COLORADANS WORKING TOGETHER: PREVENTING HIV/AIDS

2006 HIV PREVENTION NEEDS ASSESSMENT REPORT

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2006 HIV PREVENTION NEEDS ASSESSMENT

HIV/AIDS remains a major health concern in Colorado, with 1,924 cases diagnosed between 2001 and 2005. The highest percentage of diagnosed HIV/AIDS cases continues to be among the diverse population of men who have sex with men, who constituted nearly two thirds of the total cases diagnosed during that time period. As we mark the 25th anniversary of the beginning of the HIV/AIDS epidemic, it is critical that we continue to develop an in-depth and complex understanding of the factors influencing the behaviors of Colorado residents who are most at risk for getting and spreading HIV if we are to appropriately and effectively meet their HIV prevention needs. To that end, the Research and Evaluation Unit (R&E) of the Colorado Department of Public Health and Environment's (CDPHE) STD/HIV Section in collaboration with the Needs Assessment Committee of Coloradans Working Together: Preventing HIV (CWT), the state's HIV prevention community planning group, has focused the 2006 HIV Prevention Needs Assessment activities on men who identify as either gay or bisexual. This 2006 assessment is designed for use by the Section and CWT for program planning and development purposes. In 2007, the needs assessment focus will be on other populations at risk for HIV such as injection drugs users and heterosexuals who engage in high-risk behaviors.

Previous needs assessments have relied upon the statewide distribution of surveys to individuals who were considered to be at high risk for getting or transmitting HIV as the primary approach for gathering data. Over the last several years, the data from these surveys have been supplemented with information gained through more qualitative methods such as focus groups and one-on-one interviews. For this current assessment, quantitative and qualitative methods of data gathering have again been used. However, the primary emphasis has been placed on information gathered through the use of qualitative methods such as interviews and focus groups. The purpose of this emphasis was to elicit more complete information about the circumstances surrounding high-risk behaviors among gay and bisexual men in order to better understand how such behaviors fit into the complex context of these men's lives. Another critical element of this approach was the effort to gain input from gay and bisexual men who are most at risk for HIV about the most effective and appropriate approaches for addressing key issues and needs as they relate to HIV prevention. The information will aid CDPHE, its contractors, other providers of HIV prevention and related services, and other CWT members in gaining a more complete understanding of what elements should be present in HIV prevention and related programming and the most effective and appropriate ways to assist program participants through referrals to needed services.

METHODS

Four principle methods were used in gathering data for this needs assessment including: 1) reviewing aggregate epidemiological data drawn from the HIV/AIDS Reporting System (HARS), the Supplement to HIV/AIDS Surveillance Project (SHAS), the 2003-2004 Needs Assessment Survey (NAS), and the National Behavioral Surveillance Project (NBSP); 2) conducting ten focus groups with a total of 72 participants representing diverse groups of gay and bisexual men; 3) conducting fourteen one-on-one interviews with gay and bisexual men, all

but one of whom were living with HIV and had been diagnosed within the previous two years (with the exception of one who had been diagnosed five years prior to the interview); and 4) implementing a survey that was distributed at an Internet site and received 57 responses from gay and bisexual men.

Focus groups were organized by a number of partnering organizations and individuals and took place in ten different venues. The organizations and participants included: 1) Addiction Recovery and Treatment Services (gay and bisexual men who are in recovery and living with HIV); 2) El Futuro (Latino gay and bisexual men); 3) Denver Area Youth Services (gay and bisexual Latino and African American men living with HIV); 4) Northern Colorado AIDS Project (gay and bisexual men living in northern Colorado; 5) the Kicking Tina group (gay and bisexual men who were current and former methamphetamine users); 6) the Community Country Club (bathhouse employees and patrons organized by Denver Public Health); 7) the Denver Swim Club (bathhouse employees and patrons organized by Denver Public Health); 8) Brothas4Ever (African American gay and bisexual/same-gender loving men); 9) the HOPE Program (homeless gay and bisexual men living with HIV); and 10) the Southern Colorado AIDS Project (gay and bisexual men living in southern Colorado). Eight of the focus groups were held in Denver. The remaining two focus groups were held in Fort Collins and Pueblo.

Participants in the one-on-one interviews were sought through service providers from around the state, although only men living in the Denver Metropolitan Area responded. Recruitment occurred through case managers at the Colorado AIDS Project, prevention case managers at CDPHE, staff at infectious disease clinics at Denver Public Health and University Hospital, and the director of the HOPE program. The original intent was to only interview gay and bisexual men who had been diagnosed with HIV within the previous two years. However, one participant brought a friend with him who also wanted to be interviewed. The friend was a young gay man, but was not living with HIV. The results of his interview were included in the summary. Another respondent revealed during the course of the interview that he had been living with HIV for five years. The results of his interview were also included. Another man revealed that he was a heterosexual and denied any sex with other men. The results of his interview were not included in the summary.

The Internet survey used for this needs assessment was posted on the ManHunt.net website for five weeks. A banner was posted on the site offering men the option to click on a link to a Zoomerang site. Fifty-three respondents completed the entire survey; four completed parts of the survey. For a detailed summary of the Internet survey results, see Appendix One.

SUMMARY OF EXISTING AGGREGATE DATA

As mentioned above, aggregate data were drawn from four different sources and analyzed to provide critical information about the types of risk behaviors in which gay and bisexual men were engaging. Trends that were evident in these data were used to inform the population focus and the topics that were further pursued in one-on-one interviews, focus groups, and the Internet survey. One such data source was the HIV/AIDS Reporting System (HARS). HARS contains information gathered by the CDPHE Surveillance Program on all cases of HIV and AIDS

diagnosed statewide and reported to CDPHE. For purposes of informing this needs assessment, male and female African American, Latino, and White cases diagnosed between January of 2001 and October of 2005 were included in the preliminary summary (n=1819). Basic demographic, risk, and diagnostic data are fairly complete for this population of persons diagnosed with HIV.

Another data source was the Supplement to HIV/AIDS Surveillance Project (SHAS). The data summarized in this report represent 520 HIV-infected persons who received care for their infection through Denver Health and Hospitals and participated in the survey between May of 2000 and May of 2004. These data provide more detailed behavioral risk information than is available through HARS and include topics such as substance use, sexual behaviors, STD history, HIV testing history, and access to medical and social services.

The third data source reviewed for this needs assessment was the Needs Assessment Survey (NAS) conducted by the R&E Unit in collaboration with CWT in 2003 and 2004. As part of this effort, 421 surveys were collected from men who have sex with men (MSM), injection drug users (IDU), and high-risk heterosexuals from around the state of Colorado. Approximately 18% of the sample was made up of people living with HIV. A large amount of information was collected on people's risk for getting or spreading HIV, the context of risk, and people's service needs. As was the case with the SHAS data, NAS data were drawn from convenience samples.

The following represent highlights from these three data sets as they relate to gay and bisexual men. For a more complete summary of the data drawn from these sources, see Appendix Two.

- Nearly two-thirds of all people diagnosed with HIV in Colorado between January 2001 and October 2005 were men who have sex with men (MSM). Of these, over two thirds were white.
- One in three MSM diagnosed with HIV were over 40 years old at diagnosis; a higher proportion of white MSM were diagnosed at the age of 40 or older (1 in 3) than African American MSM (1 in 4) or Latino MSM (1 in 5). Conversely, a greater proportion of MSM of color diagnosed with HIV/AIDS were less than 40 years of age.
- Nearly half of all MSM answering the SHAS survey reported over 100 lifetime partners, one in four reported more than 200, and one in seven reported more than 500 sexual partners in their lifetime.
- Approximately two thirds of HIV+ MSM answering the SHAS survey reported more than one sexual partner in the past twelve months, while one in ten reported 20 or more partners.
- One in 3 HIV+ MSM answering the SHAS survey reported having had sex in a bathhouse in the previous 12 months.
- Four in ten HIV+ MSM answering the SHAS survey reported having insertive anal sex with a non-steady partner without a condom the last time they had sex. The same proportion (4 in 10) reported receptive anal sex without a condom with a non-steady partner at last sex.
- White HIV-negative or status unknown MSM answering the NAS were more likely to report having unprotected sex with an HIV+ partner, or a partner of unknown serostatus than were African American or Latino MSM.

- Four in ten HIV-negative or status unknown Latino MSM answering the NAS and nearly as many white MSM reported having sex while drunk or high, while 2 in10 African American MSM reported this risk behavior.
- Nearly half of the HIV-negative or status unknown MSM answering the NAS reported having unprotected insertive anal sex and one in three reported unprotected receptive anal sex in the past 12 months.
- One in ten HIV-negative or status unknown MSM answering the NAS reported that they knowingly had unprotected sex with an HIV+ person in the past 12 months.
- One in five African American HIV-negative or status unknown MSM answering the NAS and one in six Hispanic MSM reported never being tested for HIV, compared to one in twenty white MSM.
- Nearly half of the Hispanic HIV-negative or status unknown MSM answering the NAS and four in ten white MSM reported having five or more drinks at one sitting in the past month, compared to one in four African American MSM.
- One in three HIV-negative or status unknown MSM answering the NAS reported meeting sexual partners on the Internet, over half reported meeting partners in bars, nearly four in ten had met partners in bathhouses, one in five met on the street, and one in six reported meeting partners in parks.
- Nearly half of the HIV-negative or status unknown African American MSM answering the NAS reported experiencing feelings of hopelessness.
- Almost half of the HIV-negative or status unknown MSM answering the NAS had felt shame around their sexual orientation.
- Four in ten HIV-negative or status unknown African American MSM answering the NAS had experienced homelessness.

The fourth data source used was the National Behavioral Surveillance Project (NBSP). Beginning in December 2004 and continuing through February 2005, staff from Denver Public Health (DPH) surveyed 981 MSM who lived in the Denver Metropolitan Area, one of 16 metropolitan areas where the surveys were administered, in order to assess HIV behavioral risk among MSM. Survey participants were accessed through locations such as bars and nightclubs, social groups, bathhouses, and coffee shops at which they completed a self-administered questionnaire using handheld palm pilots. Based on survey data, DPH reported the following findings of behavioral trends that may influence the transmission and acquisition of STD and HIV among MSM living in metropolitan Denver:

- The majority of survey respondents (94%) reported a previous test for HIV. Approximately 7% of those surveyed reported that they had not been tested or had not received results of their last HIV test.
- Of the 523 men that reported the location of their last HIV test, greater than 80% were tested at a private doctor's office or at a public health clinic. A much smaller number reported being tested at an HIV CTS, hospital, STD clinic, or in an outreach setting.
- Eighty-one percent of the survey sample had seen a medical provider in the past 12 months. Among the 153 MSM that reported a positive test, 96% were seen by a provider for HIV care, and 78% reported receiving HAART. Overall, 79% of the respondents reported having health insurance.

- Of the 981 MSM respondents, 10% reported ever injecting drugs, including 17 men who reported injecting drugs in the past 12 months. Forty-four percent of all respondents reported using non-injection drugs (not including alcohol) within the past 12 months. Thirty-eight percent of respondents reported being high on alcohol or drugs while having sex in the past 12 months.
- Among the 17 MSM that reported injection drug use, methamphetamines and cocaine were reported most frequently as drugs used in the past 12 months. Among MSM reporting the use of non-injection drugs, marijuana and cocaine were the most frequently reported drugs used in the past 12 months.
- Although 11% of all the MSM surveyed reported using methamphetamines, a greater proportion of men living with HIV (20.9%) reported methamphetamine use compared to HIV negative men (9.0%).
- Methamphetamine users in the study were significantly more likely to have been arrested in the past 12 months (20.4% v. 4.0%), used erectile dysfunction drugs (22.9% v. 13.4%), and been homeless compared with men who did not report methamphetamine use.
- Unprotected anal or vaginal sex in the past 12 months was reported more frequently among methamphetamine users (70.4%) than among non-methamphetamine users (43.5%). A greater proportion of methamphetamine users (31.7%) reported testing positive for HIV compared with non-methamphetamine users (14.9%).
- Sixty-six percent of the MSM surveyed reported having a main partner in the last 12 months. Of those reporting a main partner, 58% also reported having a casual partner in the last 12 months.
- Fifty-nine percent of all MSM surveyed reported a casual partner in the last 12 months. Of the 600 men that responded to a question about where they met their last casual sex partner, almost half reported meeting this partner in a bar or club. The proportions of men that reported meeting their last casual sex partner through the Internet or at a bathhouse were much lower (i.e., at or approaching 10% of respondents, respectively).
- MSM survey respondents reported unprotected anal and vaginal sex more frequently with a main partner compared with casual partners.
- Among the 981 MSM that participated in the study, 64% reported discussing their HIV status with a partner. Among the 650 men that reported a main partner, 79% reported having a discussion with this partner about his and the partner's HIV status. Among the 580 men with casual partners, 68% reported having such a discussion with a casual partner.

SUMMARY OF THE FOCUS GROUPS, INTERVIEWS AND INTERNET SURVEY

Overarching Issues

The R&E Unit, in conjunction with the CWT Needs Assessment Committee, after reviewing previously gathered qualitative and quantitative information, decided that the following six overarching topic areas should be pursued through the focus group, interview, and Internet survey activities in 2006:

1. Major issues and concerns that gay and bisexual men in Colorado face and how HIV fits into this complex set of concerns.
2. Substance use and abuse, its place within the gay and bisexual "community", and its interrelation with HIV risk.
3. Emotional well-being and its relation to HIV.
4. Partner selection, preferred types of relationships, reasons for having unsafe sex, and anonymous sex with partners found in bathhouses, over the Internet, and in other venues.
5. Disclosure of HIV status.
6. Perceptions of the gay "community" and "culture".

Primary emphasis in the focus groups, one-on-one interviews, and the Internet survey was placed on the HIV prevention and related needs of gay and bisexual men, how to address those needs through the provision of services and community efforts, and how to encourage men to take part in prevention programs and interventions.

Demographic Profile of the Participants

A total of approximately 141 gay and bisexual men participated in needs assessment activities in 2006. Seventy-two men participated in focus groups, 14 participated in one-on-one interviews. Additionally, there were 57 responses to the Internet Survey. Two of the interview respondents also took part in focus groups. Since responses to the Internet survey were anonymous, it is unknown whether any of those respondents also participated in focus groups or interviews. Table One shows a breakdown by participant age.Table Two shows a breakdown by participant race/ethnicity.

Table One: Age of Respondents

Age Group	Focus Groups	Interviews	Internet Survey	Total
15-19	0	2	3	5
20-24	6	1	9	16
25-29	4	0	6	10
30-34	8	3	5	16
35-39	17	2	6	25
40-44	15	2	10	27
45-49	13	3	3	19
50-55	6	1	4	11
56-59	2	0	2	4
60+	1	0	1	2
Missing	0	0	8	8
Total	72	14	57	143

Table Two: Ethnicity of Participants

Race/Ethnicity	Focus Groups	Interviews	Internet Survey	Total
African American	10	2	2	14
Asian American	1	0	0	1
Hispanic/Latino	15	5	4	24
Native American	1	0	1	2
White	39	4	45	88
Other	6	3	1	10
Missing	0	0	4	4
Total	72	14	57	143

Table Three shows the number of participants who live in the Denver Metropolitan Area (DMA) and those who live outside the DMA. The results from the Internet survey give a more detailed geographic breakdown of the respondents (see Appendix One). Details of residence were not asked in the focus groups and interviews. All of the interview respondents lived in the DMA. A total of 11 men participated in the two focus groups held in Pueblo and Fort Collins. All of the other focus group participants lived in the DMA.

Table Three: Geographic Residence of Participants

Residence	Focus Groups	Interviews	Internet Survey	Total
Denver Metropolitan Area (DMA)	61	14	35	110
Outside of DMA	11	0	17	28
Missing	0	0	5	5
Total	72	14	57	143

Findings

Major issues affecting gay and bisexual men and HIV. When asked about the major concerns of gay and bisexual men apart from HIV, responses most frequently offered by participants in the interviews, focus groups, and the Internet survey encompassed issues related to discrimination against gay and bisexual men by the wider society. This included concerns about societal homophobia and stigma, a puritanical society that condemns their sexual orientation and behaviors, struggles over legal rights and government policies, and violence and safety. Other issues discussed that were related, in part, to discrimination included mental health issues such as feelings of isolation, loneliness, shame, and depression, as well as the tendency for some gay and bisexual men to stay "closeted", especially men of color and men living in rural areas. The second most commonly raised issue by interview, focus group, and survey participants dealt with the prevalence of substance use and abuse among gay and bisexual men, with special concern expressed for the preponderance of methamphetamine use. The third most discussed set of concerns was related to health, including access to health insurance and to health care. A large number of the Internet survey respondents cited STDs as a major concern. Another commonly

discussed set of issues in the interviews and focus groups included those related to basic needs such as jobs, housing, and financial resources. In contrast, issues related to basic needs were not commonly raised by survey respondents. Other issues cited as major concerns in the interviews and focus groups included problems within the gay community as well as issues related to sexual relationships, including those concerning multiple sex partners, anonymous relationships, the lack of HIV status disclosure, and men knowingly exposing others to HIV. More detailed summaries of several of these major issues (i.e., substance abuse, emotional well-being, relationships, disclosure, and the gay community) are included below.

After discussing the major issues that gay and bisexual men currently face, interview, focus group, and survey participants were asked their opinions about HIV as a priority and how it ranked relative to other concerns of gay and bisexual men. Internet survey respondents were specifically asked to rank HIV's importance relative to these other issues. Just over half the respondents said HIV was equally important, while 4 in 10 indicated that it was more important. Only 4 respondents indicated that HIV was less important than other concerns. In the interviews and focus groups the subject of HIV was discussed in a much more open-ended way. Although most of the participants thought that HIV was an important issue, interviews and focus group participants perceived that within the gay community most people were not very concerned about HIV, especially if they were negative. Many said that HIV was less fearful to people now that there were medications available to treat the disease. HIV was no longer seen as a death sentence, despite the fact that people were dying due to HIV. Many participants in the interviews and focus groups thought that men who were not living with HIV or those who were newly infected did not understand the harsh realities of HIV. These realities included the impact on the body of the disease itself and of the medications used to treat the disease as well as the impact on other areas such as employment, health insurance, housing, financial well-being, and societal discrimination. The phenomenon of "bug chasing" in which people were described as trying to get HIV was brought up in several of the groups and interviews. Participants felt that some wanted to get the disease so they could just get it over with while others wanted to get infected so they could receive certain financial benefits. Other related topics discussed included: how some gay and bisexual men think everyone already has HIV or is destined to become infected; how some men mistakenly thought that they were being careful due to misconceptions about risk (e.g., if you are a "top" you won't get HIV; if you live in a rural area or a college town you won't get HIV; if your partners look "clean" they don't have HIV; etc.); how many men do not test for HIV because they do not want to know they have it; and how many men living with HIV are exposing others and not disclosing their status to partners.

