

**COLORADANS WORKING TOGETHER:
PREVENTING HIV/AIDS**

**2007 HIV PREVENTION
NEEDS ASSESSMENT REPORT**

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2007 HIV PREVENTION NEEDS ASSESSMENT

INTRODUCTION

HIV/AIDS remains a major health concern in Colorado with 2,161 cases diagnosed between 2002 and 2006. The highest percentage of diagnosed HIV/AIDS cases continued to be among the diverse population of men who have sex with men, who constituted 66% of the total cases diagnosed during that time period. This compared to people with identified heterosexual risk who made up 13% of HIV cases during that period and injection drug users who made up 8%. Another 13% was made up of people with no identified risks. In 2006, 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/AIDS (CWT), the state's HIV prevention community planning group, conducted a needs assessment focusing on gay and bisexual men. Its principal goal was to develop a better understanding of the factors influencing the behaviors of these Colorado residents who are often most at risk for getting or spreading HIV and the best ways to meet their HIV prevention needs. Taking a similar approach and with similar goals, this 2007 assessment focuses on the needs of heterosexuals, including injection drug users, who engage in high-risk behaviors.

Needs assessments conducted prior to 2006 relied heavily 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 were supplemented with some information gained through more qualitative methods. For the 2006 and 2007 assessments, once again a combination of quantitative and qualitative methods of data collection were used. However, the primary emphasis was placed on information gathered through the use of qualitative methods such as interviews and focus groups in order to elicit more complete information about the circumstances surrounding high-risk behaviors and to better understand how such behaviors fit into the complex context of people's lives. Another critical element of this approach was the effort to gain input from people who were at high-risk for HIV about the most effective and appropriate approaches for addressing key issues and needs as they related to HIV prevention. Additionally, it was meant to determine effective ways to get high-risk people involved in prevention programming. This 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 principal 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), and the 2003-2004 Needs Assessment Survey (NAS); 2) reviewing HIV case reports of heterosexual clients diagnosed over

a two-year period; 3) conducting eight focus groups involving 60 participants representing diverse groups of high risk heterosexuals including injection drug users; and 4) conducting 23 one-on-one interviews with heterosexuals, most of whom were living with HIV.

An initial list of all non-MSM cases diagnosed between July 1, 2004 and June 30, 2006 was drawn from the HARS database. R&E staff reviewed the 337 cases from this list, mostly using interview notes entered into the Sexually Transmitted Disease * Management Information System (STD*MIS) and HARS records. Cases found to have originated from areas outside of Colorado were eliminated from the list, as were pediatric cases, transfusion/transplant recipient cases, and those later found to be MSM cases. Data from the remaining 281 cases were then entered into an Excel database. MS Access and SAS were used to summarize these data.

Focus groups organized by a number of partnering organizations and individuals were held in various venues. Partnering organizations included: 1) The Empowerment Program; 2) The Harm Reduction Project; 3) Denver Area Youth Services; 4) It Takes a Village; 5) The Women's Lighthouse Project; and 6) Sisters of Color United for Education. Focus group participants included: 1) African American women with histories of substance abuse; 2) sex workers; 3) women who were current or former injection drug users; 4) men who were current or former injection drug users; 5) African American men with histories of incarceration; 6) African American men living with HIV; 7) women living with HIV; and 8) women of color, mostly Latinas. Two other focus groups (i.e., heterosexuals from outlying areas who were living with HIV and Latino male immigrants with histories of substance use) were scheduled but did not draw participants.

Participants in the one-on-one interviews were sought through service providers from around the state; however, most participants lived in the Denver Metropolitan Area. Recruitment occurred through case managers at AIDS service organizations (primarily the Colorado AIDS Project), staff at infectious disease clinics at Denver Health and Hospitals and University Hospital, and the director of the HOPE program.

SUMMARY OF AGGREGATE DATA AND HIV CASE REVIEW

SHAS

Aggregate data were drawn from three different sources and analyzed to provide critical information about risk behaviors, demographics, and other characteristics of high-risk heterosexuals, including injection drug users (IDU). One data source was the Supplement to HIV/AIDS Surveillance Project (SHAS), which involved extensive interviews conducted with people living with HIV who were receiving care at Denver Health and Hospitals. The interviews included topics such as substance use, sexual behaviors, STD history, and HIV testing history. The data summarized below were drawn from heterosexuals who participated in the survey between May 2000 and May 2004. Table One contains demographic information on the 149 heterosexuals who completed the SHAS survey. Table Two summarizes some of the responses given by heterosexuals who completed the SHAS survey. Of particular note are the proportion of respondents who thought they should cut down on their drinking (57%), who had been in

substance abuse treatment (40%), who had a history of gonorrhea (39%), who had no previous HIV test (63%), and who tested due to illness (39%).

Table One. Characteristics of heterosexual participants completing the SHAS survey between May of 2000 and May of 2004 by gender and risk.

	IDU		HET		NIR		Other		TOTAL	
	#	%	#	%	#	%	#	%	#	%
Male	39	41%	17	18%	39	41%	0	0%	95	100%
Female	21	39%	22	41%	10	19%	1	2%	54	100%
Total	60	40%	39	26%	49	33%	1	1%	149	100%

Table Two. Summary of responses given by heterosexual participants completing the SHAS survey between May of 2000 and May of 2004 by gender.

	MALE		FEMALE		TOTAL		Total Responses
	#	%	#	%	#	%	
Thought they should cut down on their drinking	55	62%	22	49%	77	57%	134
Ever shared needles	26	27%	13	24%	39	26%	149
Used non-injected drugs in the past 12 months	38	56%	16	47%	54	53%	102
Ever been in substance abuse treatment	39	41%	20	37%	59	40%	149
Had sex by the age of 12	14	15%	15	28%	29	19%	149
Had sex by the age of 15	49	52%	36	67%	85	57%	149
Had only one lifetime partner of opposite sex	2	2%	6	11%	8	5%	149
Had 2-5 lifetime partners of opposite sex	15	16%	9	17%	24	16%	149
Had 6-10 lifetime partners of opposite sex	15	16%	10	19%	25	17%	149
Had 100+ lifetime partners of opposite sex	17	18%	14	26%	31	21%	149
Had history of gonorrhea	37	39%	21	39%	58	39%	149
Had history of chlamydia	4	4%	19	35%	23	15%	149
Had received money for sex	15	16%	18	33%	33	22%	149
Had paid for sex	27	28%	4	7%	31	21%	149
Had never previously tested for HIV	62	65%	32	59%	94	63%	149
Tested for HIV due to illness	34	52%	10	22%	44	39%	112

Needs Assessment Survey

The second data source reviewed for this needs assessment was the Needs Assessment Survey (NAS) implemented 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 living in various regions 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 data summarized below are based on responses to the survey from heterosexuals, including IDU.

