information that cannot be obtained through quantitative measures.

The facilitator for the focus group was trained by the research team to conduct such groups. This is particularly important to note, in that the research team shared the opinion that in order to gain information that was useful to the process the facilitator of the focus group needed to be someone familiar to the population. Therefore, the group facilitator was an African American male, who identified as being homosexual and was familiar with the area of the city where the men were recruited.

Using a semi-structured interview guide, three key topics were identified by the research team *a priori* as areas to be explored by the focus group facilitator. Of particular interest was information related to: (a) effective ways in which to outreach to MSM that are at risk for HIV infection, (b) safe sex practices as a way to reduce HIV risk, and (c) access to drug treatment opportunities. Male sex workers were identified as key informants based on their lived experience. The following questions were asked:

1. What is the best way to approach someone who “walks the stroll”?

2. What is the one thing that may turn you off, or make you go the other way when approached by an outreach worker?
3. If money were no object, what would the ideal outreach services need to look like?
4. If you should enroll in the program, and the program is successful in getting you into and completing drug treatment, what do you think is a necessary resource you need to maintain sobriety?
5. How would you feel if the mobile van periodically came down and did a group like this one?

Analysis

To analyze the transcript from the focus group data, several steps were involved. First, the process of data reduction was undertaken that involved transcription of the field notes and transcripts, repeatedly reviewing the transcript to allow a coding system to emerge. Secondly, data display was undertaken, which involved the organization and compressed assembly of the data in order for conclusions to be drawn. Finally, the verification of the conclusion drawing takes shape. This is an important step in the process in that meanings from the data have to be tested for plausibility (validity). This was done via review among colleague from research team to develop inter-subjective consensus. Qualitative analysis of this type is grounded in a theoretical assumption known as an *interpretive paradigm*, whereby researcher seeks to gain an understanding of the fundamental nature of the social world (accessing outreach services) at the level of subjective experiences of male sex workers (Burrell & Morgan, 1979).

RESULTS

All of the participants in the focus group identified several issues related to judgmental and non-judgmental attitudes of the outreach worker as the most important factor associated with accessing outreach service. Non-judgmental attitudes were described as someone who does not disrespect them or their opinion; someone who is “for real” and means what they say. “For real” was defined as “someone who is not fake; someone who is not trying to put us down.” In fact, participants stated the one thing that will turn them away from accessing services was feeling that their opinions did not count by the person that approached them and being “gamed” (not being taken for real). For example, one participant stated the following:

On the streets all we have is each other and our trust, and we know when someone is not being truthful. ... All it takes is one time for me to turn someone on to you and you betray that trust, that messes up the whole thing.

The participants stated that an ideal program would be voluntary, not coerced or forced, provide transportation, assist with finding housing, employment, and include random drug testing. Furthermore, the program would include a spiritual focus, not a particular religion, and provide a place where people can be accepted for who they are and not be judged. A program that provided services similar to those described above, but mandated that participants attend church was available in this city. However, all of the participants stated that this type of program would not work, as evidenced by their own decisions not to seek services at this agency.

Mental health counseling was an additional service that participants identified as important and needed in this community. For example, three of the participants stated that the men out on the streets are here because of things that happened in their past or done in their past. They need someone to help them understand that life is not hopeless; that you can achieve your dream. Another service that was identified is drug treatment. The participants agreed that drug use (cocaine and alcohol) was a contributing factor to needing mental health counseling. It was explained as:

Some of us have a lot of deep issues that go back before cocaine, but the cocaine is on the surface and those issues underneath the cocaine use are the ones that have to be addressed first.

Three of the participants gave accounts of their long-term drug use and expressed remorse for their continued use, explaining that “you can take all the cocaine you want, but once you finish getting high you got those same problems to deal with.” A final service identified was the need for support networks and group counseling. These men voiced a basic human need—the “need to belong” and “to feel connected to others.” The use of support networks as a way to feel connected was akin to the relationships described by the men when they are on the streets. All of the participants stated that the services should be provided at one place, “like a one-stop shop.” Professionals in the field recognize this as the need for comprehensive services rather than fragmented services that make access and effective utilization of resources unrealistic.

THINGS NEEDED AFTER TREATMENT

The environment after one is out of drug treatment was identified as the number one thing needed to successfully “hold onto recovery.” Environment was summarized as “a place to go where you will get support and guidance.” As one participant noted:

The routine of cocaine addiction is scary within itself ... when you come out of rehab and you find yourself back in those places where you used to go, you become weak to the drug;” “coming out of rehab with no place to go is hard.”

The need for an aftercare program became the dominant theme.

DISCUSSION

The results of this study clearly document the existence of structural and individual level barriers to the receipt of substance abuse and HIV services and, to a lesser degree, provide some guidance on overcoming these barriers among African American men who are involved in commercial sex work and use crack cocaine in the southeast. While numerous studies have measured the risk behaviors of commercial male sex workers who use crack cocaine users, there are few that have looked at barriers to the receipt of services, much less articulated strategies to improve service provision. The present analyses are only descriptive in nature and only report the perceptions of these men, rather than focusing on answering a more specific research question, for example, what factors predict treatment access, or even establishing a prevalence rate within the population. Although limited, the findings are still important as they establish the existence of these phenomena and provide the qualitative perceptions of the men who experience these phenomena.

Perhaps the most interesting findings presented here involve several themes that cut across the participants' responses. The importance of a non-judgmental attitude among service providers and service provider trustworthiness were strong themes. The fragility of this trust was also quite clear. This was related to both the willingness to access services and also to fears of what the experience receiving services would be. Participants also provided a perspective on the experiences of interacting with a non-responsive service system from a relatively powerless perspective. Participants had to overcome structural barriers to access a system that they generally assumed to be judgmental and untrustworthy.

There are several additional points that can be drawn from this data. First, the data both on the demographic characteristics of respondents as well as their relationship to treatment services is in sharp contrast to assumptions often made about crack cocaine users and/or commercial sex workers; for example, they are consumed by their use to the extent that they are not able to think clearly, do not care about themselves or others and thus do not make changes, and/or lack a willingness to consider accessing mental health services or stopping their drug use. Secondly, with the majority of the sample expressing experiences in attempting to access services, the lack of involvement in such programs may be due to a lack of availability of appropriate services for commercial sex workers who use crack cocaine or in barriers to access to such programs and not a lack of desire.

There are some obvious limitations to the data presented here. First, as the data are primarily qualitative in nature and based on snowball-sampling procedures, the responses in this study may not be representative of all individuals who use crack cocaine and are involved in the commercial sex industry. Second, the sample size clearly limits our ability to draw reliable conclusions. However, given the descriptive focus of the analyses presented and the specifications of the knowledge imparted, the sample size may be adequate to the study purpose. Additionally, the reliability of self-report data from drug users may be questioned, particularly with the study's use of a focus group interview. Given the social nature of a focus group interview, the expressed interest in mental health, substance abuse and HIV services, and the

existence of barriers to these services, may simply be a measure of the perceived social desirability of this response and not the true desire of the participants. However, given the expressed history of accessing services, this concern may be more minimal than perceived. This descriptive article has sought to provide information about the existence of barriers to service access, preferences for service delivery, and means of providing services. Actual prevalence rates and relationships to other variables are outside the scope of this study. Future research efforts may want to test such questions in a more scientific manner.

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