Substance abuse. Substance use and abuse was one of the most commonly discussed topics in interviews and focus groups. Participants indicated that substance abuse, including the use of alcohol and other drugs, was a huge problem and very common among gay and bisexual men of all ages, socioeconomic groups, and ethnicities. Young men were described as being especially prone to substance use. Participants stressed that substance abuse was almost accepted as a norm by the community. Substance use was seen by most as a major factor in the spread of HIV because of its strong association with unprotected sex and lack of disclosure of HIV status, although some participants offered that people could still be safe while using drugs and alcohol. Methamphetamine use was especially emphasized as a problem in the community due to its easy access, strongly addictive qualities, and strong association with unprotected sex and having

multiple sex partners. Other health problems associated with the use of methamphetamines and other substances were also discussed as a concern, especially for those living with HIV.

The reasons given for why gay and bisexual men use substances were varied. Some emphasized that bars were the main social environment available to gay men and that gay men were especially targeted by companies that sell alcohol. Other drugs were also seen as readily accessible in bars and in bathhouses. Participants stressed that people use drugs because they are fun and can make a person feel very empowered and uninhibited. Some discussed substance abuse as a form of escape from life's problems, and many mentioned its association with emotional problems such as low self-esteem, loneliness, and depression. Some mentioned how an HIV diagnosis can lead people to abuse drugs and alcohol to escape thinking about the realities of the disease.

When asked what needed to be done to help gay and bisexual men who abused substances and who were at high-risk for getting or spreading HIV, a number of alternative views were offered. Many thought that individuals using drugs had to decide for themselves to get help and often had to "hit bottom" before they made that decision. Others saw people getting help when they were forced into treatment through the judicial system. Others offered that encouragement and support from friends and family could help people seek treatment as could extensive outreach efforts. A number of participants discussed how the gay community should be confronting the issue of substance abuse and challenging its prevalence and normalization in the community. Several men mentioned the need for public information campaigns to discourage use, especially use of methamphetamines. Some suggested posting before and after pictures of addicts as a strategy and others thought that wider advertisement of the dangerous ingredients used to make methamphetamines could discourage some from use.

Many issues arise for those who are seeking help with substance abuse. It was emphasized that recovery from substance abuse is very difficult, and people need guidance, support, tools, and alternative activities. One person emphasized that addicts do not need to be judged, because they were already judging themselves. It was frequently mentioned how those who are trying to quit need to remove themselves from their former environment, staying away from friends who use, and from bars, baths, and neighborhoods where drugs are readily available and use is common. The need for more accessible, affordable, and effective substance abuse treatment was especially emphasized as was the need for more recovery groups. It was pointed out how different people needed different types of help, thereby necessitating the availability of more treatment options. Longer-term in-patient treatment programs were seen as potentially helpful as were various types of recovery groups. Some participants cautioned, however, that talking about drugs in groups can make some people want to use even more and described how some people go to groups to make connections for procuring drugs. Many participants emphasized the need for treatment and recovery groups to be gay-specific, so that men could discuss their issues freely, especially those related to sex. Others emphasized that many addicts could benefit from working with ex-users because they feel that their situations would be better understood by someone who had "been there". Several people mentioned the benefits of having both substance abuse and HIV risk dealt with during treatment and recovery.

Respondents to the Internet survey were asked more closed-ended questions about the needs of those who abuse substances and who are at risk for getting or spreading HIV. When asked about the most appropriate and effective types of interventions or approaches to meeting those needs, targeted information campaigns was the most frequent response, followed by interventions that involve the larger gay and bisexual community, having multiple services available at one agency, and counselors who can deal with multiple issues such as substance abuse, HIV risk, and mental health. When asked for the single-most effective approach, survey participants most often indicated having multiple services available at one agency followed by targeted public information campaigns**.** Suggestions for getting men into services included offering incentives; advertisements about available programs; encouragement from friends, family, and peers; and education concerning HIV and substance use. For more details on these responses see Appendix One.

Emotional well-being. Discussions about the emotional well-being of gay and bisexual men and its relation to HIV were not as extensive in the interviews and focus groups as those concerning substance abuse, although many of the participants saw issues such as of low self-esteem, isolation, loneliness, and depression as common. Lack of societal acceptance, homophobia, and discrimination were cited as major causes of poor emotional states. Several participants stressed how an HIV diagnosis often leads to depression in men as well. Many felt that these emotional issues influenced the fact that many men do not care about themselves and sometimes about others as well. They consequently were described as not protecting themselves when having sex and/or failing to disclose their HIV status. Participants thought that there was also a strong interrelationship with substance abuse and mental health. Some saw men using sex to avoid emotional pain, to fill voids in their lives, to deal with loneliness, and to seek validation.

When asked what gay and bisexual men need to help them with these emotional issues and HIV risk, only a few ideas were discussed in the interviews and focus groups. These included the need for more accessible mental health services, therapy and support groups, someone to listen to them, someone to help boost their sense of self-worth, and greater societal acceptance. On the Internet survey, societal acceptance and interventions that address stigma were the most common responses to the question about meeting these needs. Mental health services that were accessible and affordable was the next most commonly indicated survey response. Targeted public information campaigns, multiple services available at one agency, interventions involving the wider gay community, and support groups were all commonly selected responses. Many thought that men would access these services if they were available and people knew about them. For more details on these survey responses see Appendix One

Coming out. In about a third of the interviews and half of the focus groups, the experience of "coming out" was discussed in its relation to HIV. Many saw this as a time of experimentation and excitement, but also confusion, shame, rejection, and other difficulties. This was often considered a time involving high-risk behaviors. For men of color and men in rural areas, coming out was especially difficult and at times dangerous. For bisexual men coming out was also difficult since some thought discrimination against them was prevalent among both heterosexuals and gays. Participants who discussed this issue mostly emphasized the need for support from friends, family, and other gay and bisexual men during this period. They stressed the need for positive role models and mentors that could make this period of transition less

stressful and safer. Some did mention that coming out today is easier than it was in the past, stating that societal acceptance, at least in some areas, had increased.

Relationships and HIV risk. In the interviews, focus groups, and on the Internet survey, men were asked to discuss relationship issues. One question asked about characteristics of what they considered to be "healthy" relationships. In the interviews and focus groups, the most common responses were related to issues of honesty, trust, respect, love, and communication. Some mentioned the importance of friendship. While some thought long-term monogamous relationships were best, others stressed that long-term open relationships were preferable to some gay and bisexual men.

Participants discussed many barriers to establishing healthy relationships. Lack of societal support and prohibitions against same sex marriage were key barriers as were norms within the gay community that did not seem to support long-term monogamous relationships. Participants offered that having multiple partners was often seen as prestigious, and that single encounters and relationships with little substance seemed more the norm and preferable to some. A number of men mentioned that healthy gay relationships were not common and not visible in the community, and therefore there was a lack of good role models. Another common barrier discussed concerned the lack of suitable places to meet other men who were looking for more substantive relationships. Most of the venues where men meet are places such as bars, baths, and parks where substance use often dominates interactions and expectations are more frequently focused on single sexual encounters. Some of the participants offered that monogamy was impossible for gay men or at least extremely rare. Other barriers mentioned included: differences in socioeconomic status, education levels, age, HIV status, and ethnicity; cliquishness in the gay community; men setting their standards too high; substance abuse; dishonesty and difficulty in trusting; emotional problems and lack of emotional stability; and financial problems. When asked what gay and bisexual men needed in order to have the kinds of relationships they preferred, the responses reflected the barriers described above. Ideas included: better role models or more visible healthy relationships to emulate; societal acceptance and legal sanctioning of same sex relationships; and better social outlets and places to meet other men where expectations were more consistent with establishing substantive relationships.

Respondents to the Internet survey most commonly chose relationships that involve mutual trust, honest communication, and long-term monogamy as characteristics of healthy relationships. Long-term monogamy was selected as the healthiest. Three quarters cited commitment, responsibility, and fun. Just under half chose long-term relationships that were not monogamous and casual short-term relationships as healthy. When asked about barriers to healthy relationships, lack of community and societal support and discrimination within the gay community itself were the most common responses. Low self-esteem and fear of rejection were also chosen as common barriers. Just under half cited the lack of good places to meet other men as a barrier. When asked what men need to help them develop the kinds of relationships they want, societal acceptance was the most common response. The next common response affirmed the need for places to meet outside of bars and sex venues.

Anonymous sexual relations. Interview, focus group, and survey respondents were specifically asked to give their opinions about anonymous encounters, including discussions of why some

men were drawn to such encounters, the connection of anonymous encounters to HIV, and what men needed to make those encounters safer. Interview and focus group respondents often said that some gay and bisexual men were drawn to anonymous encounters because they were immediate, non-binding, and often thrilling. Many also attributed such encounters to sex addictions or to some men liking sex too much. Some respondents said that anonymous encounters helped men to feel wanted and validated, and they satisfied a basic need for physical contact. Others liked the aspect of conquest and developing evidence for bragging rights if they had a lot of partners. Some respondents said that men sought anonymous encounters because they thought the kinds of relationships that they really wanted were not available. Other responses included the need to hide same sex relationships due to societal disapproval, drug use, low self-esteem, men not caring about HIV anymore, and lack of good information about HIV and STD risks. Respondents to the Internet survey also emphasized the convenience, non-binding arrangements, and the eroticism and excitement often involved in having sex with strangers. Over half offered sexual addiction as the explanation for its appeal. Almost half also suggested not caring about HIV, the need for validation, and desire for privacy as alternative explanations.

Although some interview and focus group participants said that anonymous sex is often low risk, others discussed how unprotected anal sex or "barebacking" was common. Many discussed how disclosure was not common in anonymous encounters and that men who were living with HIV often lied about their status. Although many possible venues were mentioned where anonymous sex occurs (e.g., bathhouses, parks, restrooms, bookstores, etc.), the Internet seemed to be especially key in facilitating anonymous sexual encounters, with many men who used such sites, indicating online that they were looking to "party and play", meaning they wanted to do drugs while having sex.

Some of the ideas that were posed concerning making anonymous sex less risky included: conducting more outreach in bathhouses and other venues; making condoms and lubricants more readily available; cracking down on drug use and unprotected sex at the bathhouses; conducting outreach over the Internet; and increasing education about HIV and STDs. Internet survey respondents most commonly answered that more comprehensive education about HIV and other STDs and public information were needed. Some also answered that improving men's self-esteem could help to increase safer behaviors. When asked about the most appropriate and effective types of interventions, social settings where men could meet other men, targeted public information campaigns, interventions involving the larger gay community, and support groups were the most commonly offered suggestions, respectively. Incentives, media campaigns, and education were most commonly offered as means to get men involved in such prevention efforts. For more details on these responses, see Appendix One.

Reasons for unsafe sex. During the course of the interviews and focus groups, participants provided a number of opinions about why many gay and bisexual men are having unsafe sex in spite of knowing about the risks for HIV. By far the most common reason given was the use of drugs and alcohol. Such use was said to impair judgment and cause people to forget about protection or simply not care about protecting themselves or others. Not caring about themselves and/or others was the second most common reason presented. In several instances participants discussed the phenomenon of "bug chasing" in which men purposely try to become infected with

HIV, either because they wanted to "get it over with" thinking infection was inevitable, to access services, or because of self-destructive tendencies. Men not liking condoms and how they feel was also a common reason presented, as were the lack of ready availability of condoms, low self-esteem and the need for acceptance, men's desire to show trust and emotional connection to their partners, and feelings of invincibility among youth. Some participants mentioned how people often thought they were being safe or were in denial of their risk. Such men were said to make judgments about the HIV status of their partners based on appearance, socioeconomic status, age, where they reside, or if they tend to be "tops" (insertive partners) or "bottoms" (receptive partners). Other reasons for unsafe sex included condom or safe sex fatigue, especially among older gay men, and prostitution.

Disclosure. Participants in the interviews, focus groups, and Internet survey were also asked to give their opinions on issues related to disclosure of HIV status among sex partners. In the majority of interviews and focus groups, participants discussed how HIV status was not commonly discussed among partners, and that many gay and bisexual men who were living with HIV were not telling their partners about their infection or were lying about it. Some even stated that it was a norm in the gay community not to disclose one's HIV status. Disclosure seemed especially infrequent in bathhouses and when people were drunk or high. By far the most common reason given for lack of disclosure was men's fear of rejection by potential partners. The second most common explanation was men's concern that once they disclosed to a partner they could not be confident that the partner would not then tell others. Another commonly cited reason was shame that is brought on due to societal stigma of HIV and discrimination against those who have it. Other reasons for not disclosing included: a fear of violence or other cruel treatment; vindictiveness or a desire to infect others; not caring about infecting others; not knowing how to disclose; and not knowing that one is HIV positive because of avoidance of testing. It was also mentioned that some men disclose their positive HIV status to partners who then express a lack of concern and, at times, a lack of desire to use protection

Respondents to the Internet survey were first asked to choose among a list of factors that affect whether or not partners have discussions about HIV status. Assumptions about partners' HIV status, feelings for partners, and drug use were the most commonly indicated responses. Other frequent responses included fear of rejection among HIV-positive persons, potential for the relationship to move forward, behavioral expectations in the setting where men meet, concerns about confidentiality, and peer expectations. When asked why men who are living with HIV might not disclose their status, almost all respondents checked fear of rejection as a reason, and over two thirds checked fear that confidentiality would be breached. Over half responded that it was the other person's responsibility to protect himself from infection. A third of the respondents indicated that it was no one else's business, while one quarter reported fear of violence as a reason for not disclosing.

Although many in the interviews thought that men who were living with HIV should disclose their status to sex partners, many thought that it was up to negative partners to ask about status and/or presume all partners are positive and act accordingly. Some thought that if condoms were used, disclosure was not necessary. Conversely, some men were said to disclose, but then to proceed to have unsafe sex if the partner does not object no matter what the partner's status. A number of men in the interviews and focus groups who were living with HIV talked about very

positive experiences with disclosure or felt that it was necessary whether they got positive reactions from others or not. Some had chosen to remain abstinent until they felt more comfortable with disclosure. Most of these men had not had partners disclose their positive status to them before they were infected.

When asked what gay and bisexual men who are living with HIV need to help them to disclose their status to partners, several suggestions were made. The most commonly offered idea was mutual support groups. Others suggested education helping men learn how to disclose, using role-plays and giving them a chance to practice. Public information campaigns also were commonly suggested in an effort to normalize disclosure in the community and make it more important and expected. Messages were recommended that would appeal to men living with HIV not to spread the disease to others, to respect others' rights and choices to stay negative, or to counter the notion that they have the right to decide for others. Other suggestions included letting couples test for HIV and receive their results together and encouraging serosorting (i.e., seeking partners with the same HIV status).

Respondents to the Internet survey thought that what men needed most to disclose positive serostatus was greater acceptance from men who were negative and from society in general. They also suggested peer support, increased confidence, and an increased sense of morality. When asked what types of interventions would help gay and bisexual men who were living with HIV to disclose their status to partners, over three quarters suggested targeted public information campaigns while almost two-thirds suggested support groups that include both positive and negative men as well as interventions that involve the larger community of gay and bisexual men. Almost half of the survey participants suggested support groups with positive men only, and around a third indicated one-on-one sessions with a professional counselor or sessions with a trained peer or mentor. For more details on these responses, see Appendix One.

The gay community and culture. Although no questions were asked directly about the "gay community" and "gay culture", attitudes and opinions about these were discussed in almost every interview and focus group and were very useful for assessing influences on risk behavior and in looking for HIV prevention ideas. Many of the participants had very negative things to say about the gay community and culture, some stating that there really was not much of a community in Denver. The most common criticisms concerned how divided the community was according to age, ethnicity, class, HIV status, "tops" and "bottoms", etc.; how obsessed men could be about looks and status symbols; and other factors. People described the community as separated, cliquish, superficial, unaccepting, gossipy, judgmental, and hypocritical. Participants expressed concerns that gay life was now about partying, substance use, Internet "hook ups", and having multiple sex partners. Substance abuse was seen as a widespread problem that was almost normalized. Some thought that methamphetamine use and barebacking had both been glamorized to some extent. Participants expressed concern that the gay community was no longer concerned about HIV, that it was almost a norm not to disclose positive HIV status or even to discuss HIV, and spreading HIV was not criticized. Others offered that long-term monogamous relationships were not supported by the community. Many people did not feel connected to the community and looked for support elsewhere from family and small groups of friends. Bisexuals were seen by some as not being part of the community at all or not accepted by the larger gay community.

The participants did see a need for building community and developing leadership. They expressed a need for gay and bisexual men to want to help, support, and care for each other, promote emotional well-being, encourage safety concerning HIV, and promote health. There was a strong emphasis on the need for the community to refamiliarize itself with HIV and once again take responsibility for its prevention. This would include openly discussing HIV, stigmatizing unsafe sex, appealing to men to protect themselves, appealing to those living with HIV to disclose their status and not expose others, and taking on prevention efforts including public information campaigns. Participants expressed a need for mechanisms in which older gay men could share their wisdom and act as role models and mentors to younger gay men. They also expressed that the community needed to confront substance use and abuse, especially the use of methamphetamines, and create and emphasize social venues other than bars and bathhouses. Another issue that was discussed concerned the community's need to confront societal stigma and discrimination, to challenge stereotypes, and to work to raise awareness in the society at large.

The idea of having forums during which the gay community could discuss their issues was posed in some of the interviews and focus groups, and most thought it was a good idea. People thought that both HIV and substance abuse as well as other issues defined by the community as important should be topics of discussion. Some thought smaller groups that met more frequently or groups that involved more specific populations (e.g., groups based on age or ethnicity) were more appropriate than larger, infrequent gatherings. Internet survey respondents also commonly recommended that HIV and safer sex be discussed in forums as well as substance abuse, emotional well-being, other health needs, and societal acceptance.

Addressing HIV Prevention Needs of Gay and Bisexual Men: Expressed Needs and Prevention Intervention Ideas.

In all of the interviews and focus groups, participants spent a significant amount of time discussing the HIV prevention and related needs of gay and bisexual men, many of which are described in the above sections. One of the biggest concerns that was repeatedly expressed was the lack of attention paid to HIV and its prevention, both within the gay community and by the prevention system itself. Many participants recalled the time when the gay community rallied around HIV prevention as the community encouraged men to use safer sex practices and lobbied for comprehensive care services for those who were living with HIV. Information about HIV and its prevention was described as being readily available then, and a number of organizations were conducting outreach and distributing safer sex materials in venues where high-risk behavior occurred or was initiated. Participants offered that HIV was significantly less visible currently, effective prevention efforts were lacking, and the community was no longer dealing with the issue. They strongly agreed that HIV prevention efforts and related services needed to be increased. They especially cited a need for increased access to various types of substance abuse treatment (particularly treatment designed for gay men) and access to mental health services.