- Among IDU respondents, 56% had experienced low self-esteem, 56% depression, and 52% feelings of hopelessness; 39% had felt that they had no control over their lives; 30% had experienced sexual abuse; and 34% had experienced physical abuse.
- Sixty-six percent of IDU experienced poverty, and 53% had experienced homelessness. Female IDU respondents were more likely than male IDU to have experienced poverty (79%); homelessness (62%); sexual (59%) or physical abuse (52%); sex for pay (45%); isolation (45%); hopelessness (59%); and lack of control over their lives (45%). Forty-five percent of female IDU reported being unemployed.
- Female IDU respondents reported barriers to services more frequently than male IDU.
- Sixty-one percent of male IDU respondents and 69% of female IDU reported vaginal sex in the previous 12 months. Twenty-five percent had unprotected sex with someone without knowing the partners' HIV status.
- Eleven percent of IDU had an STD in the previous 5 years.
- Fifty percent of IDU had sex while drunk or high in the previous 12 months.
- Forty-one percent of IDU had five or more drinks in one sitting in the past month.
- Forty-four percent of IDU respondents had used methamphetamines in the previous 12 months; 45% had used powder cocaine; and 39% had used crack in the previous 12 months.
- Thirty-one percent of IDU thought that it was somewhat likely or very likely that they would get HIV or give it to someone else.
- The most common reasons given by IDU respondents for sex-related risks were: getting drunk or high (57%), getting caught up in the heat of the moment (50%), not liking condoms (43%), and wanting to feel close to someone (27%). Among female IDU, 28% reported feeling pressured or forced to have sex without condoms.

- Women heterosexual 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.

HARS and HIV Case Reviews

A third source of aggregate data used for this needs assessment is the HIV/AIDS Reporting System (HARS) database. HARS contains information gathered by the CDPHE Surveillance Program on reported cases of HIV and AIDS diagnosed statewide. Basic demographic, risk, and diagnostic data are recorded in HARS and are fairly complete for cases diagnosed in Colorado. For this study the HARS database was used to identify cases of HIV and AIDS reported to CDPHE between July 1, 2004 and June 30, 2006. Of the 281 cases that were identified as heterosexual (including heterosexual IDU) during that two-year period, 195 were interviewed by disease intervention specialists (DIS) employed by CDPHE. Notes from interviewed cases were reviewed by R&E staff for this needs assessment. An additional eighteen cases were interviewed by DIS at the El Paso County Health Department. Notes from those interviews were not available for review. The data summarized below were drawn from a combination of the HARS database and the case reviews.

Of the 281 people diagnosed with HIV in the two-year period described above, 60% were men and 40% were women. Although data on ethnicity and country of origin were somewhat incomplete, it is estimated that 33% of the sample were White, 21% were African American, 16% were U.S. born Latinos, 13% were Latinos born outside of the U.S., and 11% were African born. Overall, it is estimated that 25% of the sample consisted of people from countries other than the United States. Risk among 37% of the sample was listed as heterosexual (HET), meaning they had sex partners who were known to have HIV, 35% had no identified risk (NIR), and 26% had a history of injection drug use (IDU). Risk was unknown for 2% of the sample (see Table 3 below). A much higher proportion of men (41%) were classified as having no identified risk compared to women (28%). The highest proportion of NIR cases occurred among U.S. and foreign born Latino men. Men were more likely to report injection drug use. IDU made up 31% of the male sample versus 20% of the female sample. White men had the highest percentage of IDU.

Table 3. HIV cases diagnosed between July 1, 2004 and June 30, 2006 by gender, ethnicity, and risk.

MALES (n=165; 5 missing)								
ETHNICITY	HET		NIR		IDU		TOTAL	
	#	%	#	%	#	%	#	%
White	10	16%	26	41%	27	43%	63	100%
African American	9	30%	12	40%	9	30%	30	100%
Latino (U.S. born)	4	17%	12	52%	7	30%	23	100%
Latin American	7	26%	15	56%	5	19%	27	100%
African	16	94%	1	6%	0	0%	17	100%
Other (U.S. born)	0	0%	0	0%	1	100%	1	100%
Other (Foreign born)	1	25%	1	25%	2	50%	4	100%
TOTAL MALES	47	28%	67	41%	51	31%	165	100%
FEMALES (n=109; 2 missing)								
ETHNICITY	HET		NIR		IDU		TOTAL	
	#	%	#	%	#	%	#	%
White	12	29%	10	32%	9	29%	31	100%
African American	9	32%	11	39%	8	29%	28	100%
Latina (U.S. born)	12	57%	7	33%	2	10%	21	100%
Latin American	7	78%	2	22%	0	0%	9	100%
African	13	100%	0	0%	0	0%	13	100%
Other (U.S. born)	4	57%	0	0%	3	43%	7	100%
Other (Foreign born)	0		0		0		0	
TOTAL FEMALES	57	52%	30	28%	22	20%	109	100%
	#	%	#	%	#	%	#	%
TOTAL	104	38%	97	35%	73	27%	274	100%

People diagnosed with HIV during the designated two-year period ranged in age from 14 to 64. The median age for men was 38 years and for women 34 years (see Table 4).

Table 4. HIV cases diagnosed between July 1, 2004 and June 30, 2006 by gender and age.

	<15	15-19	20-24	25-29	30-34	35-39	40-44	45-54	55-64	Total
Male	1	1	14	17	29	35	29	30	14	170
Female	0	7	19	17	16	15	13	18	6	111
Total	1	8	33	34	45	50	42	48	20	281

Of the 281 people first diagnosed with HIV during the two-year period described above, 116 (41%) were already AIDS cases either at the time of diagnosis or within six months of diagnosis. A higher proportion of men (45%) were diagnosed with AIDS within six months of their first HIV diagnosis compared to women (35%) (see Table 5). The highest percentages of reported

HIV cases that were already AIDS cases within six months of diagnosis occurred among U.S. born Latinos and foreign-born Latinos and Africans (see Table 6).

Blood samples from 84 people diagnosed within the two-year period were tested using the Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS). Of those, 16 (19%) were determined to be new infections, i.e., those acquired within the previous six months. The remaining 81% of tested specimens were determined to be cases acquired more than six months prior to diagnosis. Of the 84 STARHS-tested specimens, recent infection was more likely to be observed in persons who were Latino (5 of 13 or 38.5%), female heterosexual (8 of 21 or 38.1%), and 35-39 years old (4 of 11 or 36.4%).

Table 5. HIV or AIDS cases at first diagnosis among people diagnosed between July 1, 2004 and June 30, 2006 by gender.

GENDER	HIV		AIDS		TOTAL	
	#	%	#	%	#	%
MALE	93	55%	77	45%	170	100%
FEMALE	72	65%	39	35%	111	100%
TOTAL	165	59%	116	41%	281	100%

Table 6. HIV or AIDS cases at first diagnosis among people diagnosed between July 1, 2004 and June 30, 2006 by ethnicity.

ETHNICITY	HIV		AIDS		TOTAL	
	#	%	#	%	#	%
White	58	62%	36	38%	94	100%
African American	39	67%	19	33%	58	100%
Latino (U.S. born)	24	55%	20	45%	44	100%
Latin American	16	44%	20	56%	36	100%
African	16	53%	14	47%	30	100%
Other (U.S. born)	5	63%	3	37%	8	100%
Other (Foreign born)	2	50%	2	50%	4	100%
Unknown	5	71%	2	29%	7	100%
TOTAL	165	59%	116	41%	281	100%

For 239 of the 281 people diagnosed with HIV in the two-year period, information was available on their reason for getting the HIV test by which they learned of their positive status. Forty-three percent of this sample reported getting tested because they were sick. Forty-nine percent of men tested due to illness compared to 33% of women. Some of this difference is likely accounted for by the fact that many women are screened for HIV during pregnancy (see Table 7). African Americans, foreign-born Latinos, and Whites had the highest percentages of people who received HIV testing due to illness (see Table 8).