By far the most common set of suggestions, which was discussed in every interview and focus group, concerned increasing awareness, knowledge, and concern about HIV. Towards that

end,widespread and highly visible public information, social marketing, and educational campaign efforts were recommended. Focus areas for these efforts included: helping negative men understand the harsh realities of being HIV positive during a time when many did not think it that serious; emphasizing the dangers of substance abuse, especially methamphetamine use; and improving men's knowledge about HIV and other STDs through the provision of targeted and relevant information that goes well beyond the basics. Participants thought that information, warnings, and service referrals should be made available in bars, bathhouses, parks, restrooms, clinics, bookstores, and anywhere else that gay and bisexual men frequent. They also thought that public information should appear on websites that men use to find sex partners. According to the participants, messages needed to be targeted to specific populations, appealing to both HIV negative and positive men of various age and ethnic groups and to those who abuse drugs and alcohol. Information about other STDs was also said to be a necessary part of the effort. More comprehensive sex education was recommended for schools, given that it was a good way to reach gay youth, and it was commonly thought that abstinence only programs were ineffective and insensitive to their needs.

Ideas for various types of group level interventions were the second most commonly discussed prevention topics. Support groups, social groups, and substance abuse recovery groups were among the suggested interventions. Groups needed to be targeted to specific populations of gay men and should address the most relevant issues of those populations. Suggested topics included substance abuse and recovery, disclosure of HIV status, emotional well-being, HIV and STD information, the meeting of basic needs, and dealing with and challenging societal stigma and discrimination. Participants clearly asserted that the gay community needed to play a much bigger role in HIV prevention and related services and in defining solutions to a number of key issues that the community is facing. Many agreed that community forums should be held so that gay men could discuss their most relevant issues, including those related to HIV, substance abuse, mental health, and societal homophobia and discrimination. The most commonly suggested community level effort concerned the development of safe places that were alcohol and drug free where men could meet other men and be able to socialize, access services, and participate in a number of social activities. Increased outreach efforts were also commonly proposed as means of getting information to people, making condoms and lubricant readily available, making HIV and STD testing more available, and for encouraging people to take part in other types of prevention programming and related services.

Strategies that involved social network solutions and peer advocacy and support were also commonly suggested by the interview and focus group participants as they saw many men needing small groups of friends, other peers, and family to help them deal with their most important issues, encourage healthy behaviors, and assure them that they are cared for. Mentoring programs were often mentioned as good ways for older gay men to share wisdom and offer support to younger men in environments that are safe. Several participants emphasized the importance of people being given opportunities to use their own experiences to help others.

Below is a list of some of the features and strategies that the interview and focus group participants thought should be present in HIV prevention efforts. For more specific intervention ideas suggested by the participants, see Appendix Three.

- Interventions need to be tailored to the specific populations of gay and bisexual men they are meant to serve and designed by members of those populations.

- Men need client-centered and harm reduction oriented services that include counselors or case managers that listen to them and let them decide on their needs and assist them in accessing appropriate services.

- Whenever possible and appropriate, providers of HIV and related services should be people who reflect the community they are serving and who have successfully overcome similar life challenges as the men they are serving.

- Information on available services needs to be highly visible and accessible

- Men need to receive services that are easily accessible and in which they are treated with respect, their needs are well attended to, and they are not judged.

- Providers should ensure that sound referrals are made to help people access basic needs.

- Providers need to be well-trained so that they understand gay men's issues.

- There need to be more programs available outside of the Denver Metropolitan Area.

- Issues of older gay men and of younger men need to be sensitively and comprehensively addressed.

- Programs need to be designed with input from the target population and consist of on-going evaluation by those using the services.

- Social dimensions need to be built into prevention efforts.

- Concerns about confidentiality need to be addressed in the design and provision of services.

- The consolidation of services and multi-service organizations should be in place to more effectively and efficiently meet the multiple needs of gay and bisexual men who are at high risk for HIV.

- HIV prevention providers should work with bathhouse owners to eliminate the availability of drugs in those venues and to make structural and policy changes that would ensure safer sex practices.

- Doctors should become involved in prevention efforts by discussing safer sex practices with clients, providing relevant information, and making appropriate referrals.

- ❖ The needs of bisexual men and other non-gay identified men must be addressed in ways that are appropriate and sensitive to their needs. Recognition that those needs are often different from those of gay men is essential and must be accommodated.

Limitations of the Data

Given the reliance on qualitative information for a major part of this needs assessment, convenience samples were used and cannot be considered as statistically representative of gay and bisexual men in Colorado. Efforts were made to draw information from a diverse population of gay and bisexual men, covering various age groups, ethnic groups, rural and urban residents, and both men who were living with HIV and those who were not. Emphasis was placed on finding participants who were at high risk for getting or spreading HIV. Peer recruiters and service providers were used to gain participation in the ten focus groups that were held, and a widely diverse set of men participated. However, focus group samples are inherently small and cannot be considered to necessarily represent large numbers of people. Yet given the amount of overlap of information drawn from the various groups and the significant patterns that were evident, a high degree of confidence can be placed in the results. Interview respondents were recruited through a number of service providers who work with men living with HIV. The study was advertised through fliers and word of mouth. Participation was completely voluntary and relied on men taking the initiative to call and make an appointment for an interview. Although efforts were made to interview men outside of Denver, no men living outside of the metropolitan area volunteered to participate in the one-on-one interviews. The number of interview participants was also small, but again, similar information and patterns emerged as those drawn from the focus groups. A link to the Internet survey was posted for five weeks on Manhunt.net. Other that basic demographic information, we have little knowledge of the men who chose to answer the survey, but we do know that they were frequenting an Internet site that is often used by gay and bisexual men to seek sex partners. The data gathered for this needs assessment include the perceptions of a diverse group of gay and bisexual men about HIV risks and appropriate strategies for lowering those risks. Alone, these data cannot offer a complete picture of the extent of risk behaviors, the degree to which various factors influence those risks, or the potential effectiveness of proposed prevention strategies.

Data from the quantitative sources described above were drawn from convenience samples. Although HARS contains a more complete sample than the others, it only encompasses HIV cases that have been reported to CDPHE. The Supplement to HIV/AIDS Surveillance Project (SHAS) survey data were collected from people living with HIV who were accessing care services at Denver Public Health. Needs Assessment Survey (NAS) respondents were recruited by service providers and peers throughout Colorado, and were not randomly selected, nor were participants in the National Behavioral Surveillance Project (NBSP). Therefore these cannot be considered as representative samples, although a large amount of rich data was collected from a diverse sample of gay and bisexual men that can be used with a high level of confidence in HIV prevention program planning and development.

SUMMARY AND CONCLUSION

Several themes can be identified in a review of the information summarized above. The first concerns a general belief by gay and bisexual men that HIV has "fallen off the radar screen". Most of the participants in the interviews, focus groups, and the Internet survey agreed that HIV prevention efforts had diminished and were less apparent. However, the participants still thought that HIV was a critical issue and should be addressed widely and in a highly visible, open, and honest manner by both the HIV prevention system and by the gay community itself. They called for an all-out campaign to remind people that HIV was still a serious problem among gay and bisexual men, to provide them with accurate and relevant information, and to encourage people to engage in safer behaviors.

A second theme sheds light on the extensiveness of substance use and abuse within the community as well as related challenges to people's emotional well-being. Methamphetamine use was especially highlighted as being used extensively and as destructive to individuals who use the drug, those in their social networks, and the community. Participants emphasized how the extensive use of drugs and alcohol needed to be challenged and that information campaigns and prevention and treatment services needed to be in place. Once again, the need for services and providers that can address complex sets of issues that include substance abuse, mental health, HIV, and other related issues in an integrated way was reiterated.

A third theme consists of a call for the revitalization and reorganization of the gay community, challenging men to question behavior trends and confront important issues. This would include HIV and high-risk sexual behaviors, widespread substance abuse, mental health, men's need for healthy social outlets and ways to connect to community, and the challenges posed by what is seen as a homophobic society. Many participants expressed the need for opportunities for people to learn from each other, share experiences, and support each other. The point was often made that gay and bisexual men needed to develop their own solutions to problems affecting the community and, once again, become major participants in designing, implementing, and evaluating HIV prevention strategies and interventions.

A review of the information summarized in this needs assessment also serves as an important reminder that many of the issues associated with the spread of HIV have not been adequately addressed, in spite of the fact that they have been cited as problems by needs assessment participants and community partners for a number of years. Participants in this study remarked that they were not seeing enough action taken either by the HIV prevention system or by the gay community. Therefore, significant discussion and planning concerning how these issues can be more substantively addressed would be appropriate. Most apparent is the need to approach HIV prevention in a holistic manner within the wider context of the other issues and concerns that gay and bisexual men find most critical.

RESOURCE LIST

1. **HIV/AIDS Reporting System (HARS), January 1, 2001-October 31, 2005**. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Atlanta, Georgia. Data collected and compiled by the HIV Surveillance Program, STD/HIV Section, Colorado Department of Public Health and Environment.

2. **HIV Prevention in Colorado 2003-2004: An Assessment of Needs: An Addendum to the CWT 2002-2003 Needs Assessment Report**. Research and Evaluation Unit, STD/HIV Section, Colorado Department of Public Health and Environment.

3. **"National HIV Behavioral Surveillance: Men who have Sex with Men – December 2004 – February 2005."** Presentation by Mark Thrun, MD, to Colorado's community planning group, Coloradans Working Together: Preventing HIV/AIDS, on June 3, 2005.

4. **Supplement to HIV/AIDS Surveillance Project (SHAS), May 2000-May 2004.** Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Atlanta, Georgia. Data collected from clients by staff at Denver Health Medical Center's Infectious Disease Clinic.

APPENDIX ONE: INTERNET SURVEY RESULTS

Fifty-seven persons responded to the survey on the Man-Hunt web site. As indicated in the table below, most of the respondents were White (87%). Four were Hispanic, two were African American, one was Native American, and one indicated Tirgueño.

34. What is your race/ethnicity?	Number of Responses	Response Ratio
African American	2	4%
American Indian/Native American	1	2%
Asian American	0	0%
Hispanic/Latino	4	8%
White	45	87%
VIEW Other, Please Specify	1	2%

The majority of respondents were from the Denver metropolitan area (67%). Twelve percent were from Boulder/Longmont, 12% were from Colorado Springs, 4% were from Ft. Collins/Greeley and 2% or 1 person was from Pueblo.

35. Place of residence	Number of Responses	Response Ratio
Denver metropolitan area	35	67%
Boulder/Longmont area	6	12%
Colorado Springs	6	12%
Ft. Collins/Greeley area	2	4%
Pueblo	1	2%
Western Slope area	0	0%
Other city in Colorado	1	2%
Town in Colorado	0	0%
Rural community in Colorado	1	2%
Outside Colorado	0	0%
Total	52	100%

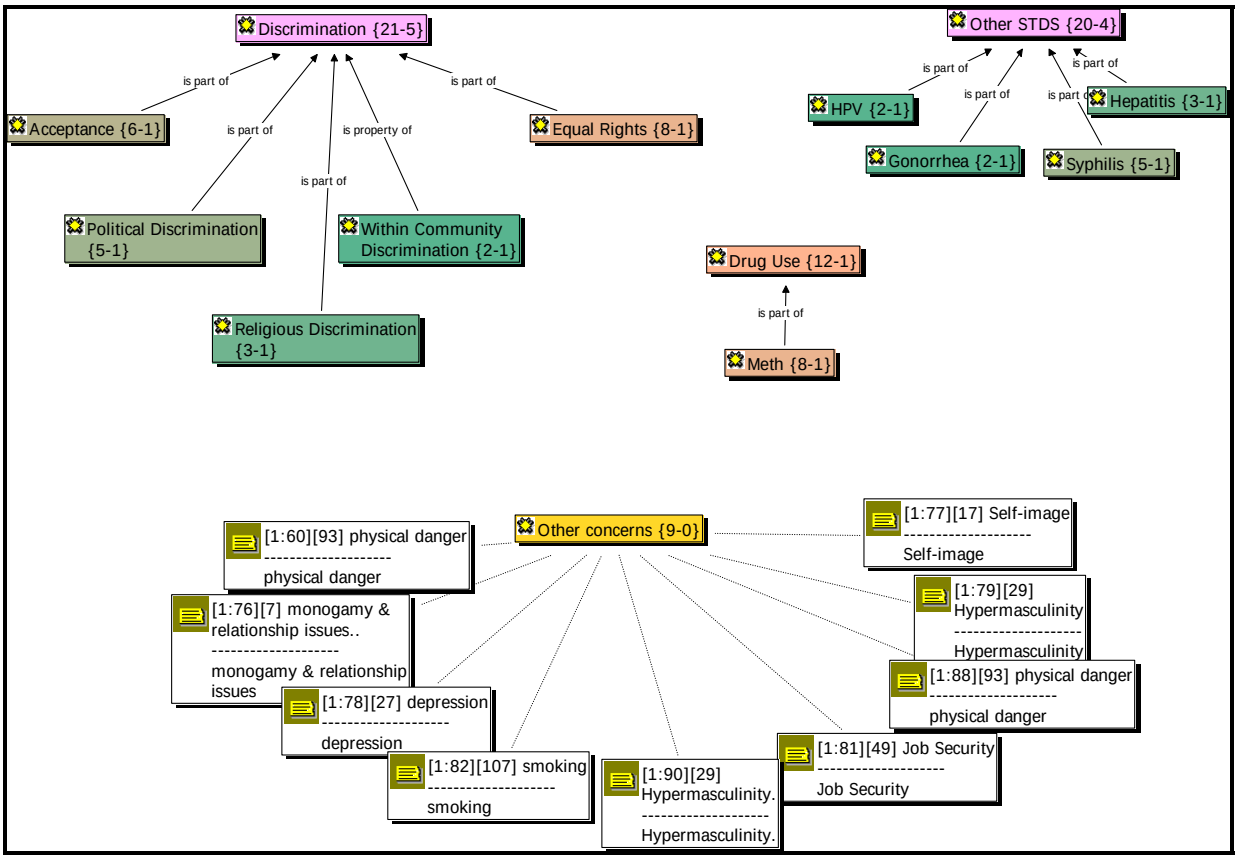
The respondents were from a variety of age groups, although, the largest percentages were in the 20-29 and 40-49 year age groups. Some 26% were 20-29 years old, 19% were 30-39, 23% were 40-49, and 11% were 50-59 years old. Fourteen percent did not provide their age.

Age of Respondents

Age	Frequency	Percent
15-19	3	5.3%
20-24	9	15.8%
25-29	6	10.5%
30-34	5	8.8%
35-39	6	10.5%
40-44	10	17.5%
45-49	3	5.3%
50-54	4	7.0%
55-59	2	3.5%
65+	1	1.8%
Missing	8	14.0%
Total	57	100.0%

Survey results indicated that the biggest concerns faced by gay and bisexual men in Colorado are discrimination (21 respondents), STDs (20 respondents), and drug use (12 respondents). Within the category of discrimination, equal rights (8 respondents), religious (3 respondents) and political discrimination (5 respondents), societal acceptance (6 respondents), and intra-group discrimination (2 respondents) were specified. Within the category of drug use, methamphetamines were mentioned 8 times. Within the category of STDs, hepatitis, HPV, syphilis, and gonorrhea were specifically mentioned. Other concerns included job security, depression, hypermasculinity, physical danger, smoking and self image.

1. Other than HIV, what are the biggest concerns that gay and bisexual men in Colorado currently face?



When asked how important HIV is compared with these other concerns, 93% felt HIV was equally important or much more important.

2. How important is HIV compared with these other concerns?	Number of Responses	Response Ratio
HIV is much more important	23	42%
HIV is equally important	28	51%
HIV is less important	4	7%
HIV is much less important	0	0%
Total	55	100%

When asked what types of relationships gay and bisexual men engage in that would be considered healthy, over eighty percent selected relationships that involve: mutual trust (82%), honest communication (88%), and long-term monogamy (82%). Over seventy percent checked

relationships that involve total commitment, responsibility (75%), and fun(71%). Slightly fewer than half indicated relationships that involve some but not total commitment, long-term steady non-monogamous relationships, or casual short-term relationships. A minority indicated anonymous sexual relationships (21%) and relationships that involve no responsibility and commitment (13%).

3. What are the types of relationships that gay and bisexual men engage in that you would consider "healthy" (however you choose to define that)? (Please check all that apply)	Number of Responses	Response Ratio
Relationships that involve no responsibility and commitment	7	13%
Relationships that involve some responsibility and commitment	27	48%
Relationships that involve total responsibility and commitment	42	75%
Anonymous sexual relationships	12	21%
Casual, short-term relationships	24	43%
Long-term, steady, monogamous relationships	46	82%
Long-term, steady relationships that are open (not monogamous)	26	46%
Relationships that involve mutual trust	46	82%
Relationships that involve honest communication	49	88%
Relationships that are fun	40	71%
VIEW Other, Please Specify	4	7%

Other relationships designated as healthy included non-sexual friendships, relationships based on companionship, or any responsibly agreed to relationship. One person implied that it would be difficult to get gay men to engage in healthy relationships.

3. What are the types of relationships that gay and bisexual men engage in that you would consider "healthy" (however you choose to define that)? (Please check all that apply)	
#	Response
1	Any responsibly agreed-to relationship
2	relationship based on companionship.
3	good luck getting gay men to act "healthy"
4	non-sexual friendships are also healthy

When asked which of the relationship types would most likely be considered healthy, long-term, steady monogamous relationships were the most popular answer (34%). Twenty-three percent also selected relationships that involve total commitment and responsibility and 25% selected relationships that involve honest communication.

4. Which one of the above types of relationships would you most likely consider "healthy"? (Check only one)	Number of Responses	Response Ratio
Relationships that involve no responsibility and commitment	0	0%
Relationships that involve some responsibility and commitment	1	2%
Relationships that involve total responsibility and commitment	13	23%
Anonymous sexual relationships	0	0%
Casual, short-term relationships	0	0%
Long-term, steady, monogamous relationships	19	34%
Long-term, steady relationships that are open (not monogamous)	5	9%
Relationships that involve mutual trust	4	7%
Relationships that involve honest communication	14	25%
Relationships that are fun	0	0%
VIEW Other, Please Specify	0	0%
Total	56	100%

When asked what barriers gay and bisexual men confront in trying to create and maintain the relationships they most want, 68% reported discrimination within the gay community and 71% reported lack of community and societal support for creating and maintaining same sex relationships. Sixty-three percent reported low-self esteem and 61% reported fear of rejection. Forty-three percent reported that there are no good places to meet men to establish these kinds of relationships, 39% indicated shyness, and 34% indicated differences in HIV status.

5. What are some of the barriers that gay and bisexual men confront in trying to create and maintain the relationships they most want? (Please check all that apply)		Number of Responses	Response Ratio
There are no barriers		0	0%
There are no good places to meet men to establish these kinds of relationships		24	43%
Differences in HIV status		19	34%
Low self-esteem		35	63%
Fear of rejection		34	61%
Shyness		22	39%
Discrimination within the gay community (based on age, race, class, HIV status, etc.)		38	68%
Lack of community and societal support for creating and maintaining same sex relationships		40	71%
VIEW Other, Please Specify		7	13%

Other barriers specified included fear of the consequences of coming out, drugs, the overall social view of homosexuality, the lack of variety of gay men or good matches, the lack of activities where gay men can feel free to interact, the difficulty of honesty, and past personal issues.