Table 7. Reason for testing among people diagnosed with HIV between July 1, 2004 and June 30, 2006 by gender.

REASON FOR TEST	MALE		FEMALE		TOTAL (n=239)	
	#	%	#	%	#	%
Screen	16	11%	4	4%	20	8%
Pregnancy	NA	NA	15	15%	15	6%
Illness	69	49%	33	33%	102	43%
Immigration Exam	7	5%	4	4%	11	5%
Positive Partner	13	9%	21	21%	34	14%
High Risk Partner	2	1%	2	2%	4	2%
Incarceration	21	15%	7	7%	28	12%
Blood/Plasma Donation	9	6%	6	6%	15	6%
Other	3	2%	7	7%	10	4%
TOTAL	140	100%	99	100%	239	100%

Table 8. Reason for testing among people diagnosed with HIV between July 1, 2004 and June 30, 2006 by ethnicity and place of origin.

REASON FOR TEST	African Amer.		Latino		White		African		Latin Amer.		Other U.S.		Other Non-U.S.		TOTAL (n=237)	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Screen	5	12%	2	5%	6	8%	4	14%	2	6%	0	0%	1	33%	20	8%
Pregnancy	2	5%	2	5%	4	5%	4	14%	3	9%	0	0%	0	0%	15	6%
Illness	21	49%	16	38%	36	47%	6	21%	17	49%	3	38%	2	67%	101	43%
Immigration Exam	NA		NA		NA		11	38%	0	0%	NA		0	0%	11	5%
Positive Partner	5	12%	8	19%	7	9%	3	10%	8	23%	3	38%	0	0%	34	14%
High Risk Partner	0	0%	0	0%	3	4%	0	0%	0	0%	1	13%	0	0%	4	2%
Incarceration	6	14%	3	7%	13	17%	0	0%	5	14%	1	13%	0	0%	28	12%
Blood/Plasma Donation	4	9%	6	14%	5	6%	0	0%	0	0%	0	0%	0	0%	15	6%
Other	0	0%	5	12%	3	4%	1	3%	0	0%	0	0%	0	0%	9	4%
TOTAL	43	100	42	100	77	100	29	100	35	100	8	100	3	100	237	100

Of the 281 non-MSM cases diagnosed between July 2004 and June 2006, 155 contained information about previous testing history. Thirty-nine percent of the 155 cases had never tested before. Men were much more likely to have never tested previously than women, with close to half of the men (47%) having no previous HIV test. Twenty-two percent of the men had tested previously, but had not tested in more than five years before their HIV diagnosis (see Table 9).

Table 9. Testing history among people diagnosed with HIV between July 1, 2004 and June 30, 2006 by gender.

	First Test		Tested within 1 year of dx		Tested within 2 years of dx		Tested within 3-5 years of dx		Tested over 5 years before dx		TOTAL	
	#	%	#	%	#	%	#	%	#	%	#	%
Male	41	47%	8	9%	13	15%	6	7%	19	22%	87	56%
Female	20	29%	17	25%	12	18%	10	15%	9	13%	68	44%
TOTAL	61	39%	25	16%	25	16%	16	10%	28	18%	155	100%

As mentioned above, notes from 195 HIV cases diagnosed between July 2004 and June 2006 and entered into STD*MIS were reviewed by R&E staff. Given the nature of disease intervention work, the same data were not available for each of the 195 cases. The information summarized below was drawn from this case review, and, when possible, was supplemented by HARS data.

- Of the 202 people for whom marital status information was available, 30% were single, 43% were married or had steady partners, 25% were divorced or separated, and 2% were widowed.
- Of the 184 people who responded to questions about the types of relationships in which they tended to be involved, 78% said that they were or had been involved in long term, steady relationships. Nine percent had been involved in short-term, steady relationships, 33% in casual relationships, and 24% reported having anonymous sex partners or “one-night stands”. Forty-three percent of those responding reported having been involved in more than one type of relationship in the recent past.
- Of the 143 people responding to questions concerning number of sex partners, 66% reported averaging one or fewer partners per year. Twenty-four percent reported 2-5 partners per year, 5% reported 6-10 partners per year, and another 5% reported more than 10 partners per year. The number of partners ranged from 0 to 50 per year.
- Of the 142 people responding to questions about disclosure, 76% reported disclosing their HIV status to at least one current or previous partner, 13% reported not disclosing, and 11% reported that they planned to disclose in the future.
- Of the 135 people responding to questions about histories of STDs, 39% reported having an STD in the past.
- Of the 129 people responding to questions about the use of alcohol, 35% reported a history of alcohol abuse.
- Of the 170 people responding to questions about drug use, 36% reported no history of drug use. Twenty-three percent had used cocaine, 19% marijuana, 13% methamphetamine, 11% crack, and 9% heroin. Greater than one-fifth (21%) of respondents reported using more than

one drug. Another 15% reported a history of drug use, but no information was available related to the specific drugs they used.

OVERVIEW OF INTERVIEW AND FOCUS GROUP INFORMATION

Participant Demographics

Twenty-three individuals participated in one-on-one interviews for this needs assessment, all but one of whom were people living with HIV. The participant that was not a person with HIV was the wife of a man who was diagnosed with AIDS when he first tested for HIV. Participants were accessed through infectious disease clinics, AIDS service organizations in Denver and Southern Colorado, and the Hope Program. In most cases participants saw fliers posted at these locations and called R&E staff to request an interview. An additional 60 individuals participated in one of eight focus groups organized through the partnering agencies listed in the “Methods” section of this report. Table 10 displays the demographic breakdown of the interview participants by gender, ethnicity, age, and risk. Table 11 displays the demographic breakdown of focus group participants.

Table 10. Needs Assessment interview participants by gender, ethnicity, age, and risk.

INTERVIEW PARTICIPANTS			
Ethnicity	Males	Females	Total
African American	4	3	7
Latino	1	3	4
White	5	6	11
White/Latino	1	0	1
Total	11	12	23
Age	Males	Females	Total
20-29	0	1	1
30-39	2	4	6
40-49	5	6	11
50-59	4	1	5
Total	11	12	23
Risk	Males	Females	Total
Heterosexual	3	8	11
IDU	5	2	7
Heterosexual, IDU	0	2	2
Sexual Assault (same gender)	1	0	1
Sexual Assault (same gender), IDU	1	0	1
Bisexual	1	0	1
Total	11	12	23

Table 11. Needs Assessment focus group participants by gender, ethnicity, age, and risk.

FOCUS GROUP PARTICIPANTS			
Ethnicity	Males	Females	Total
African American	14	9	23
Latino	6	11	17
White	2	8	10
Mixed Race	0	7	7
Other/Unknown	1	2	3
Total	23	37	60
Age			
Age	Males	Females	Total
15-19	0	1	1
20-29	1	6	7
30-39	2	12	14
40-49	6	13	19
50-59	7	4	11
60-69	2	0	2
Unknown	5	1	6
Total	23	37	60

Discussions Topics

Participants in the interviews and focus groups were asked to discuss the following topics: 1) life issues and priority concerns and where HIV tended to fit relative to those concerns; 2) the main reasons why people participate in sexual risk behaviors and needle sharing; 3) the reasons why so many people who get HIV are poor and/or people of color and the most appropriate and effective ways to approach HIV prevention in light of this; 4) substance abuse, emotional well-being, and histories of trauma and the most appropriate and effective ways to address these issues and HIV risk; 5) issues related to conversations about HIV status among sex and needle-sharing partners and disclosure of HIV status by those who are living with HIV; 6) issues related to HIV testing, counseling, and the new CDC recommendation for “universal” testing in the U.S.; and 7) the best ways to approach HIV prevention including the types of programs that should be available, the most appropriate strategies used by programs, the role of health care providers in prevention, and the best ways to get people involved in programs.

Issues and Concerns

Participants in the interviews and focus groups were first asked to discuss the principal life issues and concerns of people from populations of which they feel a part. The conversations differed as individuals and groups focused to varying degrees on issues pertinent to men, women, Latinos, African Americans, substance users, people with histories of incarceration, and people living with HIV. Given that many of the participants were from relatively disadvantaged groups, a commonly discussed topic concerned people’s ability to meet basic needs. Difficulty accessing housing was the most commonly mentioned issue in this category, as a significant number had

experienced some degree of homelessness. Lack of adequate income was also frequently mentioned as people relayed problems in getting and keeping jobs, obtaining disability benefits, surviving on fixed incomes, and being able to pay bills and pay off debts. Several participants mentioned problems associated with not having official identification cards.

Health problems and access to adequate and affordable health care and mental health care services for oneself and for family members were also of principal concern to many of the participants. Also of concern were issues such as domestic violence, sexual assault, and childhood sexual abuse. Lack of transportation was particularly problematic for some people, especially those needing to access a number of services in different locations. Substance use and abuse was a concern highlighted in most of the interviews and focus groups. Among those with substance abuse problems, the effect that addictions had on their lives was the most common issue discussed. Lack of access to clean needles was also problematic for injection drug users who were not ready to quit. Discrimination against drug users by the wider society, law enforcement, and health care and other providers was also a common topic. Additionally, participants expressed concerns about the large number of youth who were using drugs. Issues and concerns related to substance abuse are described in further detail below.

Since all but one of the interview participants and many of the participants in the focus groups were people living with HIV, a number of issues and concerns were highlighted that related to HIV. In over two-thirds of the interviews and focus groups the issue of discrimination against those who are HIV positive was raised. Coupled with this was the high level of stigma still surrounding the disease, which was attributed to the wider society's lack of knowledge about HIV and how it is transmitted. Several participants mentioned being treated like lepers. Some discussed situations in which people avoided being in their presence or would not allow their children to be around them. One woman described an experience in which people would not ride in the same elevator with her. A number of the participants living with HIV described situations in which family members served them food on paper plates or asked them not to bring food to gatherings. Others mentioned people being concerned about respondents spreading HIV through sneezing and coughing. Participants also spoke of job-related discrimination and especially poor treatment in jails and prisons. Some noted that many people still thought of HIV as a gay disease or something people only got because they deserved it due to their behavior. Because of HIV-related stigma and discrimination, a number of participants discussed their concerns about confidentiality and described instances in which confidentiality had been breached by family members, friends, service providers, and corrections staff.

Participants living with HIV also commonly discussed health-related concerns such as their efforts to improve or maintain their health through better nutrition, exercise, quitting smoking, or taking medications. Several talked of feeling weak and experiencing other HIV-associated health problems and difficulties with HIV medications. Access to health care and health insurance were very important issues for HIV-positive participants, which included difficulties associated with costs and transportation. For those living with HIV who were homeless, appropriately storing and taking HIV medications was especially difficult. Several people mentioned disrespectful treatment by health care and other providers as well as experiences they had with providers who were insufficiently informed about HIV. Mental health issues were also said to be common among those living with HIV. Depression, loneliness, feelings of

hopelessness, feeling overwhelmed, feelings of shame, and low self-worth were topics that were frequently discussed.

Given that almost all of the participants in the interviews and focus groups identified as heterosexual, several of those who were living with HIV discussed difficulties associated with being “straight” and positive. For those who were single, finding partners was a special concern for them. For those in relationships, maintaining those relationships was often problematic. Several people mentioned that positive couples often blamed each other for their infections. Others discussed difficulties associated with disclosure and concerns about keeping their partners safe. Accessing services more appropriate for heterosexuals was highlighted by a number of participants as they noted that most services were more oriented around meeting the needs of gay men. The desire to be around other straight people who were positive was prevalent. An eagerness to help others and participate in prevention efforts was also commonly expressed.

Issues specific to people of color were highlighted in a number of interviews and focus groups. Several people described communities of color as being neglected and lacking a number of necessary services. People talked about problems associated with racial discrimination and racial profiling. For African American men, such profiling and police harassment was a concern discussed at length. Some mentioned the higher rates of HIV in communities of color along with an overall lack of knowledge about the disease. However several people mentioned that available information about health disparities was misleading or inaccurate, arguing that the numbers of HIV cases in people of color were over-emphasized while those for Whites were masked.

As part of discussions on principal concerns, participants were asked where HIV fit relative to these other issues. For many of those living with HIV it was, as expected, one of their top concerns and a major factor influencing their lives. Many of the participants who did not have an HIV diagnosis also saw the disease as important, however, most thought that the vast majority of people did not talk about HIV, think about it, or consider it a priority issue. Participants said that HIV was not on people’s minds and that many people were in denial about their risks. The participants with substance abuse issues offered that substance users in particular did not think about HIV, especially when they were high. It was also mentioned that people with low self-esteem often placed HIV low on their list of priorities. Most of the participants thought that HIV had been “put on the back burner” by U.S. society, citing that there was virtually no visible public information about HIV nor any available information on prevention activities and programs.

Reasons for Risk Behaviors

People not thinking about HIV or not having HIV on their “radar screen” was a common response given by interview and focus group participants when asked about the reasons why people participate in unsafe behaviors such as unprotected sex and needle-sharing. People in general were said to be ignorant about HIV and how it is transmitted, or were said to not understand the realities of HIV or take it seriously. Several people brought up the image of Magic Johnson and how he could leave people the impression that HIV was treatable and

therefore not much of a concern. One person attributed unsafe behaviors to people being irresponsible. A number of participants mentioned that some people just do not care. Many participants also talked about people's denial of their risk. For example, participants offered that some people still think they are not at risk because they are not gay. Others think they do not have risk because they have steady partners and think they can trust those partners, even when signs may be there to the contrary. According to participants, many people think that their partners look like the kind of people that would not have a disease – their partners look “clean” – therefore, they do not consider themselves to be at risk.

Other reasons for unsafe behavior offered by the interview and focus group participants included emotional factors such as low self-esteem and the need to be accepted and loved by someone. For some participants this was attributed to childhood neglect that resulted in people not getting the kind of love and support they needed as children. Several participants thought that histories of childhood sexual abuse had much to do with people not tending to care enough about themselves to protect themselves. Women participants also offered how partners and others can be suspicious of women who carry condoms, passing judgments on their behaviors. Some of the sex workers talked about how a woman can get arrested for carrying condoms, and others mentioned the possibility of women getting beaten if they suggest condom use. Other commonly cited reasons for unsafe sex included: 1) the high cost of condoms; 2) the fact that people may not have condoms available in the “heat of the moment”; 3) men's resistance to using condoms, claiming they do not like the way condoms feel; and 4) rape of both men and women.