5. What are some of the barriers that gay and bisexual men confront in trying to create and maintain the relationships they most want? (Please check all that apply)	
#	Response
1	Fear of consequenses of coming out/denial
2	drugs
3	over all social view of homosexuality
4	Lack of variety of gay men, no good matches
5	Honesty is huge, and very difficult. out of space.
6	activities where gay men can feel free to interact
7	their own past issues

When asked which one of the above is the most significant barrier to creating and maintaining the relationships they most want, there was significant variation in response, however, lack of

community and societal support for creating and maintaining same sex relationships was the most popular response (39%).

6. Which one of the above is the most significant barrier to creating and maintaining the relationships they most want? (Check only one)		Number of Responses	Response Ratio
There are no barriers		0	0%
There are no good places to meet men to establish these kinds of relationships		6	11%
Differences in HIV status		1	2%
Low self-esteem		8	14%
Fear of rejection		4	7%
Shyness		1	2%
Discrimination within the gay community (based on age, race, class, HIV status, etc.)		9	16%
Lack of community and societal support for creating and maintaining same sex relationships		22	39%
VIEW Other, Please Specify		5	9%
	Total	56	100%

Other barriers considered highly significant were drugs, lack of suitable men, past life issues, and societal views of homosexuality.

6. Which one of the above is the most significant barrier to creating and maintaining the relationships they most want? (Check only one)	
#	Response
1	drugs
2	over all social view of homosexuality
3	Lack of suitable men
4	why limited space???
5	their own past issues

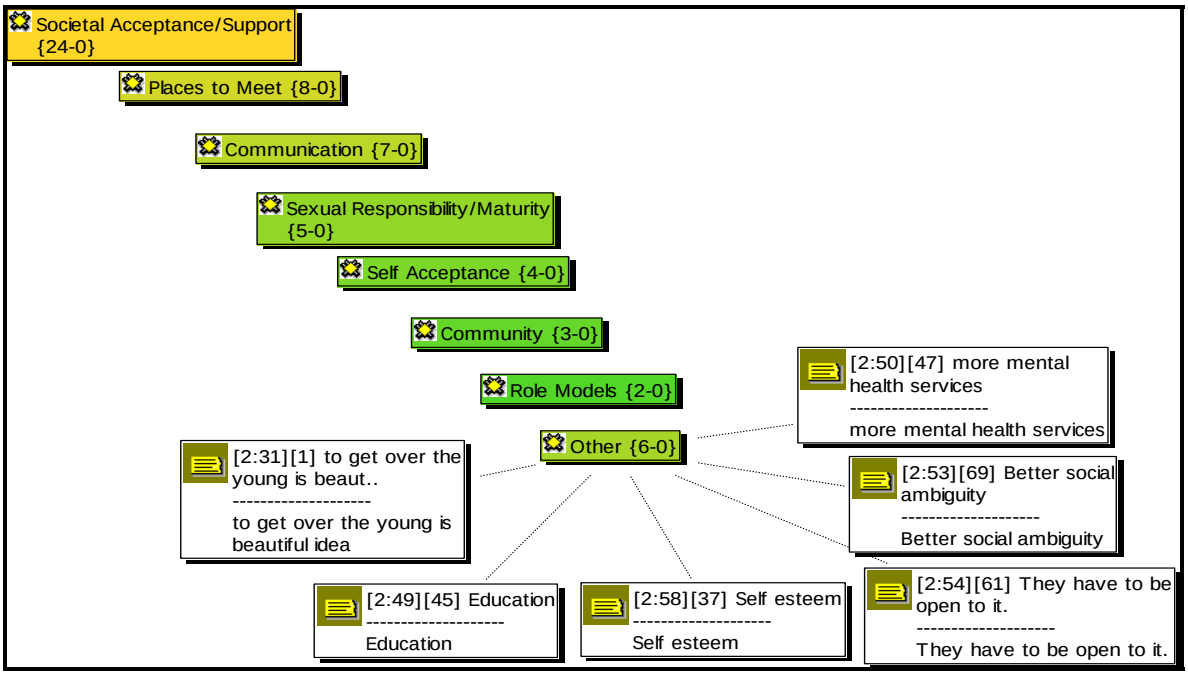
When asked what gay and bisexual men need to help them more easily develop the kinds of relationships that they most want, societal acceptance and support was the top response (24 respondents). A quotation that reflects this need is: “They need to exist in a community that is open and affirming of who they are. It is very difficult living as a gay/bi man in Colorado for a lot of people. The atmosphere here is very harsh, and this contributes to the difficulty of finding,

establishing, and maintaining a healthy relationship." Related responses involved the need for self-acceptance and support from within the gay/bisexual community (4 respondents).
Eight respondents expressed the need for places to meet outside of bars, clubs, and sex venues. The following quotation is an example of responses that demonstrated this need: "Self esteem plays a big part, but also societal support and or at least tolerance would allow more men to explore relationship rather than just sex....but the commercial-gay community as a whole is also to blame...everything for gay men is sexualized and the culture is so bar-oriented....there needs to be better places to meet quality gay men for friendship/socializing as well as for dating and/or sex.....it's can't all just about sex"

Seven respondents designated a need for improved communication, and five respondents mentioned sexual maturity and responsibility. This quotation reflects the expressed need for sexual maturity and responsibility. "Strong influence from the world and community that it is not okay to just have sex with anyone and everyone. A lot of sexual perverts find their homes with the gay community and they influence a lot of its sexual problems. They actually cause a lot of its sexual problems. You don't see straight bathhouses attached to straight nightclubs. Straight people have more of a sense of sexual responsibility and interest in monogamy than gay men do, and I think this is because they are sometimes forced into a promiscuous lifestyle because everyone else (gay men) condone this type of behavior."

A few respondents suggested a need for a greater sense of community (3) and role models from within the community (2). Other responses included mental health services, education, and openness to relationships.

7. What do gay and bisexual men need to help them more easily develop the kinds of relationships that they most want?



When asked “What are some of the reasons that some gay and bisexual men have unprotected sex with anonymous partners?”, a wide array of responses was given. Over half indicated eroticism (54%), fantasies (57%), sexual additions (54%), and the lack of conditions or restrictions associated with anonymous partners (61%).

8. What are some of the reasons that some gay and bisexual men have unprotected sex with anonymous partners (e.g., those met at bathhouses, over the Internet, or through other means)? (Please check all that apply)		Number of Responses	Response Ratio
It's a quicker, easier way to find sex partners		27	48%
Sex is more exciting and fun with anonymous partners		25	45%
Sex is more erotic with anonymous partners		24	43%
Sex is more erotic without condoms		30	54%
There are no strings attached		34	61%
There are more partners to choose from		27	48%
It's safer than meeting men in other ways		6	11%
There is a good possibility of meeting someone to establish an on-going relationship with		7	13%
They fear commitment		20	36%
They fear they will be rejected by men that they know or get to know		16	29%
It's the only way available for some men to find partners		23	41%
It's a good way to keep your sexual orientation private		24	43%
They don't have to worry about HIV transmission because the risks are understood by all		2	4%
They don't care if they get HIV		25	45%
They don't care if they give HIV to someone else		24	43%
They are trying to fulfill fantasies		32	57%
They want validation		25	45%
They have a sexual addiction		30	54%
They fear rejection if they say they want to use condoms		19	34%
VIEW Other, Please Specify		11	20%

Other reasons for unprotected anonymous sex included drugs, low self esteem/worth/respect, personal level of maturity and responsibility, easiness of anonymous sex, attractiveness of the

taboo, desire for sex without a relationship, self destructiveness, sense of invulnerability to disease, and willingness to take informed risks. Responses also indicated that reasons for anonymous sex and reasons for unprotected sex need to be addressed separately.

8.	What are some of the reasons that some gay and bisexual men have unprotected sex with anonymous partners (e.g., those met at bathhouses, over the Internet, or through other means)? (Please check all that apply)
#	Response
1	Drugs
2	Responsible guys know the risks & decide for thems
3	They don't want a relationship, they just want sex
4	low self esteem/self worth
5	I first thought it meant only sex, not unprosex.
6	they're immature and irresponsible.
7	it's still a "taboo" that people are drawn to
8	It is easy to hook up... lack of self respect.
9	self destructive behavior
10	You've really asked two questions in one here
11	thinking it won't happen to them

When asked the most important reason gay and bisexual men engage in unprotected anonymous sex, a variety of responses were given, however, the most popular was that sex is more erotic without condoms (25%). Other responses checked by 4% to 11% of respondents included speed and ease of finding sex partners (11%), fear of rejection for wanting to use condoms (9%), lack of concern about contracting HIV (9%), greater eroticism of sex with anonymous partners (7%), ability to keep sexual orientation private (7%), fulfillment of fantasies (5%), and freedom from

conditions and restrictions (5%).

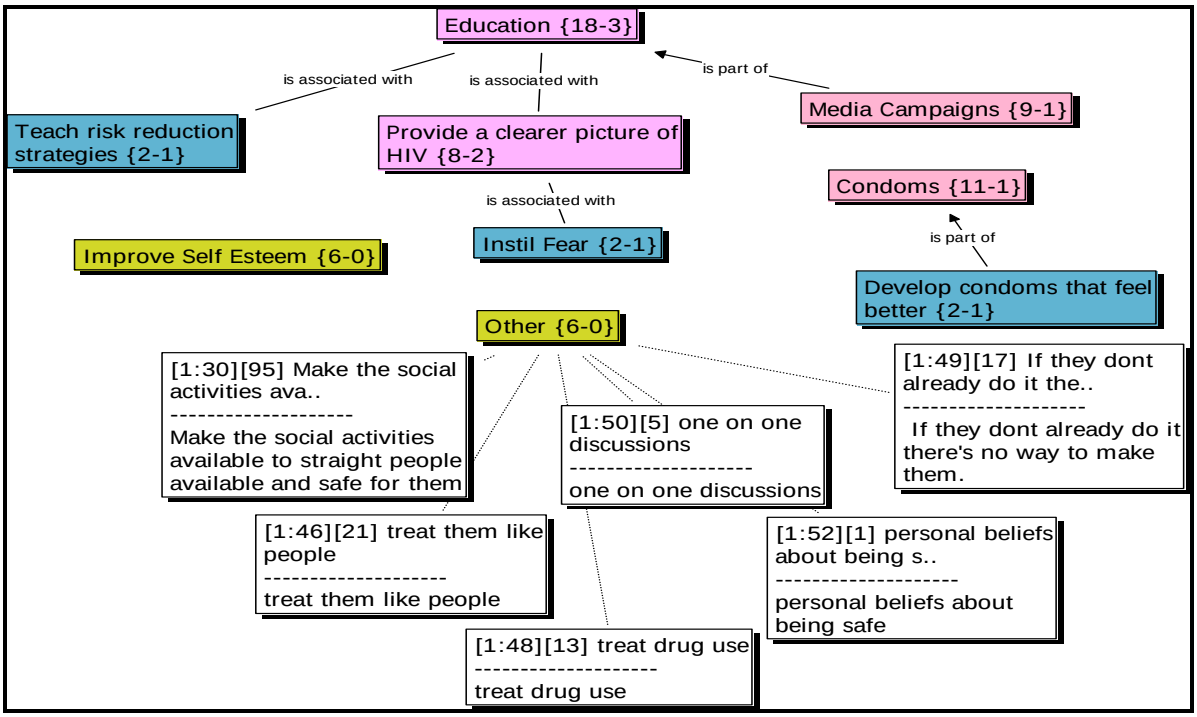
9. Which one of the above is the most important reason that some gay and bisexual men have unprotected sex with anonymous partners? (Check only one)		Number of Responses	Response Ratio
It's a quicker, easier way to find sex partners		6	11%
Sex is more exciting and fun with anonymous partners		3	5%
Sex is more erotic with anonymous partners		4	7%
Sex is more erotic without condoms		14	25%
There are no strings attached		3	5%
There are more partners to choose from		2	4%
It's safer than meeting men in other ways		0	0%
There is a good possibility of meeting someone to establish an on-going relationship with		0	0%
They fear commitment		0	0%
They fear they will be rejected by men that they know or get to know		0	0%
It's the only way available for some men to find partners		2	4%
It's a good way to keep your sexual orientation private		4	7%
They don't have to worry about HIV transmission because the risks are understood by all		0	0%
They don't care if they get HIV		5	9%
They don't care if they give HIV to someone else		0	0%
They are trying to fulfill fantasies		3	5%
They want validation		0	0%
They have a sexual addiction		0	0%
They fear rejection if they say they want to use condoms		5	9%
VIEW Other, Please Specify		5	9%
	Total	56	100%

Other responses included irresponsibility, drug use, self-destructiveness, and a lack of perceived vulnerability.

9.	Which one of the above is the most important reason that some gay and bisexual men have unprotected sex with anonymous partners? (Check only one)
#	Response
1	treat drug use
2	Doing drugs- under the influence of something
3	irresponsible
4	sefl destructive behavior
5	thinking it won't happen to them

When asked "What would be the most effective and appropriate ways to encourage gay and bisexual men to engage in safer behaviors when having sex with anonymous partners", education was the top response (18 respondents). Within the category of education, the media was listed approximately nine times as an effective tool for education, however, 8 respondents felt that the media message should provide a clearer understanding of HIV than it has in the past. These respondents felt the message should include HIV statistics, side effects of antiretroviral medications, strands of HIV, and information on other incurable STDs. Some respondents reported that this knowledge has the potential to instill fear, which would encourage safer behaviors. Two respondents suggested education about harm reduction strategies such as serosorting and safer sexual positions based on serostatus. Encouraging and distributing condoms was the second most popular response (11 respondents). Within this category respondents mentioned eroticizing condom use, developing better feeling condoms, and reducing stigma around condom use. The last set of responses centered on the theme of improving the self-esteem of MSM, six respondents provided responses in this category.

10. What would be the most effective and appropriate ways to encourage gay and bisexual men to engage in safer behaviors when having sex with anonymous partners?



Respondents were asked what would be the most appropriate and effective types of interventions or approaches to help meet the HIV prevention needs of gay and bisexual men who seek anonymous partners. The most popular responses were social settings/events where men can meet other men (73%) and targeted public information campaigns (66%). Forty-seven percent also selected interventions that involve the larger community of gay and bisexual men, and 40% selected support or discussion groups with peers. Twenty-four percent selected one-on-one sessions with a professional counselor and 27% selected one-on-one sessions with a trained peer or mentor.

11.	What would be appropriate and effective types of interventions or approaches to help meet the HIV prevention needs of gay and bisexual men who seek anonymous partners? (Please check all that apply)	Number of Responses	Response Ratio
Support or discussion groups with peers		22	40%
One-on-one sessions with a professional counselor		13	24%
One-on-one sessions with a trained peer or mentor		15	27%
Targeted public information campaigns		36	65%
Interventions that involve the larger community of gay and bisexual men		26	47%
Social settings/events where men can meet other men (other than bars, bathhouses, over the Internet, etc.)		40	73%
VIEW Other, Please Specify		11	20%

Other interventions suggested included Internet interventions, social settings including bars/clubs and non-sex venues, low cost easily accessible rapid HIV tests, education, and a change in norms concerning safe sex.

11.	What would be appropriate and effective types of interventions or approaches to help meet the HIV prevention needs of gay and bisexual men who seek anonymous partners? (Please check all that apply)
#	Response
1	Readily available instant HIV tests at little/no $
2	social setting/events including bar/clubs
3	Make people feel stupid for not being safe.
4	better public awareness of HIV
5	knolage is power
6	banner ads on websites like this
7	find creative ways to utilize the internet
8	Good social settings would help very very much.
9	bad question. all u list r avail now
10	Use safer sex banners on cruise sites
11	Sponsor non sex social activities for gay men not

When asked which of the above interventions would be most effective in helping to meet the HIV prevention needs of men who seek anonymous partners, the most popular reply was social

settings where men can meet other men (39%), followed by targeted public information campaigns (20%).

12.	Which one of the above interventions or approaches would be the most effective in helping to meet the HIV prevention needs of men who seek anonymous partners? (Check only one)	Number of Responses	Response Ratio
Support or discussion groups with peers		5	9%
One-on-one sessions with a professional counselor		2	4%
One-on-one sessions with a trained peer or mentor		4	7%
Targeted public information campaigns		11	20%
Interventions that involve the larger community of gay and bisexual men		4	7%
Social settings/events where men can meet other men (other than bars, bathhouses, over the Internet, etc.)		21	39%
VIEW Other, Please Specify		7	13%
	Total	54	100%

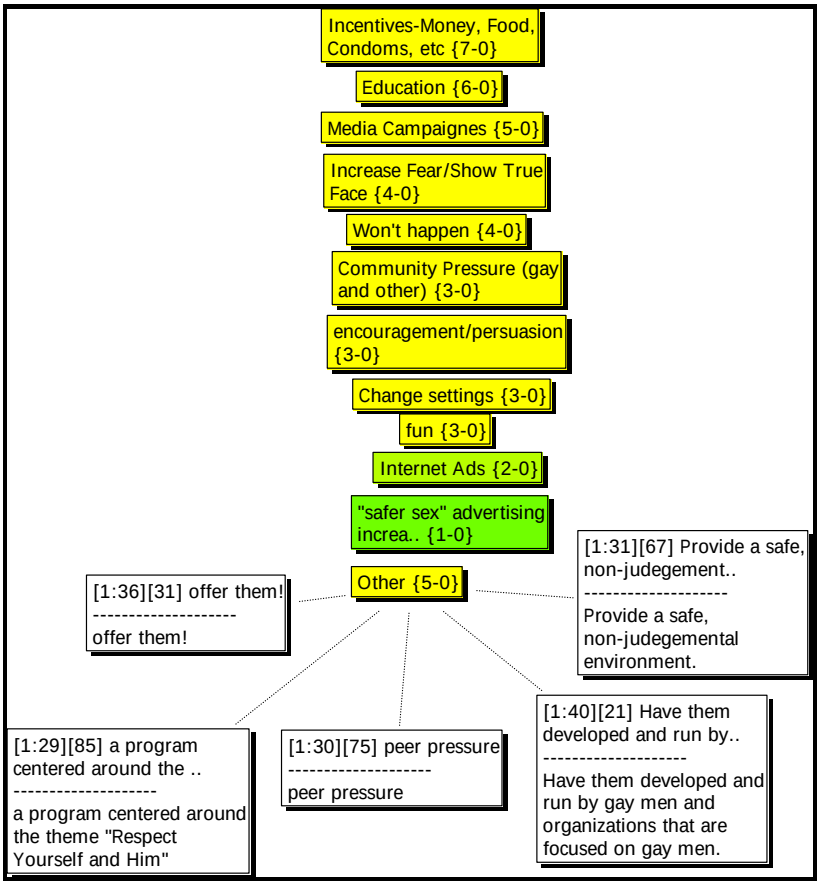
Other interventions that were considered highly effective included banners on the Internet, interventions in social settings including bars/clubs, low cost easily accessible rapid HIV testing, public awareness campaigns, and changing community norms about unprotected anonymous sex.