By far the most common explanations for unsafe sex were those concerning substance use and abuse. Participants talked about people's lowered inhibitions when they were high, lack of responsibility, or decreased capacity for self-protection. They discussed how nothing else mattered when people were high, and they did not think about using condoms in such situations. Some participants stressed that people who were addicted would have sex with anyone and fail to use protection. Crack and methamphetamine use were both said to be highly associated with sexual risks. Many spoke of women addicted to crack who would do almost anything to get access to the drug, especially exchanging sex for crack or for the money to buy it. Methamphetamine was said to enhance sexual pleasure and make many people obsessive about sex, although this was said to be truer for men than women. Women were also said to exchange sex for methamphetamine as well. Some participants discussed ways that methamphetamine use could enhance risk of HIV transmission due to its association with prolonged sex and its tendency to dry vaginal fluids, both of which could compromise vaginal tissues. A few participants offered that Ecstasy was also a drug associated with sex, especially among young people.

When asked about risks related to needle “sharing”, the most common reason offered by the participants was the urgency people feel when they want to get high. If there were no new needles around, people would share rather than take the time to access a new needle. This was especially the case for people who were “dope sick” and needed to “get well” or feel normal. It could also be the case for people who were coming down from a high and wanted to recapture the feeling. Some participants said that drug users did not care about anything else when they wanted or needed to get high. Several participants talked about difficulties in accessing sterile syringes in Denver given that not all merchants would sell them without a prescription in spite of

their being no prescription law in Colorado. One person noted laws against having needles in one's possession as a contributing factor. Others explained that many people know the people they share with and therefore think it is safe. One person said that some people think that all the people they are sharing with are already HIV positive. Other reasons for sharing needles included: 1) people rinsing syringes with water and thinking they are clean enough to reuse; 2) denial of risk or thinking HIV is mostly spread through sex; 3) ignorance; 4) pressure from partners; and 5) the need to divide drugs evenly among people who are using together.

HIV and Vulnerability

Behaviors that pose a high risk for acquiring or spreading HIV and the multiple factors that influence those behaviors are not unique or necessarily concentrated in particular socioeconomic groups. Yet HIV rates do tend to be elevated within certain populations, such as among people who are living in poverty and within communities of color. Interview and focus group participants were asked to reflect on why some people may be more vulnerable to getting HIV than others. All participants were asked about the relationship between HIV and poverty, although only a few responses resulted from that part of the discussion. Only African American and Latino participants were asked to reflect on any greater vulnerability they perceived among people of color.

Several participants suggested that poor people did not have enough to do in terms of entertainment given their limited resources. Therefore, many became involved in drug use and associated risk behaviors as a form of entertainment. One participant suggested that more places be made available for people to have fun such as free days at the zoo, activities at recreation centers, or church activities. Lack of access to education and information about HIV was also cited as a reason for greater vulnerability, as was lack of access to health insurance and medical care. Several people also pointed out the high price of condoms, which might not be seen as a priority to people in the face of other expenses. One participant talked about how homeless people may do drugs as they reach out to fit in somewhere. Another noted that poverty can result from difficult situations such as divorce or job loss, and people in those situations may turn to drugs and sex to feel better. One person expressed that the statistics about HIV infection are misleading, and that infections among wealthier people are underreported.

The most common reason given for the vulnerability of people of color was a lack of education and information about HIV. Participants also added that some people were in denial about their risk, thinking that HIV was a disease that only affected Whites. Those that were infected with HIV tended to keep it to themselves for fear of being judged. Consequently, they did not get the help and support they needed. Shame kept people from getting help, even from their churches and family. Some would not even seek information about HIV because of the community's negative view of it. Participants in various interviews and focus groups also talked about a tendency for gay and bisexual Latinos and African American men to not disclose their sexual orientation out of fear of being judged and persecuted. Many would have sex with women and put them at risk. Participants also discussed a general lack of access to health care and health insurance for people of color. Latina participants discussed how women often did not have time to go to the doctor, although they would make sure other family members sought medical

attention. These same participants discussed a tendency for Latinas to fear losing their men. They said that many Latinas were willing to put up with anything as long as their men were providing for the family, even when the women suspected their husbands were unfaithful. They said many women would not ask about condom use for fear they would be accused of infidelity. Several participants expressed that childhood sexual abuse was common in both African American and Latino communities. This led to depression or low self-esteem, which was often associated with risk behaviors. One African American man who was living with HIV discussed his concerns about Black culture and the Black media encouraging boys and men to be sexual and have multiple partners and encouraging girls and women to attract men and have babies. He considered these cultural influences as playing a part in the vulnerability of African Americans to HIV.

Disclosure

As described above, many of the participants in the interviews and focus groups did not think that HIV was generally on people's minds. Part of the discussion in these sessions focused specifically on the extent to which sex partners or needle sharing partners were talking about HIV. Participants were first asked about how often men and women talked about HIV before they had sex. In the majority of the discussions, participants stated that sex partners did not talk about HIV unless they were in committed relationships or one of them knew they had HIV. Several people said that couples often did not even think about HIV, especially if they were in the "heat of the moment" or if they were high. Others noted that HIV was difficult to talk about, embarrassing, or it ruined the moment. One person said that bringing up the subject could raise suspicions, and another said it could cause a partner to be violent. Several participants mentioned that there was no need to ask partners about their HIV status because they would likely lie about it if they were positive. However, a large number of participants agreed that sex partners should be having these discussions and protecting themselves.

The discussions then turned to the subject of why some people who are living with HIV did not disclose their status to their partners. Although many participants agreed that people should tell their partners, disclosing was said to be difficult and something that took a lot of courage. There were a number of reasons given why some people did not disclose their positive HIV status. The reason given most frequently was a fear of rejection by partners, which could exacerbate loneliness or prevent people from having sex. Some people were said to fear that their confidentiality would be breached if they disclosed to partners. Others feared facing the stigma and discrimination that was often imposed on those who have HIV. Other reasons offered for why some people did not disclose included: 1) being drunk or high; 2) sex workers needing the money or drugs; 3) pride; 4) shame; and 5) fear of violence. Participants in the interviews and focus groups also emphasized that many people living with HIV would never consider not telling their partners about their infections, nor would they knowingly expose others to the virus. It was also pointed out that some people were comfortable letting others know they have HIV. Participants also noted that many partners did not reject people when they disclosed. It should be mentioned that several of the participants who were living with HIV had been infected by steady partners who knew about their diagnosis and did not disclose it.

When asked what people needed to help them to disclose their HIV status to partners, the most common response was one-on-one counseling. Some emphasized that it needed to be impressed upon people that they should not infect others with HIV, and people should be reassured that good people would not reject them if they disclosed. Several participants also suggested groups and classes in which people could offer each other support and ideas and help each other practice disclosure techniques. Providing better education and information on disclosure was another suggestion as was showing videos of people telling their stories. Other suggestions included: 1) encouragement and support from friends and family; 2) making non-disclosure against the law; and 3) confronting the widespread stigma and discrimination associated with HIV.

Substance Abuse, Emotional Well-Being, and Histories of Trauma

A wealth of information is available about the significant impact of substance abuse, emotional problems, and histories of trauma, particularly childhood sexual abuse, on people's risk for HIV. For this needs assessment it was deemed unnecessary to revisit those connections in much detail. However, one goal for this study was to elicit ideas about the most appropriate and effective approaches to helping people with these problems and to address their needs in conjunction with HIV prevention. Given the strong evidence that mental health, substance abuse, and HIV risk are so highly interrelated, gaining ideas from participants about ways to appropriately address multiple problems in combination was also part of this goal. Additionally, ideas about ways to get people to access help or get into programs were also pursued in the discussions with interview and focus group participants.

Substance Abuse. Even though discussion questions were not meant to elicit further information on the impact of substance use or its relation to HIV, given the profound role drugs had played in many of the participants' lives, discussions often turned to these topics. One focus was on the reasons why people got involved in substance use. Most commonly participants talked about how emotional issues such as low self-esteem and depression often stemmed from histories of trauma or neglect. People began to use substances as a way of "self-medicating" or masking emotional pain or as a means to gain acceptance by others. Other people were said to begin using because of the influence of their partners or because drugs and alcohol were so much a part of the environment in which they were raised or currently lived. Three people mentioned that some people began abusing substances after they had been diagnosed with HIV.

Another common topic concerned the impact that substance abuse had on people. Participants spoke of how addictions could take over people's lives. They spoke of addictions overshadowing everything else, affecting people's ability to make a living or use their incomes on necessities other than drugs. Addictions were said to keep people from taking care of themselves, their families, and their responsibilities as well as limiting future prospects. Addictions were also described as being detrimental to people's relationships with partners, family, and friends. Participants discussed how substance abuse damaged people's physical and emotional health as well and was associated with other problems such as domestic and other types of violence and prostitution.

A lot of information is available on the use of methamphetamine among gay and bisexual men and its relation to sexual risk for HIV. Less is known about how this relationship manifests itself among heterosexuals. Therefore, participants were asked to discuss what they knew about this topic. Many of the participants discussed that methamphetamine use was very commonly related to sex risk among heterosexuals as it stimulated sex drive. Given that the effects of methamphetamine on libido could be very prolonged, some participants noted how prolonged sex could often lead to soreness that may increase HIV transmission risks. Some mentioned that this stimulation of sex drive was more common for men than for women, as women also often used methamphetamine to boost energy so they could get things done or lose weight. Several participants discussed how destructive methamphetamine addiction was to people's health and other aspects of their lives.

Although interviewers and focus group facilitators did not ask specific questions about other drugs, participants offered several points they thought to be important. Many participants had experience with crack use and discussed how destructive the drug had been in their lives and to communities as well, especially the African American community. Given that crack highs are very short, people often felt a desire to keep using to prolong their high. This often meant that large amounts of money and other resources were spent on crack use. Women were often said to trade sex in exchange for crack. Heroin was also a topic raised by some of the participants. The high from heroin was described as lasting longer, but when a person is coming down off of the drug they could become very sick. Therefore, some people may use continuously in an attempt to "get well" or feel normal.

Substance users in the interviews and focus groups talked of difficulties in trying to stop using drugs once they were addicted, including getting away from drug infested environments, accessing and paying for methadone treatment, and accessing affordable and effective substance abuse treatment in a timely manner. However, participants perceived that most of society just expected them to quit using and did not seem to understand why it was so difficult. They mentioned many problems associated with substance abuse treatment, including availability, costs, long waiting lists, treatment lengths that are too short, and poor quality.

Trauma and Emotional Well-Being. As with substance abuse, mental health issues were also common topics of discussion in the interviews and focus groups. For the purposes of this needs assessment, the intent was to pursue ways to appropriately and effectively meet the needs of people who did not necessarily have clinical diagnoses of serious mental illness, but who still battled with varying levels of depression and associated low self-esteem. Participants in the focus groups and interviews discussed histories of trauma, especially childhood sexual abuse, as very common sources of depression and low self-esteem. According to participants, many people with these experiences were often not allowed to talk about them nor did they receive help dealing with these experiences when they were young. Both men and women living with HIV who participated in one-on-one interviews shared that they had been sexually abused as children, often by family members and friends. A number of women participating in the focus groups divulged this as well. In the focus group involving sex workers, all of the women said they had been sexually abused as children, a factor which, in most cases, was cited as leading to substance abuse and prostitution. Histories of abuse and their emotional impact were not only

said to influence substance abuse and prostitution, but also domestic violence, an inability to establish sexual boundaries, sex addictions, and risk behaviors for HIV. Substance abuse was also said to then exacerbate poor mental health. Many of the participants living with HIV also spoke of HIV as a source of depression for them. Although a widespread need for mental health services was expressed, several of the participants discussed how difficult it was to access those services by the poor or those without insurance. Also the mental health services some of the participants had accessed in the past were said to be ineffective.

Associated Needs. The participants in the interviews and focus groups highlighted a wide array of needs of those burdened by substance abuse and mental health issues. First and foremost was the need for better access to effective and affordable substance abuse and mental health treatment services. Substance users were said to need a wide range of treatment services to be available including: 1) free methadone; 2) medical detoxification; 3) recovery groups such as Alcoholics Anonymous and Narcotics Anonymous; 4) recovery groups that cover a broader range of issues such as HIV, HCV, the reasons why people abuse substances, the impact of substance abuse, and how to get one's life on track; 5) mentoring; and 6) in-patient and out-patient services that involved a combination of groups and one-on-one counseling to help people get to the root of their problems. Mental health services, especially for those with histories of childhood sexual abuse, were also said to need a range of approaches including one-on-one counseling and groups with people who share those same experiences. Some participants expressed how important it was for people to be able to find a counselor who was a good match and not just be assigned to whomever was available. Given the strong interconnection between substance abuse and poor mental health, several participants expressed the importance of having services that could help people with both of these issues.

Participants also discussed a number of other things that substance users and those with emotional problems needed to help them get their lives on track. One set of ideas concerned general education and classes on specific topics such as nutrition, life skills, childhood sexual abuse, self-esteem, and HIV. Job assistance and job skill training were also mentioned frequently as was housing assistance. Better access to medical and dental care constituted another set of needs. Getting respect from service providers was mentioned several times, reflecting the many times that substance users were said to be treated poorly when trying to access services. Another factor considered important for substance abuse recovery was for users to be able to remove themselves from environments in which their drug use had previously occurred or from environments where drugs and drug use were prevalent. Family support was also said to be critical to some as was having someone to talk to. Another suggestion included access to inexpensive or free entertainment that offered people alternatives to drug use. Many of the participants discussed the need to be able to access multiple services or services addressing multiple issues in one location as well as the need to know where to go to get help. Another common response concerned the need for health care providers to be better trained in the areas of addiction and childhood sexual abuse so they could better understand and help their patients.

Approaches to HIV Prevention and Meeting Multiple Needs

The 83 interview and focus group participants offered a large number of general and specific ideas concerning the types of programs and approaches necessary to meet the HIV prevention

and related needs of people who were at high risk for getting or spreading HIV and for the general population. Their ideas are summarized here. For a more detailed listing of the suggestions offered in the interviews and focus groups, see Appendix One.