12.	Which one of the above interventions or approaches would be the most effective in helping to meet the HIV prevention needs of men who seek anonymous partners? (Check only one)
#	Response
1	Readily available instant HIV tests at little/no $
2	social setting/event including bars/clubs
3	public awarness of HIV
4	banner ads on websites like this
5	looked down upon it in the gay com. it will end
6	same as 11
7	Use safer sex banners on cruise sites

What would it take to get men who are at high risk for HIV to participate in programs that focus on safer behaviors with anonymous partners? Seven respondents indicated that it would take

various types of incentives such as money, food, and condoms while six referred to education. An example of an education related response is: "Better ways of educating them without making them feel like they're being subordinated". Five respondents thought media campaigns including internet advertisements would be effective, although one respondent indicated disagreement by writing, "most 'safer sex' advertising increases HIV-related stigma, so something that doesn't do that". Also related to the media and education was the concept that media and advertising should portray HIV as dangerous and harmful, for example, "Just stop showing all the sexy HIV+ guys on sailboats, and running along beaches, and start reminding people about the true face of AIDS." and "Increase awareness of the real facts and what is happening today with the long term HIV treatment and side effects."
Four respondents indicated that nothing could done, "You aren't going to get that to happen. The only way they would participate was if there were hot men or they were under court order." Three men felt it would take pressure as well as understanding from the homosexual and/or heterosexual community, "maybe pressure from within the community will help them realize that their actions not only put them at risk but also reflects on the community as a whole....how can we expect compassion, understanding and acceptance when we act in irresponsible, dangerous ways???" Other respondents indicated that it would take fun sessions in fun settings and eroticizing condom use. Other respondents felt it would take peer pressure, gay organizations, gay facilitators, safe non-judgmental settings, a gay focus, and a focus on respect. While one suggested that by simply offering the programs and men would participate.

13. What would it take to get men who are at high risk for HIV to participate in programs that focus on safer behaviors with anonymous partners?



When asked how common it is for gay and bisexual men to discuss their HIV status with their sexual partners, the majority of respondents said it happens sometimes (43%) or it is pretty common (31%).

14. How common is it for gay and bisexual men to discuss HIV status with their sexual partners?	Number of Responses	Response Ratio
It never happens	1	2%
It rarely happens	8	15%
It happens sometimes	23	43%
It's pretty common	17	31%
It's very common	5	9%
Total	54	100%

When asked “What affects whether or not those discussions occur?” results indicated that a number of factors affect whether the discussions occur. Sixty-one to sixty-five percent of

respondents marked assumptions about HIV status (66%), feelings for partners (64%), drug use, and the settings where the partners are met (64%). Fifty-one to fifty-five percent selected fear of rejection among HIV positive persons (55%), potential for relationship to move forward (59%), behavioral expectations in the settings where men meet (53%). Nearly one-third indicated that concerns about confidentiality (38%) and peer expectations (30%) affect whether these discussions occur.

15. What affects whether or not those discussions occur? (Please check all that apply)	Number of Responses	Response Ratio
The settings where men meet each other	32	60%
The expectations for behavior in the places where men meet each other	28	53%
The expectations of peers	16	30%
Whether or not people are drunk or high	34	64%
How partners feel about each other	34	64%
Assumptions about partners' HIV status	35	66%
Fear of rejection for those who are living with HIV	29	55%
Perceived potential for the relationship to move forward	26	49%
Concerns about confidentiality	20	38%
VIEW Other, Please Specify	3	6%

Other things that affect whether these discussions occur included common sense, conscience, and acceptance of personal responsibility.

15. What affects whether or not those discussions occur? (Please check all that apply)

#	Response
1	Acceptance of personal responsibility
2	consceince, common sense
3	I've never encountered a guy who lied about HIV

When asked which of the above most often affects whether the discussions occur the most popular answer to this question was fear of rejection for those who are living with HIV (23%).

Other popular responses were whether or not people are drunk or high (15%) and the settings where men meet each other (15%).

16. Which one of the above most often affects whether or not those discussions occur? (Check only one)		Number of Responses	Response Ratio
The settings where men meet each other		8	15%
The expectations for behavior in the places where men meet each other		7	13%
The expectations of peers		2	4%
Whether or not people are drunk or high		8	15%
How partners feel about each other		4	8%
Assumptions about partners' HIV status		4	8%
Fear of rejection for those who are living with HIV		12	23%
Perceived potential for the relationship to move forward		2	4%
Concerns about confidentiality		4	8%
VIEW Other, Please Specify		2	4%
	Total	53	100%

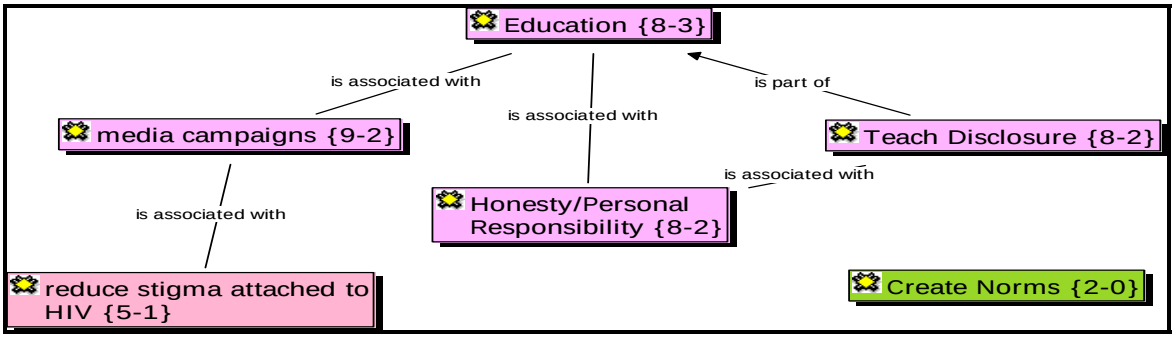
Other factors that quite frequently affect the occurrence of discussions about HIV status were common sense, conscience, and acceptance of personal responsibility.

16. Which one of the above most often affects whether or not those discussions occur? (Check only one)	
#	Response
1	Acceptance of personal responsibility
2	consceince, common sense

When asked reasons why gay and bisexual men who are living with HIV might not disclose their status 96% checked fear of rejection, and 68% checked fear that their confidentiality would be breached. Fifty-three percent felt it was the other person's responsibility to protect himself from infection. Forty percent felt that it is no one else's business, and 25% reported fear of violence as a reason for not disclosing.

Respondents provided suggestions on effective and appropriate ways to encourage men to have conversations about HIV status with their partners. These suggestions centered around the concept of education including providing information on the dangers of HIV, information on how to disclose status, information on how to deal with rejection resulting from disclosure, and instruction that instills a sense of honesty, respect, and personal responsibility. One respondent added that the education should be provided in a non-degrading way. Several (9) respondents felt that media campaigns should be used to encourage these conversations. Four responses implied that since current efforts to get men to disclose their status are not effective nothing would be effective. Two respondents indicated that a change in community norms is needed.

17. What would be the most effective and appropriate ways to encourage men to have conversations about HIV status with partners?



When asked reasons why gay and bisexual men who are living with HIV might not disclose their status, 95% checked fear of rejection, and 69% checked fear that their confidentiality would be breached. Fifty-five percent felt it was the other person's responsibility to protect himself from infection. Thirty-eight percent felt it was no one else's business, and 24% reported fear of violence as a reason for not disclosing.

18. What are some of the reasons why gay and bisexual men who are living with HIV might not disclose their status to sex partners?		Number of Responses	Response Ratio
Fear of rejection		52	95%
Fear of violence		13	24%
Fear that their confidentiality will be breached		38	69%
It's no one else's business		21	38%
It's the other person's responsibility to protect himself if he's concerned about getting infected		30	55%
VIEW Other, Please Specify		5	9%

Other reasons provided for HIV positive men not disclosing their status were a desire to punish HIV negative men, denial, anger, lack of concern for others, and a continuing need to process their own HIV status.

18.	What are some of the reasons why gay and bisexual men who are living with HIV might not disclose their status to sex partners?
#	Response
1	The desire to "punish" those who are HIV-
2	denial
3	They flat don't give a shit about anyone else
4	anger
5	they haven't processed it own their own yet

Sixty-nine percent of men cited fear of rejection as the most important reason why gay and bi-sexual men might not disclose their status.

19.	Which one of the above is the most important reason why gay and bisexual men living with HIV might not disclose their status to sex partners? (Check only one)	Number of Responses	Response Ratio
Fear of rejection		38	69%
Fear of violence		0	0%
Fear that their confidentiality will be breached		8	15%
It's no one else's business		3	5%
It's the other person's responsibility to protect himself if he's concerned about getting infected		5	9%
VIEW Other, Please Specify		1	2%
	Total	55	100%

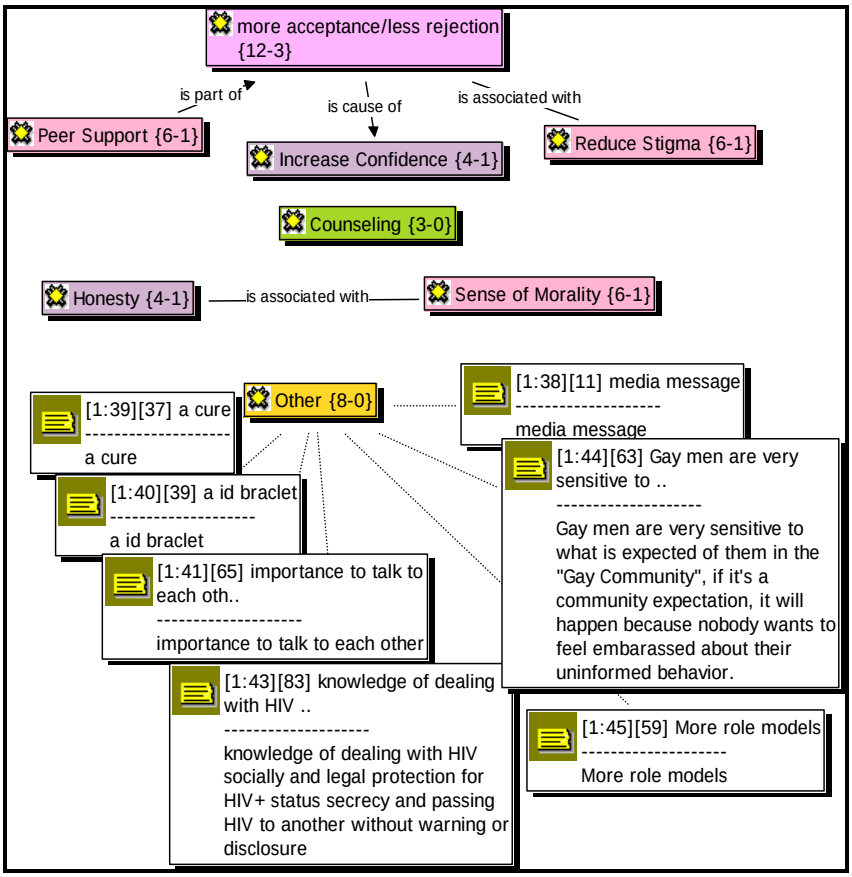
Other reasons regarded as highly important were anger and self-destructiveness.

19.	Which one of the above is the most important reason why gay and bisexual men living with HIV might not disclose their status to sex partners? (Check only one)
#	Response
1	anger, self destructive behavior

When asked what gay and bisexual men who are living with HIV need to help them disclose their status to their sex partners, a large theme that arose was the need for greater acceptance and less rejection from negative men. Two quotes that exemplify this theme are: "need the neg people to stop rejecting them solely based on their status… need to be comfortable suggesting safe ways to still hook up..." and "Not sure. Maybe to let them know that not ALL gay men who are neg would rule them out. I think that would be huge."

Two associated themes that arose were the need for peer support and the need for a reduction in the stigma associated with HIV. Three respondents suggested counseling as a more specific strategy. The need for honesty and morality in regards to HIV disclosure were also popular responses. Other responses suggested by only one respondent included a cure, an id bracelet, communication, community norms, role models, and knowledge of the social and legal ramifications of disclosure or lack of disclosure.

20. What do gay and bisexual men who are living with HIV need to help them disclose their status to their sex partners?



When asked what interventions would help gay and bisexual men who are living with HIV to disclose their status to their sex partners, 77% marked targeted public information campaigns, 62% marked support groups that include both HIV positive and negative men, and 62% checked interventions that involve the larger community of gay and bisexual men. Forty-eight percent selected support groups for men who are living with HIV, 38% marked one-on-one sessions with a professional counselor, and 31% marked one-on-one sessions with a trained peer or mentor.

21. What would be appropriate types of interventions or approaches to help meet the needs described in Question #20? (Please check all that apply)		Number of Responses	Response Ratio
Support or discussion groups only for men who are living with HIV		25	48%
Support or discussion groups that include both men who are living with HIV and those who are not		32	62%
One-on-one sessions with a professional counselor		19	37%
One-on-one sessions with a trained peer or mentor		16	31%
Targeted public information campaigns		40	77%
Interventions that involve the larger community of gay and bisexual men		32	62%
VIEW Other, Please Specify		5	10%

Other interventions suggested included laws protecting HIV negative persons, informational messages, and support from 'The Center'. Individual level responses such as acceptance of personal responsibility and expectations of honesty were also provided.

21.	What would be appropriate types of interventions or approaches to help meet the needs described in Question #20? (Please check all that apply)
#	Response
1	Acceptance of personal responsibility for actions
2	everyone who has sex expecting honest and responsi
3	I would have liked info on support from the Center
4	getting this information out
5	laws protecting HIV - persons

When asked which of the above interventions would be most effective in helping gay and bisexual men who are living with HIV disclose their status to sex partners, the top responses were targeted public information campaigns (27%) and support or discussion groups that include both men who are living with HIV and those who are not (24%).

22.	Which one of the above would be the most effective in helping gay and bisexual men who are living with HIV disclose their status to sex partners?	Number of Responses	Response Ratio
Support or discussion groups only for men who are living with HIV		6	12%
Support or discussion groups that include both men who are living with HIV and those who are not		12	24%
One-on-one sessions with a professional counselor		6	12%
One-on-one sessions with a trained peer or mentor		3	6%
Targeted public information campaigns		14	27%
Interventions that involve the larger community of gay and bisexual men		8	16%
VIEW Other, Please Specify		2	4%
	Total	51	100%

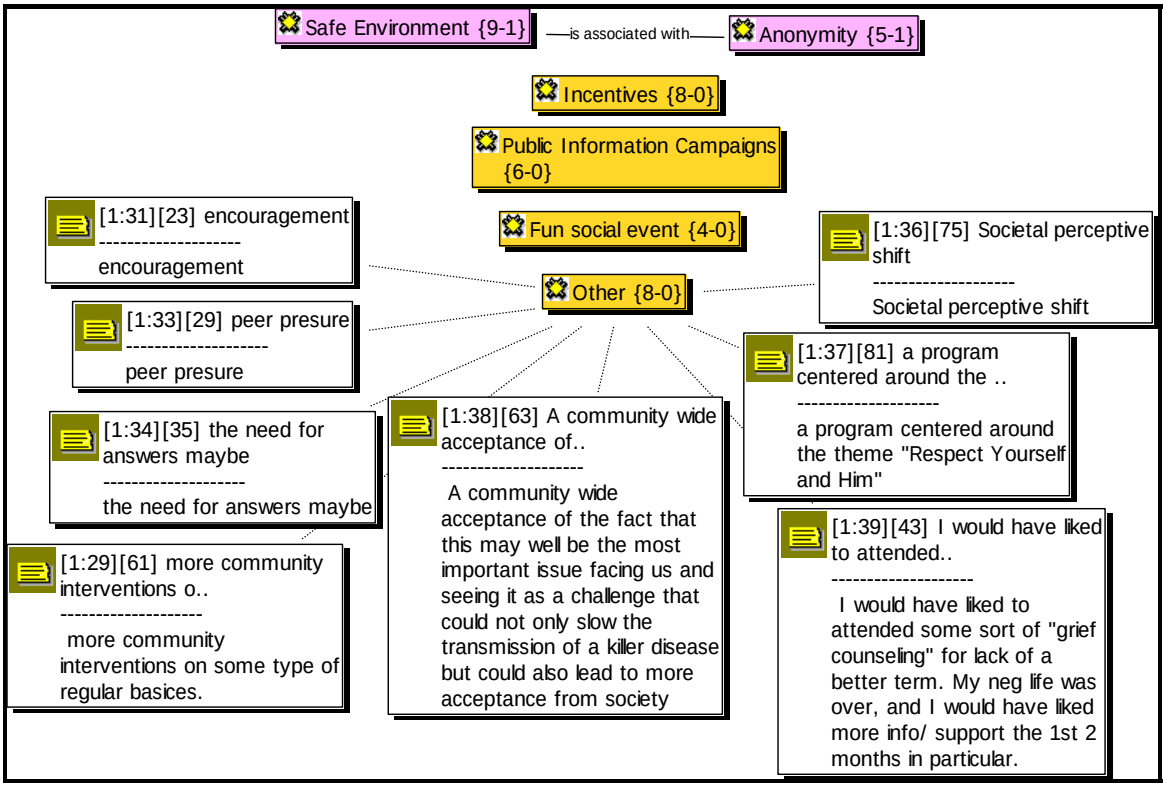
Other responses included having CDH interviews handled by ‘The Center’ and laws protecting HIV positive men.

22.	Which one of the above would be the most effective in helping gay and bisexual men who are living with HIV disclose their status to sex partners?
#	Response
1	Having my CDH interview handled by The Center
2	laws protedting HIV- men

Responses to the question “What would it take to get men to participate in programs that focus on disclosure of HIV status” focused more on what these programs should not be as opposed to what they should.