Types of Programs. The most commonly suggested type of program was outreach. Participants saw great importance in having service providers and peer volunteers go out to areas where people who participate in high-risk behaviors tended to congregate and at hours when people were likely to be there. Conducting street outreach to drug users and sex workers came highly recommended as did talking to people in bars and clubs where they are often getting drunk or high and meeting sex partners. Groups were the second most commonly mentioned type of intervention discussed by the participants. People expressed a real benefit in being able to work together with others with similar issues and concerns. Such groups could be based on gender, ethnicity, sexual orientation, or HIV serostatus or on common substance abuse and mental health problems. Some of the ideas about what groups could offer high-risk individuals included: support; HIV-related information; friendly confrontation about risk behaviors; encouragement for lowering risks; ideas about disclosure; emotional reassurance; and social outlets.

The third most commonly recommended type of intervention was needle exchange. Only two participants openly expressed any opposition to needle exchange programs. Most saw the need to ensure the health and safety of those who were injecting drugs but who were not ready to try and quit. Aside from assuring access to sterile needles, suggestions for other services that a needle exchange program could provide included: access to other items necessary for clean injections such as cottons, cookers, and alcohol swabs; help with meeting basic needs such as food, housing, health care, and jobs; HIV prevention information; and substance abuse treatment for those who are ready to quit using. The fourth most commonly recommended intervention was one-on-one case management and counseling for those living with HIV and for those at high risk. Like the group interventions described above, participants offered that counseling could help people with drug and alcohol issues, issues of trauma, risk reduction, and disclosure. Counseling could also help people to understand the underlying causes of their current drug use, mental health problems, and risk behaviors. Case management could help people to access the services they need. Another commonly recommended intervention for high-risk individuals involved offering HIV prevention workshops in numerous locations including substance abuse treatment centers, mental health treatment centers, correctional facilities, safe houses, and people's homes.

Approaches and Strategies. Participants recommended two primary approaches or strategies for HIV prevention among high-risk individuals. The most common concerned increasing the availability of condoms. Participants thought condoms should be free and made available in a wide variety of places including, but not limited to, on the street, in bars and clubs, at all agencies providing HIV prevention and care services; in various types of social service agencies; in schools; at health care clinics; and in stores. The second most commonly proposed strategy was for those who are providing HIV prevention and related services to be people who had lived similar lives and overcome many of the same obstacles as the people they were serving. Suggestions for such providers included recovering addicts working with drug users; those with histories of trauma, including childhood sexual abuse, working with others with similar histories; former sex workers providing services to current ones; and those who were living with HIV

working with others who were positive and with people engaging in high risk behaviors. This was coupled with a desire expressed by a number of the participants to find outlets through which they could help others who are living with HIV to get the services they need and to prevent HIV among those who may be at risk. Having providers from the same ethnic groups as the people they served was also recommended.

Another strategy commonly recommended by the interview and focus group participants was to highlight the realities of living with HIV to those who were at risk but who may not be taking HIV seriously. Participants offered that this could be done through HIV-positive speakers, showing movies that address the subject and then holding discussions, or showing pictures on the impact that HIV can have on a person's body. Many also suggested using pictures to help people face some of the realities of the impact of drug use. As another strategy, participants repeatedly emphasized the need to integrate HIV prevention with other related services and to deal with other related issues, especially substance use, mental health, and poverty. Other commonly recommended strategies included using a harm reduction approach to prevention and addressing self-esteem. One participant emphasized the need to adapt approaches to different types of people.

Overall participants expressed that there needed to be more funding directed at HIV prevention and related programming to better meet the needs of high-risk individuals. This would make possible the establishment of more programs in more areas. The fact that most programs are currently concentrated in Denver was very problematic for those living in other parts of the state and for those in the metro area who had to take long bus rides to access services. Participants called for more programs for heterosexuals and for people of color. They also stressed the need for programs to: be located outside of drug-infested areas; provide settings that were comfortable, including drop-in centers; offer transportation assistance and child care; and provide appropriate, thoughtful referrals.

Although much of the discussion in the interviews and focus groups centered around meeting the HIV prevention and related needs of those at high risk for HIV, at least as much emphasis was placed on the need for HIV to be in the public eye. Most of the participants agreed that HIV was not on people's "radar screens" due to the lack of public information and HIV education available. As discussed above, many people living with HIV suffered the brunt of widespread ignorance on the part of the general public about HIV and how it is transmitted as well as from the stigma that accompanied such ignorance. Participants also noted that many people did not consider their risks for HIV or take appropriate precautions. When presented with the information that a high percentage of people already had AIDS when they were first diagnosed with HIV, participants offered that this could, in part, be prevented if HIV were more "in people's faces". They called for more widespread public information about HIV using a variety of media such as television, radio, newspapers, and the Internet, as well as fliers and pamphlets placed in multiple locations. A large number of participants thought that straightforward and comprehensive HIV prevention education needed to be taught in schools, beginning when children were young. Several also thought that HIV education should be offered by churches. Another suggestion was that people should learn information and then share it with friends and family. Community events were recommended by several participants as good ways to raise people's awareness about HIV and better understand risk behaviors.

Getting People Into Services. When asked about the best ways to encourage people to participate in HIV prevention programs, the most common suggestion was to offer incentives. These could include money or gift certificates or other things that might attract people such as food, gifts, prizes, and entertainment. Participants especially stressed how important it was for agencies to better advertise their programs so that more people knew they existed. Other suggestions included: conducting outreach, having participants bring friends with them, and providing transportation and childcare.

Role of Health Care Providers. A specific topic of discussion about HIV prevention centered on the role of health care providers. Many of the participants thought it was a doctor's role to provide information about HIV to their patients and talk to patients about their risk behaviors and how to protect themselves. A few mentioned that providers should talk to their HIV positive clients about prevention and talk to the steady partners of positive patients. One participant also offered that doctors should talk to patients about substance use and histories of trauma and provide appropriate referrals. Several people also expressed that doctors and clinics should make condoms and literature on HIV available to their patients. Several participants noted that many doctors needed to learn more about HIV and how to help people to reduce risk. This would involve doctors making sure that they were comfortable talking to patients about sexual behaviors.

HIV Testing

As shown in Tables 5-9 above, 41% of heterosexuals diagnosed with HIV between July of 2004 and June of 2006 were already AIDS cases at the time of or within six months of their first positive test. Forty-three percent of the sample were tested because of illness, and 39% of those testing positive had never been previously tested for HIV. This same pattern of delayed testing for HIV has been documented in published epidemiological information for a number of years. Based on this information, participants in the interviews and focus groups were asked to discuss reasons why many people do not seek testing for HIV and ways to improve testing rates so that more people were aware of their serostatus. Participants were also asked to discuss the role of counseling and HIV testing. Additionally, they were asked their opinions about CDC's current recommendation for "universal" testing in the United States, i.e., the call to offer testing to all people ages 13 to 64 who access health care services for any reason.