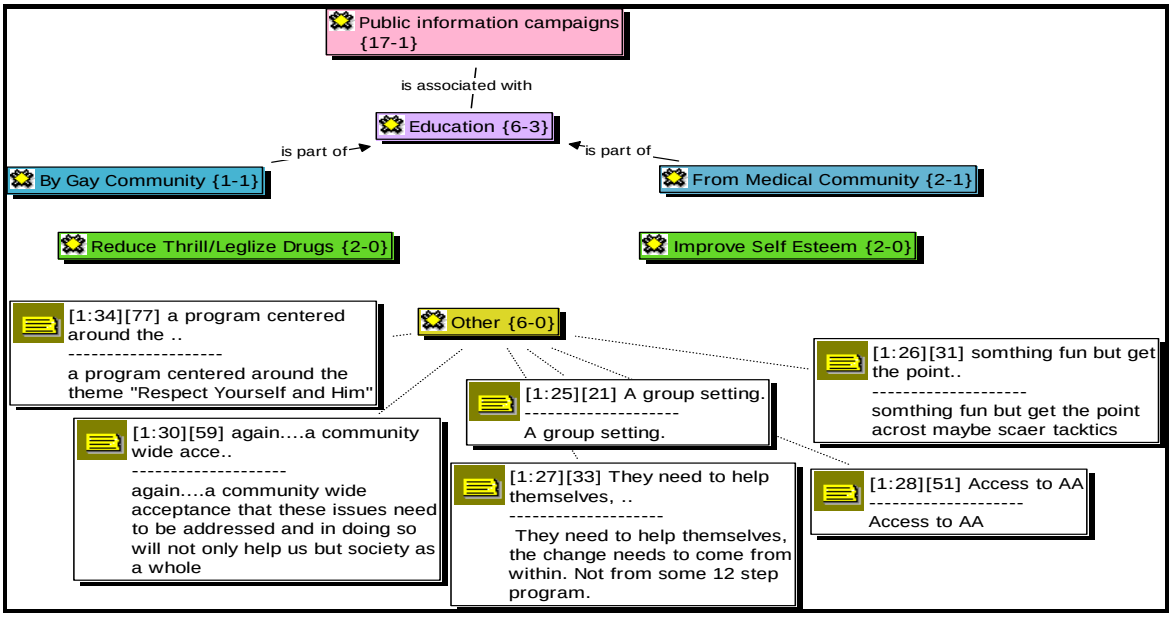
“Less stigma attached to going to a support group for HIV infected men”
“HIV not being looked down upon”,
“a nonjudgmental stance with regard to one's sexuality and/or sexual history” ,
”The elimination of the inherent embarrassment that would result from being implicated with such programs.” and
“I think the fear of disclosure is too high to draw people in directly to a program specifically targeted on disclosure.”
Other respondents indicated a desire not to be personally associated with such programs by requesting “full anonymity. ”
Second to the cry for a safe private environment were requests for a variety of incentives including money, food, beer, condoms, antiretroviral drugs, and services for people living with HIV. The third level of responses indicated that it would require educational public awareness campaigns to get men to participate in such programs. Four respondents felt it would require a fun social setting to get men to participate. For example “Social events where men know they will have opportunities to meet other men of similar interest” and “a social event that provided a fun and safe environment”. Other responses included encouragement, a shift in societal perceptions, peer pressure, community interventions, grief counseling for new positives, programs based on respect for partners, and acceptance of the importance of the issue.

23. What would it take to get men to participate in programs that focus on disclosure of HIV status?



Respondent suggestions for appropriate and effective ways to address substance abuse and HIV risk among gay and bisexual men included media and advertising campaigns in bars, on the Internet, and in the gay media. Respondents suggested that the messages delivered through this media should improve self esteem, educate, and show the extent of the crisis. Education was another category of responses. This group of responses incorporated requests for education about the relationship between drug use and HIV risk and requests that the information come from both the gay community and the medical/public health community. Other suggestions included improving self-esteem, reducing the thrill and the taboo possibly by legalizing drugs. Other ideas included promoting community wide acceptance that the issue needs to be addressed, group sessions including Alcoholics Anonymous, scare tactics, personal change from within, and programs focused on respect for self and partners.

24. What would be some of the more appropriate and effective ways to address substance abuse (including alcohol abuse) and HIV risk among gay and bisexual men?



When asked, ”What would be appropriate and effective types of interventions or approaches to help meet the needs of men who abuse drugs and/or alcohol and engage in high-risk sex?” The most popular responses were targeted public information campaigns (73%), multiple services at one agency (65%), one-on-one sessions with a counselor trained to deal with both HIV risk and substance abuse issues (65%), and interventions that involve the larger community of gay and bisexual men (67%).

25. What would be appropriate and effective types of interventions or approaches to help meet the needs of men who abuse drugs and/or alcohol and engage in high-risk sex? (Please check all that apply)	Number of Responses	Response Ratio
Support or discussion groups with peers	27	53%
One-on-one sessions with a professional counselor who can deal with both HIV risk and substance abuse issues	33	65%
One-on-one sessions with two different counselors at different agencies, one to help with HIV risk and one to help with substance abuse	15	29%
Multiple services at one agency	33	65%
One-on-one sessions with a trained peer or mentor	17	33%
Targeted public information campaigns	37	73%
Interventions that involve the larger community of gay and bisexual men	34	67%
VIEW Other, Please Specify	2	4%

Other suggested interventions or approaches included 12-step programs and legalization of drugs.

25.	What would be appropriate and effective types of interventions or approaches to help meet the needs of men who abuse drugs and/or alcohol and engage in high-risk sex? (Please check all that apply)
#	Response
1	See #24
2	encouragement ofAA, NA, CA, ...all the anonymous's

The types of interventions considered most effective in helping meet the needs of men who abuse drugs and/or alcohol and engage in high-risk sex were multiple services at one agency (25%) and targeted public information campaigns (22%). Eighteen percent checked one-on-one sessions with a professional counselor who can deal with both HIV risk and substance abuse issues, and eighteen percent checked interventions that involve the larger community of gay and bisexual men.

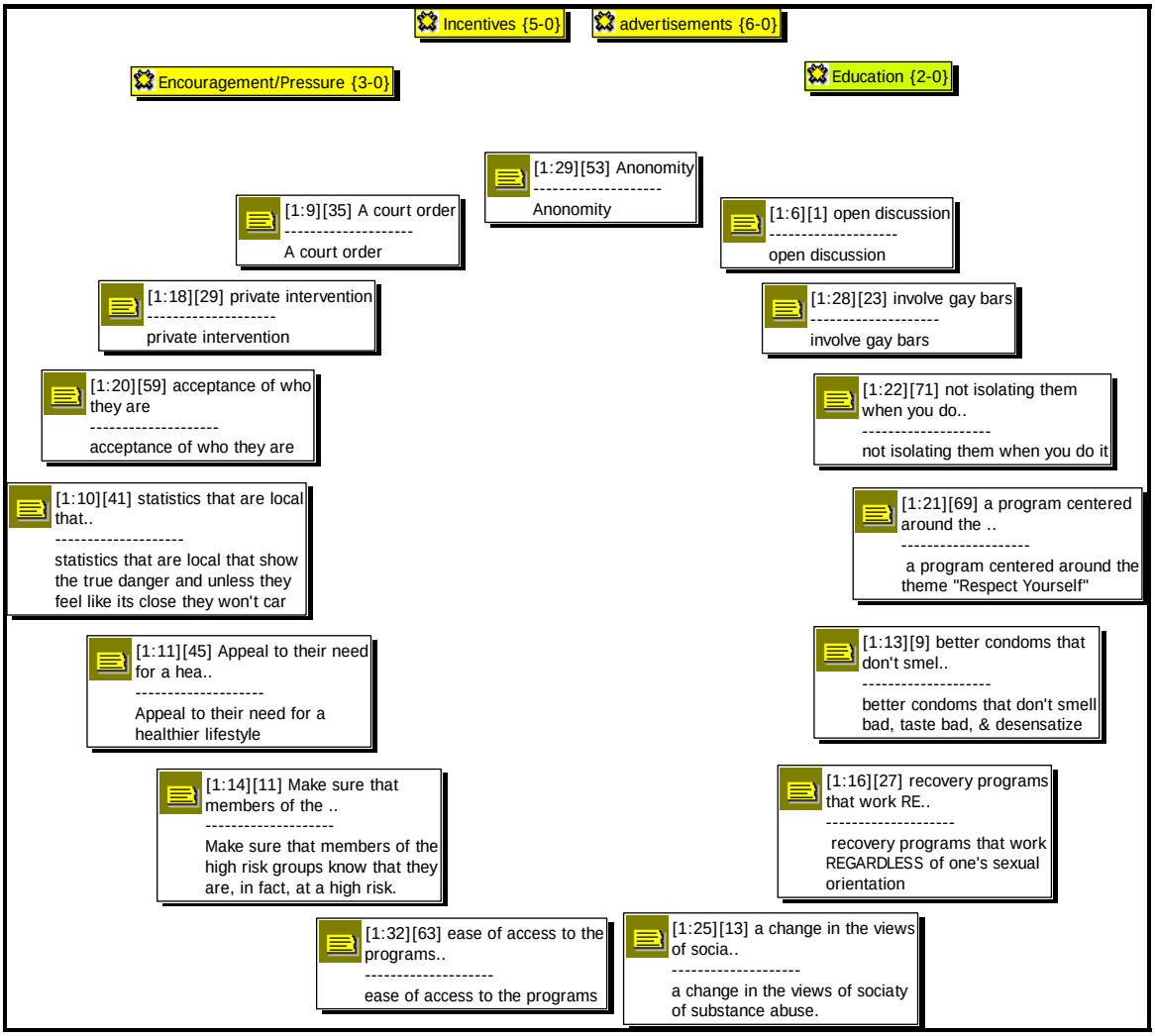
26.	Which one of the above types of interventions or approaches would be the most effective in helping to meet the HIV prevention needs of men who abuse drugs and/or alcohol? (Check only one)	Number of Responses	Response Ratio
Support or discussion groups with peers		1	2%
One-on-one sessions with a professional counselor who can deal with both HIV risk and substance abuse issues		9	18%
One-on-one sessions with two different counselors at different agencies, one to help with HIV risk and one to help with substance abuse		2	4%
Multiple services at one agency		13	25%
One-on-one sessions with a trained peer or mentor		3	6%
Targeted public information campaigns		11	22%
Interventions that involve the larger community of gay and bisexual men		9	18%
VIEW Other, Please Specify		3	6%
	Total	51	100%

Other responses included legalization of drugs.

26.	Which one of the above types of interventions or approaches would be the most effective in helping to meet the HIV prevention needs of men who abuse drugs and/or alcohol? (Check only one)
#	Response
1	See #24
2	I'm offended you lump drug abusers with POZ men!
3	there is no one right answer.

According to survey respondents it would take: incentives such as money, food, beer, condoms or “hot guys”; advertisements to inform them of the programs; and education to get men who are risk to participate in programs that address substance abuse and HIV risk. A variety of other approaches were also provided including anonymity, court orders, open discussions, involvement of gay bars, private interventions, self acceptance, HIV statistics, ease of access to the programs, change in societal views, better condoms, a focus on self respect, traditional recovery programs that do not focus on sexual orientation, realistic risk appraisals, and integration with others.

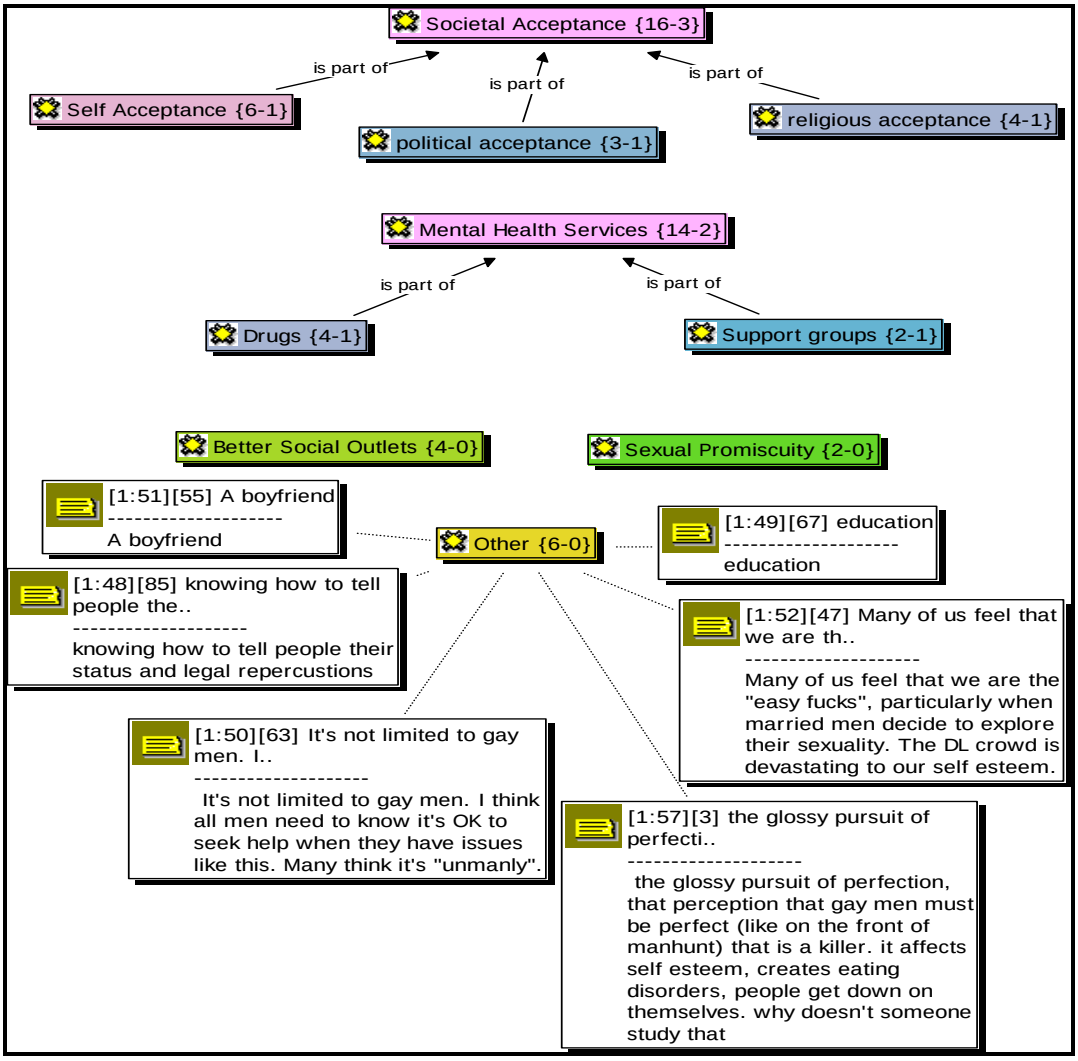
27. What would it take to get men who are most at risk to participate in programs that address substance abuse and HIV risk?



Societal acceptance was the most common answer to the question of what gay and bisexual men need to deal with issues such as feeling down, low, or depressed; low self-esteem; shame; loneliness; and feelings of isolation. This societal acceptance encompassed self acceptance and acceptance by politicians, religions, the media, family, and other MSM. Fourteen men indicated that mental health services were needed, specifically low cost affordable medications, counseling/therapy, peer counseling, support groups, and open and affirming counselors who understand the issues of MSM. Four respondents specified better social venues outside of bars and bathhouses. Two respondents suggested resorting to sexual promiscuity, drug, and alcohol use to deal with these issues. Other needs specified were long-term partners, legal repercussions, knowledge that it's ok and not unmanly to seek mental health services, education, freedom from

stereotypes of physical beauty associated with gay males, and attendance to feelings resulting from interactions with married or “DL” MSM.

28. A number of studies have shown that issues such as feeling down, low, or depressed; low self-esteem; shame; loneliness; and feelings of isolation commonly affect gay and bisexual men to varying degrees. What do gay and bisexual men need to help them deal with these issues?



When asked what interventions or approaches would be appropriate and effective to help gay and bi-sexual men deal with issues such as feeling down, low, or depressed; having low self-esteem, shame, or loneliness; and feelings of isolation approximately half of the respondents checked interventions that address stigma and homophobia within the community at large (gay and straight)(55%), targeted public information campaigns (53%), and multiple services at one

agency (49%). Slightly less than half of respondents selected interventions that involve the larger community of gay and bisexual men (45%) and support or discussion groups with peers (41%). Thirty-three percent checked one-on-one sessions with a professional counselor who can deal with both HIV risk and emotional issues, and 31% checked one-on-one sessions with a trained peer or mentor.

29. What would be appropriate and effective types of interventions or approaches to help meet the needs described in Question #28? (Please check all that apply)	Number of Responses	Response Ratio
Support or discussion groups with peers	20	41%
One-on-one sessions with a professional counselor who can deal with both HIV risk and emotional issues	16	33%
One-on-one sessions with two different counselors at different agencies, one to help with HIV risk and one to help with emotional issues	9	18%
Multiple services at one agency	24	49%
One-on-one sessions with a trained peer or mentor	16	33%
Targeted public information campaigns	26	53%
Interventions that involve the larger community of gay and bisexual men	22	45%
Interventions that address stigma and homophobia with the community at large (gay and straight)	27	55%
VIEW Other, Please Specify	6	12%

Other interventions considered effective in dealing with issues such as feeling down, low, or depressed; low self-esteem; shame; loneliness; and feelings of isolation were legalization of gay marriage, positive media attention, public campaigns directed at gay acceptance, legal repercussions, and fewer conservative politicians.

29.	What would be appropriate and effective types of interventions or approaches to help meet the needs described in Question #28? (Please check all that apply)
#	Response
1	None of these will be effective until #28 occurs
2	Legalize gay marriage
3	positive media attention.
4	public campaigns directed at gay acceptance
5	Voting the Wing-nuts out of office
6	Legal repercussions

When asked which of the above would be the most appropriate and effective type of intervention to address these issues, interventions that address stigma and homophobia with the community at large (gay and straight) (31%), targeted public information campaigns (18%), and multiple services at one agency (12%) were the most popular responses.

30.	Which one of the above would be the most appropriate and effective type of intervention or approach to help address these issues?	Number of Responses	Response Ratio
Support or discussion groups with peers		3	6%
One-on-one sessions with a professional counselor who can deal with both HIV risk and emotional issues		5	10%
One-on-one sessions with two different counselors at different agencies, one to help with HIV risk and one to help with emotional issues		2	4%
Multiple services at one agency		6	12%
One-on-one sessions with a trained peer or mentor		1	2%
Targeted public information campaigns		9	18%
Interventions that involve the larger community of gay and bisexual men		3	6%
Interventions that address stigma and homophobia with the community at large (gay and straight)		16	31%
VIEW Other, Please Specify		6	12%
	Total	51	100%

Other interventions suggested were changes in laws and media and public campaigns that promote acceptance of homosexuality.

30.	Which one of the above would be the most appropriate and effective type of intervention or approach to help address these issues?
#	Response
1	Legalize gay marriage
2	positive media attention.
3	public campaigns directed at gay acceptance
4	there is no one right answer. all work
5	Voting the wing nuts out of office
6	legal repercussions

When asked What would it take to get men who are most at risk to participate in programs that address HIV risk and issues such as feeling down, low, or depressed; low self-esteem; shame; loneliness; and feelings of isolation, many respondents indicated that we should simply make these programs available and make sure that people know about them. Public information campaigns such as literature and Internet ads were suggested as ways to get the information out. Many respondents also felt these sessions should be fun and take place in setting where the behaviors are taking place such as bathhouses, group sex sessions, Gay Pride activities, White Parties, clubs, and drag shows. A few suggested incentives such as beer, money, and food. Two suggested safe, non-judgmental, affirming environments.

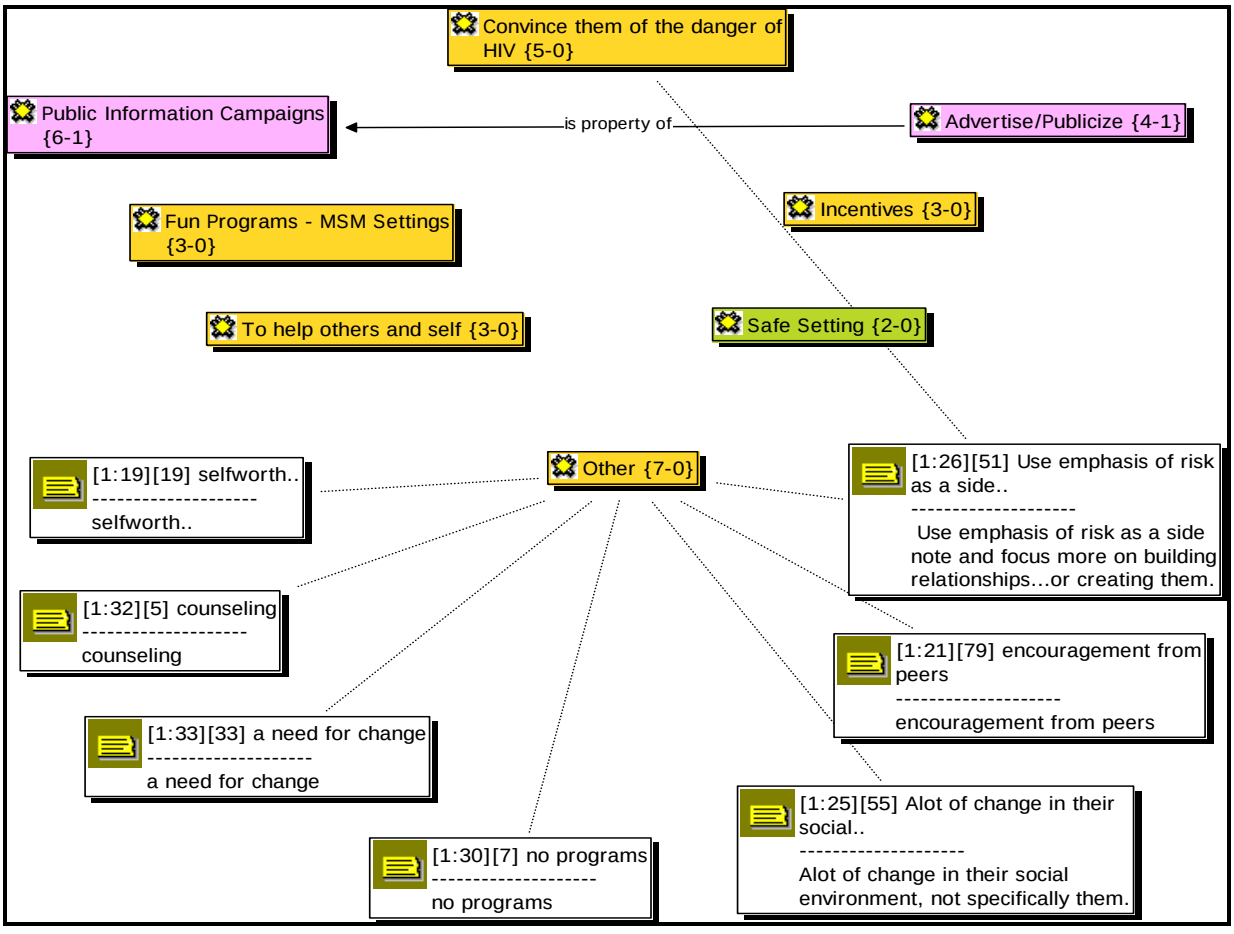
Other responses focused on giving respondents reasons to participate such as convincing them of the need help themselves and others convincing them of the danger of HIV. For example, "A true danger or evidence of a true danger. I live in Colorado Springs and most gay men here believe they are not going to contract that here because its rather small and the most people who are infected are in their 40's. Until a serious risk factor or some real statistics that show a good idea of what the local situation is really like come out, it will be hard to change the minds and opinions of local gay men. Local manwhore sites like Manhunt and Gay.com don't help either. They do more to promote HIV than they do to help it. Its no wonder we have an HIV and STD

problem. Sex is promoted on every level in gay culture. You don't see straight websites advertising porn?!! Its frowned upon so why should the gay community do it?"

"Those who are concerned about HIV and safe sex, usually play safe. Many young people now just see it as "a condition", but not lethal."

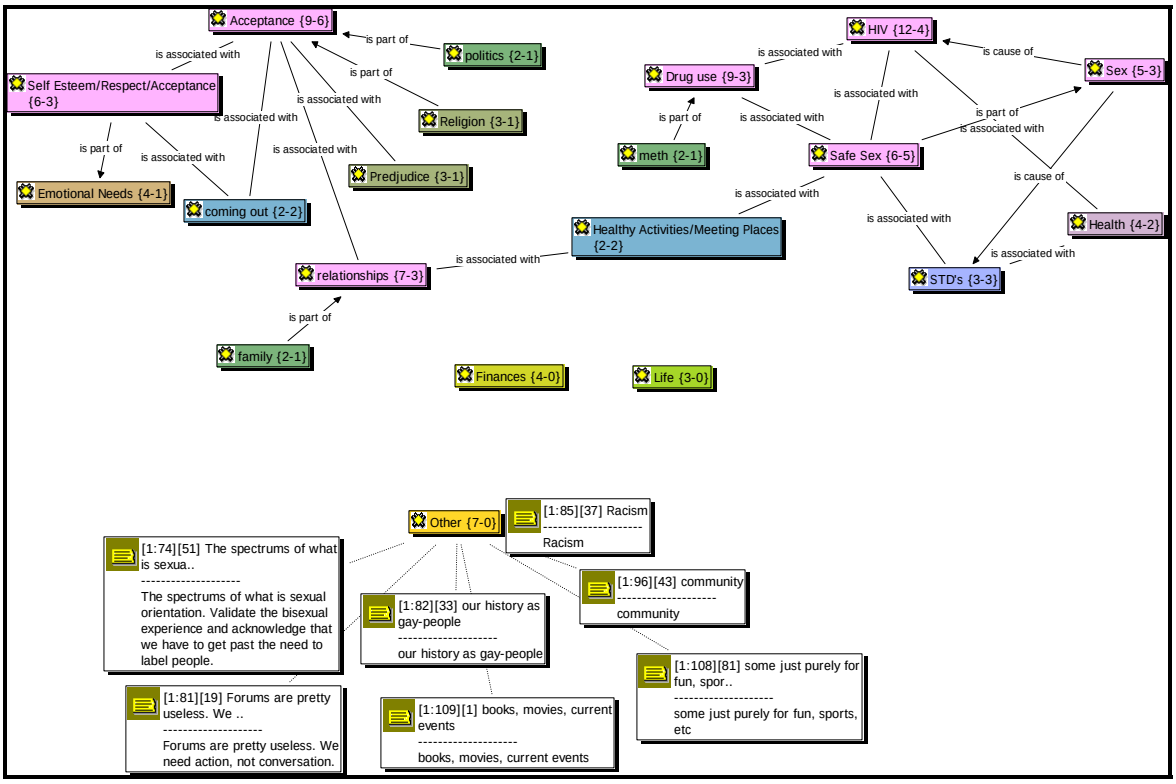
Other responses included increasing sense of self worth, encouragement from peers, focus on building relationships, change in their social environment, counseling, and a personal need for change. One respondent felt programs were not needed. In previous responses, this respondent indicated that the discussion should be a part of the fun of going out.

31. What would it take to get men who are most at risk to participate in programs that address these issues and HIV risk?



When asked what topics would be most relevant for gay and bisexual men to discuss if community forums were to be organized, the topics centered around community acceptance and HIV with associated risk behaviors. The following quote exemplifies some of the comments about acceptance. "How badly it feels to hear every day in the media about what a horrible person you are because you're gay. I don't think the straight community realizes how those words and actions affect gay people." Topics related to acceptance included self-acceptance/respect/esteem and related emotional needs, politics, religion, prejudice, coming out, and relationships and family. Topics related to HIV included drug use-methamphetamines in particular, sex, safe sex, STDs, and health. The suggested topics and the relationships between them suggest a hypothetical model linking societal acceptance to HIV risk and ultimately HIV. This model is depicted in the diagrams below. Further studies are needed which quantitatively explore this possible relationship.

32. If there were to be community forums organized for gay and bisexual men to discuss issues most relevant to their community, what topics do you think should be discussed at those forums?



APPENDIX TWO: NEEDS ASSESSMENT DATA SUMMARY

The following information provides a summary of factors that can be used to inform efforts by CDPHE and CWT to assess the HIV prevention needs of people around the state of Colorado and to prioritize target populations, activities, and interventions. The information is drawn from three distinct data sources, each with its strengths and limitations. The first data source is the HIV/AIDS Reporting System (HARS). This system contains information gathered by the CDPHE Surveillance program on all cases of HIV and AIDS diagnosed across the state of Colorado and reported to the state health department. HARS data includes demographic information, including gender, age, and race/ethnicity on all reported cases. It also includes any risk information that is obtained from providers by Surveillance staff and from clients by Client Based Prevention staff. Though these data are highly complete in their accounting of HIV/AIDS case reports, very little behavioral data is collected as part of this reporting system.

The second data source utilized in this summary was obtained through the Supplement to HIV/AIDS Surveillance Project (SHAS). This project was conducted with 2285 HIV-positive patients who received services at the Infectious Disease Clinic at the Denver Health Medical Center (DHMC) from 1991 to 2004. Only the data reported by 520 people who accessed services between May 2000 and May 2004 are included in this summary. The 65 page survey instrument utilized for this project covered a number of topics related to people's risk behaviors and the context of risk, including substance use, sexual behaviors, STD history, HIV testing history, and access to medical and social services. A wealth of behavioral information is available from this project, but the sample is limited DHMC clients.

The third data source from which information was drawn for this summary is the 2003-2004 Needs Assessment Survey conducted for CWT by the Research and Evaluation Unit at CDPHE. As part of this effort, 421 surveys were collected from MSM, IDU, and high-risk heterosexuals from around the state of Colorado. Approximately 18% of the sample was made up of people living with HIV. A large amount of information was drawn from this study concerning people's risk for getting or spreading HIV, the context of risk, and people's service needs. Given that a convenience sample was used for this needs assessment, it is not representative of all people from the risk groups mentioned above.

HARS

(The following figures concern HIV cases reported to CDPHE between January 2001 and October 2005. These figures only include African Americans, Latinos, and Whites; n = 1819)

MSM (n = 1178)

- 64.8% of all people diagnosed with HIV from 2001-2005 (October) were MSM; of those 68.4% were White, 22.7% were Latino, and 8.9% were African American.
- 14.0% of all MSM diagnosed with HIV from 2001-2005 (October) were under 25 years old; 29.9% were under 30.
- 55.3% of all MSM diagnosed with HIV from 2001-2005 (October) were between 25 and 39 years old; 39.4% were 30-39.
- 30.7% of all MSM diagnosed with HIV from 2001-2005 (October) were 40 and older; 18.0% of Latino MSM diagnosed during that time, 25.7% of African American MSM, and 35.6% of White MSM were 40 and older.
- 8.4% of the MSM diagnosed with HIV from 2001-2005 (October) were also injection drug users.
- 40.4% of MSM/IDU diagnosed with HIV from 2001-2005 (October) were under 30 years old, 37.4% were 30-39, and 22.2% were 40 and older.

IDU (n = 134)

- 7.4% of all people diagnosed with HIV from 2001-2005 (October) were non-MSM injection drug users.
- 55.2% of all IDU diagnosed with HIV from 2001-2005 (October) were White, 27.6% were Latinos, and 17.2 were African Americans; 35.8% were women.

<u>Other Identified Risks (n = 227)</u>

- 12.5% of all people diagnosed with HIV from 2001-2005 (October) had identified risks other than MSM and IDU, including sex with an IDU, sex with a bisexual male, sex with a person known to be living with HIV, and transfusion/transplant recipient; 82.8% of these people had sex with a person known to be living with HIV as their identified risk.
- 49.3% of the people in this category were African American, 29.5% Latino, and 21.2% were White; 56.4% were women.

NIR (n = 280)

- 15.4% of all people diagnosed with HIV from 2001-2005 (October) had no identified risk; 49.3% were White, 30.4% were Latino, and 20.4% were African American.
- 69.9% of those with no identified risk were men and 30.1% were women.

- Of all male NIRs, 50.0% were White, 34.0% were Latino, and 16.0% were African American.
- Of all female NIRs, 47.7% were White, 30.2% were African American, and 22.1% were Latina.

Women (n = 262)

- 14.4 % of all people diagnosed with HIV from 2001-2005 (October) were women.
- Of all women diagnosed with HIV from 2001-2005 (October), 35.9% were African American, 35.1% were White, and 29.0% were Latina.
- 18.3% of all women diagnosed with HIV from 2001-2005 (October) were injection drug users, 48.9% had other identified risks (including heterosexual sex with IDU, MSM, and men known to be living with HIV), and 32.8% had no identified risk.

Heterosexual Men (n = 379)

- 20.8% of all people diagnosed with HIV from 2001-2005 (October) were men who identified as heterosexual.
- Of all heterosexual men diagnosed with HIV from 2001-2005 (October), 44.3% were White, 29.8% were Latino, and 25.9% were African American
- 22.7% of all heterosexual men diagnosed with HIV from 2001-2005 (October) were injection drug users, 26.1% had other identified risks, and 51.2% had no identified risk.

SHAS

(All of these data were gathered between May of 2000 and May of 2004; n = 520)

- 25.9% of women respondents had 100 or more lifetime sex partners; 9.3% had 200 or more; 11.1% had only one lifetime partner, and 27.8% had 5 or fewer lifetime partners
- 44.2% of MSM respondents had 100 or more lifetime sex partners; 26.6% had 200 or more; 14.2% had 500 or more; 7.1% had 1000 or more
- 34.5% of MSM respondents had only one partner in the previous 12 months; 34.5% had 5 or more partners in the previous 12 months; 21.9% had 10 or more; 12.2% had 20 or more
- 56.8% of MSM respondents had been in a steady relationship in the previous 12 months; of those 20.9% had receptive anal sex without a condom
- 8.2% of the MSM respondents with a steady partner were drunk the last time they had sex with that partner and 16.5% were high on drugs
- 68.4% of MSM respondents had sex with someone other than a steady partner in the previous 12 months
- 43.3% of those having insertive anal sex with a non-steady partner did not use a condom the last time they had sex; 40.5% of those having receptive anal sex with a non-steady partner did not use a condom the last time they had sex
- 34.5% of all MSM respondents had sex in a bath house in the previous 12 months

- 55.6% of all respondents said that they had ever felt they ought to cut down on their drinking; 30.8% had ever been annoyed by people criticizing their drinking; 42.2% had ever felt guilty about their drinking; 29.6% had ever had a drink first thing in the morning to steady nerves or deal with a hangover
- 62.1% of all respondents had used non-injected drugs in the previous 12 months; 17.1% had used (not injected) cocaine; 10.6% had used crack; 10.4% had used methamphetamine; 37.7% had used marijuana; marijuana was the drug that the majority said they used most often
- 27.3% of all respondents had ever injected drugs; 11.2% had ever injected heroin; 18.9% had ever injected cocaine; 12.9% had ever injected stimulants
- 17.5% of all respondents had ever "shared" a needle; of those, 39.6% had shared with a lover, 70.3% with friends, and 30.8% with people they did not know
- 8.5% of all respondents had injected drugs in the previous 12 months; of those, 65.9% said it was very easy to access new needles
- 34.4% of all respondents had ever been enrolled in substance abuse treatment
- 14.0% of all respondents had sex for the first time by the age of 10; 24.4% had sex for the first time by the age of 12, 34.8% by the age of 13, 46.4% by age 14, and 56.0% by age 15
- 38.7% of all respondents had ever had genital gonorrhea; 12.5% had ever had syphilis; 23.7% had ever had anal/genital warts; 11.5% had ever had chlamydia; 10.8% had ever had herpes
- 22.5% of all respondents had ever received money in exchange for sex; 14.6% had ever paid for sex
- 50.6% of all respondents had never previously been tested for HIV; another 3.3% had been tested but never received results
- For those who had been previously tested, there was an average of 2 years between their last negative test and their first positive test; the median was one year; for 75% the time elapsed was two years or less
- 31.8% said they tested because of illness
- 59.6% thought that they got infected from sex with another man (MSM); 8.9% thought they were infected from sharing needles (IDU); 20.2% thought that they were infected through heterosexual contact

NEEDS ASSESSMENT SURVEY (2003-2004)

(These data were gathered in late 2003 and 2004; n = 421)

- 53% of the respondents had experienced feelings of low self esteem; 41% had experienced feelings of isolation or alienation from others; 38% had experienced depression; and 36% had experienced feelings of hopelessness; 48% of African American MSM had experienced feelings of hopelessness; Among IDU, 56% had experienced low self-esteem, 56% depression, and 52% feelings of hopelessness.
- 48% of MSM respondents had felt shame around their sexual orientation

- 50% of the respondents had experienced poverty; 66% of IDU and 58.1% of people living with HIV had experienced poverty
- 38% of the respondents had experienced substance abuse; 84% of IDU reported substance abuse as did 39% of people living with HIV
- 38% of African American MSM respondents had experienced homelessness as had 53% of IDU respondents and 31% of people living with HIV
- 24% of the respondents had experienced sexual abuse, including 28% of people living with HIV and 30% of IDU; 24% of the respondents had experienced physical abuse, including 28% of people living with HIV and 34% of IDU.
- 26% of the respondents had felt that they had no control over their lives, including 39% of people living with HIV and 39% of IDU.
- Female IDU respondents were more likely than male IDU to have experienced poverty (79%), homelessness (62%), sexual (59%) and physical abuse (52%), sex for pay (45%), isolation (45%), hopelessness (59%), and lack of control over their lives (45%); 35% reported sex with both men and women; 45% reported being unemployed
- Female IDU respondents reported barriers to services at a much high rate than male IDU
- Women respondents were more likely than heterosexual men to have reported both physical and sexual abuse, low self-esteem, depression, feelings of hopelessness, mental illness, and substance abuse
- 54% of respondents living with HIV had more than one sex partner in the previous 12 months; 10% had more than 5, and 10% had more than 10; 78% of MSM respondents had more than one sex partner; 14% had 6-10, and 30% had more than 10
- 28% of respondents living with HIV had insertive anal sex without a condom in the previous 12 months and 26% had unprotected receptive anal sex; 45% of MSM respondents had unprotected insertive anal sex, and 34% had unprotected receptive anal sex; 10% of MSM knowingly had unprotected sex with someone living with HIV
- 61% of male IDU respondents and 52% of male heterosexuals had unprotected vaginal sex in the previous 12 months; 69% of female IDU and 49% of female heterosexuals had unprotected vaginal sex.
- 23% of respondents living with HIV, 32% of MSM, 25% of IDU, and 12% of heterosexuals had unprotected sex with someone without knowing the partners' HIV status
- 37% of respondents living with HIV, 35% of MSM, 50% of IDU, and 24% of heterosexuals had sex while drunk or high in the previous 12 months
- White MSM respondents (14%) were more likely to have unprotected sex with an HIV positive partner than African American MSM (0%) and Latino MSM (6%); White MSM were also more likely to have sex with someone of unknown serostatus (W = 36%, AA = 22%, L = 28%); they were also more likely to meet partners in bathhouses and on the internet
- Latino MSM respondents were most likely to have had sex while drunk or high (W = 36%, AA = 18%, L = 39%)
- 27% of respondents living with HIV, 24% of MSM, 11% of IDU, and 17% of heterosexuals had an STD in the previous 5 years
- Of the respondents living with HIV, 18% met partners on the internet, 37% in bars, 31% in bathhouses, 19% in parks, and 22% on the street; 35% of MSM respondents met

partners on the internet, 55% in bars, 38% in bathhouses, 17% in parks, and 23% on the street

- 34% of respondents living with HIV, 42% of MSM, 41% of IDU, and 40% of heterosexuals had 5 or more drinks in one sitting in the past month; 14% of all respondents had done this more than twice a week; among MSM, White (41%) and Latino (49%) men had higher rates of drinking than the African American MSM in the sample (26%)
- 11% of respondents living with HIV, 9% of MSM, 44% of IDU, and 14% of heterosexuals had used methamphetamines in the previous 12 months; among MSM Latinos had the highest rates of reported methamphetamine use (16%), though the rate of regular use (once a week or more) was small (3%) for all MSM
- 16% of people living with HIV, 11% of MSM, 45% of IDU, and 19% of heterosexuals had used powder cocaine; among MSM, Latinos had the highest use rate (22%) in the past 12 months (versus 5% for Whites and 9% for African Americans)
- 39% of IDU and 19% of heterosexuals had used crack in the previous 12 months
- 31% of people living with HIV, 19% of MSM, and 31% of IDU thought that it was somewhat likely or very likely that they would get HIV or give it to someone else; among MSM, Latinos had the highest rate (29%) versus 16% of Whites and 13% of African Americans.
- The most common reasons given for risks among the entire sample were: getting caught up in the heat of the moment (41%), getting drunk or high (31%), don't like condoms (28%), wanting to feel close to someone (24%), and wanting to demonstrate love and trust (22%); 14% of the sample felt pressure or forced to have sex without condoms
- Among MSM, 22% of African Americans and 16% of Latinos had never tested for HIV compared to 4% of White MSM.

APPENDIX THREE: NOTES ON IDEAS RELATED TO INTERVENTION STRATEGIES AND APPROACHES DRAWN FROM INTERVIEWS AND FOCUS GROUPS

Public Information and Education

- Not much public information or condoms at bars; not focused on safer sex; need more public information and condoms out there
- Use celebrities for public information; use the Internet for public information
- Need to maintain interest
- Need to appeal to positives not to spread the disease
- Should promote talking about HIV status (in bars, coffee shops, etc.)
- Need public information in bars, baths, coffeehouses, Rainbow Alley, the Center, downtown, etc.
- Need to revitalize fear and appeal to self-protection
- HIV should be more advertised; increase awareness of realities of HIV; HIV needs to be more in your face
- Need creative ad campaigns and ten times more than now (on billboards, at baths and bars)
- Hep C ad effective – emphasizes harsh realities; people don't realize real danger of HIV
- Meth made with dangerous, toxic chemicals; people need to know that; Should advertise meth recipe
- Meth posters with before and after pictures are effective
- Posters should cover a whole wall; need to get people's attention; make public information so it can't be ignored
- Should try to appeal to sense of duty; if person is immoral, don't know what to do
- Need more information about services available; must advertise services widely; people need to know where to go; need detailed data base
- Need realistic depictions of what things can do to you
- Scared straight stuff works; have to scare people about HIV and STDs
- Need more public information encouraging people to get help
- Public information needs to be direct, not beat around the bush
- Keep HIV on people's minds all the time; advertising works; need more
- Need to keep people aware, especially in places where seeking anonymous partners
- They should put the numbers out there
- Could do something for prevention with posters; visual things are the strongest
- Need to generate interest in HIV
- Not enough information out about HIV and people ignoring it; not paying attention
- Don't see anything about HIV prevention when out; need more signs/public information

- HIV should be more advertised on TV; let the public know more; HIV should be more talked about now and more advertised; need to increase awareness; need public information that will get attention; make it scarier
- Should have public information to discourage people from exposing others
- Internet sites should be required to carry STD/HIV warnings; sites should be held accountable
- HIV needs to be more at the forefront; shine the light of day on it; Need continuing education (comprehensive); should be all over; constant reminder
- Conservatives limit effective public information
- Should put disclaimers at beginning of movies with sex; on doors in baths need signs reminding that unsafe sex can kill you
- Need to remind people that HIV is a preventable disease
- Need public information in the shelters; make people aware of HIV
- Need more visible public information; Need to show people the harsh realities of HIV
- There use to be more information about HIV and a lot more prevention; today nobody's driving prevention
- Effective public information with dramatic pictures of what a disease can do leads to conversations; remind people of the ugly realities of HIV; there needs to be more visibility
- Other cities have more aggressive public information campaigns; don't see much prevention in Denver; nothing outside of Denver
- You don't hear anything about HIV on TV anymore; need to advertise more
- Media only reports number of AIDS cases = old information; need ad campaigns
- Could do a campaign about STDs on the Iinternet; put people in chat rooms to do prevention; can do health-related ads on Manhunt
- Should get people to educate about safe sex and design public information campaign
- Need to talk to different people differently; messages must be tailored
- Must address men on down low; need to know that behavior in harming the community
- Should focus messages on tops
- People see posters but don't process the information
- Message not getting out to men of color; must target men of color
- Target population should design messages and interventions for themselves
- Do media campaigns; bombard people with messages; people need information
- Need public information in places with high risk behavior; constant reminders; in your face; emphasize cost of HIV drugs; also side effects
- Public information should be plain and simple
- Change posters weekly
- Use Latinos to design public information materials that they would respond to
- Play on men's vanity
- Emphasize positive gifts men have to offer and the loss when one dies
- When people on-line, want to hook up; safe sex ads are a buzz kill
- Need good information on reinfection
- Should educate the community via radio, TV; offer information in Spanish; people not educated about HIV and need to be

- Could reach NGIs through media (vignettes)
- Should put out poster cards that make people more aware of STDs and HIV issues; put public information on Internet sites; public information on TV, education in schools, outreach, education parties
- There's a lot of pamphlets and fliers, but people don't read them; need brief and eye-opening
- Should do pamphlets in different languages; not just English and Spanish
- In public information should emphasize how to prevent disease
- Could encourage positives to use protection even if they don't disclose
- People don't know about what's out there; needs to be better advertised
- Need public information that is more dramatic; take it to the baths and put it all over; remind people of what they can get and consequences if they're not careful
- Pamphlets are in baths but not being picked up
- Should have safe sex billboards; more obvious awareness campaigns
- Give out messages that are positive about life that appeal to good self-esteem; encourage you to want to protect yourself
- Should have more public information around disclosure
- Destigmatize HIV and make messages open, honest, and accessible
- No public information in rural areas about HIV; no condom distribution
- Use ads that shock people; scare; show harsh realities
- Need strong visual images; before and after shots
- Need fancier marketing campaigns
- Need to put HIV back in people's faces; show harsh realities
- Should focus on consequences of HIV
- Advertise how meth is made
- Need on-line interventions; Internet is new gay pick up place
- Should advertise statistics about HIV and STDs with information number
- Community is tired and if message not in front of them, won't be as concerned
- Let people know that HIV positive people aren't as healthy as in ads
- Need to let people know about harsh realities (nausea, diarrhea, etc)
- People don't see the messages about HIV prevention
- Public information should make them think about themselves and those they love
- There should be public information about substance abuse and protection
- You don't see condom commercials
- Messages need to be not only about staying safe but about not infecting others

Education

- Need better safer sex education, testing; be informed about HIV and STDs
- Kids need to learn at a younger age; need comprehensive sex education in schools
- Need live presentations from people they can relate to
- There isn't HIV education like before;
- Education starts at home

- Need to make people realize that HIV is serious; need more education; make HIV more serious
- High school is a good place to start with HIV education
- Should start with parents and in schools to address substance use
- Need more education to make anonymous sex safer
- Expectations that kids will remain abstinent is unrealistic and pushing it is ineffective; a lot of critical information lost; need to get information so they are prepared and take fewer risks
- Kids in high school and college need to get the message about HIV
- Some people need more information about condoms to make them easier to use or more comfortable
- Schools need to provide more sex education and normalize homosexuality; need to encourage kids to have safe sex
- Should provide education in schools; Teenagers don't go to baths or bars; get no information
- There's no education; AIDS Walk is only time it's talked about; need more education
- Need to do safe sex program in schools and recreation centers, etc.
- Little education for African American gay men; need more, especially for young men
- People need to understand the whole truth about HIV; people need to realize consequences
- Need to educate parents; have trouble talking to kids
- Knowledge can empower people; help to negotiate safe sex; encourage friends not to get drunk and have unsafe sex
- Need to educate people early and educate about the realities of the disease
- Public needs to know more about HIV; consistent
- Need more education and statistics showing people it's in the area; would encourage people to be more protective
- Scare tactics, especially for teenagers
- Inform people about STDs
- Many people don't understand how HIV works; more embarrassing for gay men to admit not understanding about HIV; need to be more aware about HIV; need more knowledge
- Need to educate negatives and positives; need to know what you have and what to do
- Need to educate people about HIV and make them more sensitive to those who are positive
- Have positive people do public speaking
- People should take responsibility to educate others
- Need to tell people about problems associated with being positive
- Make sure people know the consequences of HIV; how it changes your life
- Health insurance is a huge issue; financial issues also huge; not just medical complications
- When positive, life revolves around refrigeration, medications, bathrooms, etc.
- People don't have current information about HIV
- Need to keep education in front of people
- Men think they know about HIV but they don't

- Need to empower people through education
- Help people know what's out there (services) and how to access it
- Give people knowledge to make healthy decisions

Outreach

- Should give out condoms regularly and often, not just for special events
- Some don't know where to get free condoms; condoms should be free and available
- Need more outreach
- Peers can do outreach
- Outreach with condoms could help lower risk of anonymous sex
- Need more outreach around HIV and substances (16th street, shelters, etc.); need outreach to get people into substance abuse treatment; try Detox and jails
- Need more outreach to get people involved in programs; got to keep trying
- Do outreach at Cheesman park; talk to people; had out information and condoms; need to be out there consistently; offer juice, water, etc.
- Clubs may have condoms out, but no lube; no one's going to use them without lube
- Outreach testing is good; there should be more outreach testing
- Good to make sure condoms and lube are available for free
- Need to have more people out in bars doing outreach and at events
- People need to have condoms available when in the moment
- Do more testing at festivals
- Need more outreach in baths and bars; need condoms in bars; talk to people/give condoms
- People doing outreach should reflect community ethnically
- Many don't know infected and they infect others; need more testing in high-risk places; testing needs to be more available in more places and daily
- Can put condoms in all parts of baths
- Rubber Raiders used to go to bars and pass out condoms and information every night; should do something similar in baths
- Bring back condom crusaders; do outreach with condoms and syringes
- Do outreach with hustlers
- Hand out dental dams
- Need more condoms everywhere; in high risk areas
- Organize a group and get those who show up to do outreach to bring more in
- People get involved in programs through word of mouth; need more outreach

Individual Level Interventions

- People need more help getting into right programs; accessing services is like a full-time job

- Need to ask people what they need and not decide for them; people need to come to own understanding
- Case managers must really get to know people before deciding what they need
- Case managers have limited suggestions/offerings
- Case managers need to be a good fit or should refer on
- Need better and more compassionate post test counseling; don't just send people out there; critical to get good counseling when testing positive; some places don't make referrals
- First encounters need to be one-on-one; get good information on needs
- Kids need mentors and to see consequences
- One-on-one interventions better for some; not comfortable talking in groups; shy
- Counseling can be helpful to people who use
- Need to offer free counseling to high-risk people
- People need support when diagnosed; need help accessing services
- One-on-one interventions with someone who's been there can help substance abusers
- Men who are positive can help to mentor those who are negative
- Older positive men can give younger positive men advice and allay fears
- Need newly diagnosed people connected with mentors/advocate; should get in touch with a counselor and have referrals; doctors should give information to newly infected people
- Referrals can't just be written; need one-on-one contact and assistance in accessing services
- Approaches need to be client-centered
- People need help finding the right services and negotiating systems
- Case management needs to be more caring; incorporate partners
- Provide more counseling
- Service providers need to listen better to clients about their needs

Group Level Interventions

- Need support groups and social groups; need support groups for gay and homeless
- In groups, people can breach confidentiality
- There are a couple of social groups to deal with life-defining issues; need more
- Need group therapy to talk out problems and get feelings out
- Support groups can help
- Meth group helpful, but hard to be new in group
- Men and women in same group doesn't work well; all gay group better
- Should address healthy relationships in support groups
- Support groups work for some; often too negative (venting) and not about getting better
- Workshops only about prevention; not about bigger picture; not about relationships/dating
- Groups can help with disclosure; use role plays
- Recovery groups help; meetings help; need more recovery groups; need groups for gay men; need common bond/community

- Groups can help; people must be willing to go
- A lot of talk about drugs in groups can lead to relapse
- Those with poorer English skills often not comfortable in groups
- People need support systems; need to find the right one; have support groups for those who don't have family support; there needs to be more groups and more support
- Should be support groups for men who are negative
- Helps to talk to others about ideas and issues
- Groups for mostly gays don't work well for bisexuals
- Groups should focus more on life management, stress, financial issues, emotional issues about HIV, disclosure issues, medications.
- Open discussion groups can offer men support if safe environment; need to not have men hitting on each other
- A sexually neutral environment would seem safer for bisexuals and more supportive
- Need more groups where men can just talk; support
- Need more time for discussion in groups; could discuss nutrition, reinfection, relapse, disclosure, fundamentals of HIV, etc.
- Can learn from others in groups
- Need support groups for African Americans
- Should have group for African American men who are positive
- Should deal with substance abuse in support groups
- HIV and STD education should be part of rehab and recovery groups
- Get groups together so men can meet other men that feel good about themselves
- There are some social groups out there based around activities/interests
- Groups that are just about complaining get old; need to be more positive
- Support groups can help people be safer
- Need men's group that addresses relationships, etc.; drug free

Social Network Solutions

- Need more peer advocacy; peer support and help
- Need someone to say worth more, deserve better; boost confidence
- Need someone to listen to them and give advice
- People should help each other within social networks; need social network solutions
- Group members can also look out for each other
- Most effective way to help is through social support/interventions from friends
- People need to know someone cares
- Families should intervene and get people in treatment
- People need support when positive; need support around disclosure and other things
- Need to be ready to stop using and need support from friends and encouragement
- Friends/partners can encourage others to be tested
- Some will listen to the people who care about them
- People find support among friends
- People need support to feel comfortable about being gay when they're younger

- Need education for parents to support gay youth; support from parents is key
- Need alternative support system, especially when don't get support from family
- Friends should help each other to stay safe

Community Level Interventions

- Gay community should promote safer sex
- Gay men need a safe space; need alternative to bars; need alternative activities
- Up to older men to share history; young men could learn from older men; older men want to share knowledge; young want to learn; young coming out need guidance
- Substance abuse should be dealt with as a reality and not pushed aside
- Need social events and social dimensions to interventions; need prevention that's fun; social gatherings
- HIV still a problem as are other STDs; should be addressed in open, accepting way
- No good places to meet men for healthy relationships; hard to meet others; men mostly meet in bars; not good place to meet; can't judge others accurately; many meet at park
- Need places to go outside of high risk areas
- Before there was more community and mutual support, education, etc.
- Need drop-in centers; having a place to go with people to help and give referrals is motivating
- Adults should educate young
- Need to get word out; hold groups to address substance use
- Gay community should plan and conduct HIV prevention; gay men aren't involved and not calling the shots
- There needs to be more honest discussions of sex; society in denial
- Need to address stigma and talk more about HIV and homosexuality
- Rights and responsibilities of HIV-infected men should be written by positives and talk about community responsibilities
- Make being safe trendy
- Should identify gate keepers or groups to get message out; outreach workers
- Need "buddy program" within the community; social network solutions; mutual support
- Need to normalize getting tested; make testing routine; need to encourage people to get tested and know their status
- Need to change expectations to being safe
- Need positive role models/mentors; some men want to be role models
- Should have gay/straight alliance in every school
- Interventions by us, for us are the best; need to empower communities to get own solutions
- Need to educate the gay community more; increase public information; people need to be more aware about HIV
- Gay community needs to do outreach to gays and discourage risk behavior; discourage anonymous sex; discourage behaviors that make gay men look bad to society
- Need community leaders to participate in prevention and planning

- Encourage men to talk to partners about HIV and substance use
- Should promote civil unions to improve legal rights
- Should put efforts into the prevention of meth use
- Need community center; social outlets
- Need education that fights stigma
- Need the community to be more accepting of prevention activities
- Need to stigmatize bareback culture; contributes to demise of the community
- Need to reduce stigma in society
- Need more social outlets for rural gay men and ones that are safe; need activities to do together
- Need to advertise non-bar activities
- Older men need to remind younger men of the realities of HIV
- Need for positives to get the word out more
- Hold community forums
- Gay men need to share information with each other, younger and older
- Get people to vote against anti-gay initiatives
- There aren't good role models or definitions for good relationships
- Need ways to connect older men and younger men as mentors
- Meth needs to be stigmatized
- Still having the same conversations about HIV as in 80's; right information still not getting to people and people still getting infected.
- Should hold meetings to help men be safer
- Need to help men to connect to others; retreats, etc.
- Men need social support; safe place to talk about issues
- Need drop-in center for men in Pueblo
- Older men used to teach the younger ones; doesn't happen any more and younger men don't know what's going on; need mentoring
- Need to empower community; encourage people to talk to each other
- Need to promote a life giving lifestyle
- Must empower people to get involved
- Encourage individual responsibility
- Get information out to the community

Other Intervention Ideas

- People want to use their experiences to help others; people want to listen to those who have had similar experiences; people need help from those who have had similar experiences
- Need more paying jobs through which people can make a difference and a living
- Need an apartment complex that has services available on site
- Need providers who can deal with multiple problems
- Need services that help people get on their feet (e.g., job services)

- Helps people to talk to others who have been there and helps those people too; People who have been through stuff need to be talking to people
- Some in recovery could relapse if trying to help others
- Volunteers/staff often have very different lives than those they try to help; hard to relate; need effective people doing programs; people who have been there
- People who are positive want to give back and help others; need opportunities
- Mental health counselors can help with substances and HIV
- Need to build on people's assets to help
- Some doctors don't talk to positives about prevention; need to
- Doctors need to talk to patients more and listen to their issues; be more supportive
- Takes a long time to get services; need system that is tied together across agencies; information shared; consolidation takes a huge burden off the person; don't have to go here and there for help; some don't go because accessing services is too difficult; expensive
- Need more of a one-stop shopping place to get services rather than multiple places
- Need to have positive people out talking to young people about prevention; people who are positive should be doing prevention; need positive speakers bureau at colleges, high schools;
- Helping others is an education in itself
- Physicians need more education on HIV and how to deal with people testing positive
- No prevention efforts outside of Denver, except Boulder
- Need gay specific substance abuse treatment and treatment for African American gay men
- Need to approach prevention in multiple ways
- Need more motivational speakers that are peers
- Focus on empowerment
- Having people willing to tell stories about drug use can have an impact
- The best help to an addict is another addict; can talk to common language; offer solutions
- In accessing services feel bounced around from place to place