When asked why people delay getting tested for HIV, the most common response from the interview and focus group participants was fear. People were said to be afraid of finding out they have a disease that could kill them. They were also said to be afraid of the stigma and discrimination they would be subjected to if they tested positive as well as fear of having to disclose their status to partners. The second most common response was that people did not test because they did not think they were at risk, did not think HIV would happen to them, or simply did not think about HIV at all. The third most common response was that people just did not want to know and therefore would not have to face all of the realities of being positive. They were said to think that if they did not know, it would not affect them. Other reasons for people not testing offered by the participants included: 1) people did not care; 2) fear of their

confidentiality being breach if they went for testing; 3) not being able to afford testing; 4) embarrassment or shame; 5) drug use; 6) lack of education; 7) lack of transportation to test sites; 8) not knowing where to get tested; 9) not having the time; 10) lack of responsibility; and 11) not wanting to admit that their steady partners may be cheating.

Participants in the interviews and focus groups were asked to discuss the role of counseling when people are tested for HIV. A number of participants talked about how counseling was not always offered with testing, which they thought was problematic. Some of the participants who were living with HIV discussed bad experiences when they did not receive counseling following their first positive test. Others spoke of getting messages from their health care providers that were more destructive than helpful. In the majority of the interviews and focus groups, participants talked about the importance and benefits of having counseling available to those testing for HIV. For those testing positive it was important for them to get information from counselors about how to take care of themselves and their partners and how to access medical care and other services that they needed. They also said it was important for people to be given hope, to let them know they were not alone and that there was help available to them for taking care of their health and meeting other needs. For people testing negative, counseling was also seen as important. Participants discussed that people needed help coming to terms with their risk behaviors. They also needed the encouragement and knowledge necessary for lowering risks. A few participants pointed out that health care providers should be better trained to provide appropriate counseling. One person expressed how a counselor needed to know the person being tested in order to be helpful.

The participants offered many suggestions for increasing testing rates. One of the most common responses concerned the need for more advertising and public information about HIV testing. Such information would help people to think about HIV testing, understand its importance and why it is better to know one's status, understand that there is help for those testing positive, learn more about the types of testing available, and learn where they can access testing. The majority of these discussions centered on ways to make testing more available to more people. Participants suggested that more free testing be available in more locations. They especially thought that there needed to be more testing sites in more geographic areas and that there needed to be more outreach testing. Several people suggested that testing be available on the streets in high-risk areas, ideally through the use of a mobile health care van. Other suggestions about where testing should be offered included: substance abuse treatment centers, high schools and colleges, people's homes at "testing parties", community-based organizations, stores, shelters, jails, community health care clinics, and at public events.

Other suggestions concerned the types of people and organizations that should encourage people to get tested for HIV. Some thought it should be friends, family, and partners that encourage people to test, and others mentioned health care providers, counselors, and churches. Several people thought it would be useful for people living with HIV to talk to others and encourage them to test. One person suggested that testing should be offered by people who have HIV or by peers. A few people suggested offering incentives to get people to test. Another person recommended that couples be allowed to test together. Five of the participants expressed that they thought HIV testing should be mandatory.

Almost all of the participants in the interviews and focus groups thought that universal testing was generally a good idea, with many expressing enthusiastic support. They thought it was a very good way for more people to find out their status, especially people that may not normally think of getting tested. If people knew they had HIV, many would be less likely to spread it, and they could access care sooner. Most of the respondents also expressed that testing still needed to be a choice and not something forced on people or done without their knowledge. Many thought that there needed to be counseling provided with testing, and confidentiality needed to be assured. Several participants also noted that the effort for universal testing would not help people who may be at high risk for HIV but who do not tend to access medical care, so outreach testing would still be necessary. One person suggested that if more people were tested for HIV it might alleviate some of the HIV-related stigma.

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 high-risk heterosexuals and injection drug users in Colorado. This needs assessment was designed to address HIV-related issues of a broad and diverse range of people who fall within these categories, however, it was inevitable that adequate representation for all appropriate groups would not be obtained, despite the efforts of R&E staff and colleagues at partnering agencies. Since R&E staff primarily interviewed people who called and volunteered to participate, assuring participation across a broader range of populations was not feasible. Efforts to access more recently diagnosed volunteers from the caseloads of CDPHE disease intervention specialists (DIS) to fill some of these gaps did not prove fruitful. Consequently, few people in their twenties were interviewed. Also, many of the people who volunteered for interviews had been living with HIV for extended periods. Therefore, the sample included fewer people with more recent diagnoses. Several other key groups were not represented or were seriously underrepresented in the sample. Attempts to enlist respondents from African or Latin American countries failed, and efforts to talk to people with HIV living outside of the Denver area resulted in two interviews. Also, given that recruitment of respondents occurred mostly in public clinics primarily serving people with more limited resources, people with higher incomes or socioeconomic status did not participate in interviews and focus groups. Additionally, focus group samples are inherently small and cannot be considered to necessarily represent large numbers of people.

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. The 2003-2004 Needs Assessment Survey (NAS) respondents were recruited by service providers and peers throughout Colorado, and were not randomly selected and cannot be considered representative samples. Despite this, a large amount of rich data was collected from a diverse sample of people that can be used with a high level of confidence for HIV prevention program planning and development.

Another data limitation stems from the nature of HIV reporting. Much of the data analysis summarized above in the section on aggregate data and case reviews is based on information provided by clinicians and information acquired by CDPHE Surveillance staff and DIS. Health care providers often do not report complete information on their patients who test positive for HIV, especially information concerning risk behaviors. Efforts by CDPHE Surveillance staff to fill gaps in information are usually quite fruitful; however, acquiring complete information on every patient is virtually impossible. Some patients die before more complete information is obtained and others are lost to follow-up, often because they leave Colorado or do not return for medical services. Also, medical providers only have the information that patients are willing to share. Other gaps in the information summarized above are inherent to the nature of disease investigations. DIS attempt to follow all possible cases of HIV diagnosed in Colorado by interviewing clients within a short time after their diagnosis. Interviews cover a wide range of sensitive topics concerning risk behaviors and partner information. Some doctors do not give permission for their patients to be interviewed. A number of people that DIS attempt to interview are never located while others refuse to be interviewed. As with the information obtained by other providers, most of the information obtained by DIS is dependent on what clients are willing to share. Some clients are very cooperative in talking to DIS and are grateful for their services, while others can be very apprehensive and provide limited information.

Future assessments need to address the gaps in information described above and increase outreach to underrepresented populations.

SUMMARY AND CONCLUSIONS

Despite the limitations described above, a wealth of information was gained from the 83 people who participated in the interviews and focus groups and through the review of aggregate data and the 195 HIV case summaries of DIS interviews. Several themes can be identified in a review of the information summarized above. The first concerns a general belief that HIV has “fallen off the radar screen.” Most of the participants in this 2007 needs assessment agreed with perceptions of gay and bisexual men who participated in the 2006 assessment that HIV prevention efforts had diminished and were less apparent. The participants thought that HIV was a critical issue that should be addressed widely and in a highly visible, open, and honest manner, with efforts not only targeting individuals considered at high risk but the general public as well. They called for a widespread campaign to remind people that HIV was still a serious problem affecting diverse populations, including heterosexuals. The purpose of such a campaign would be to raise awareness about HIV, provide accurate and relevant information, dispel myths, encourage people to recognize their risks and engage in safer behaviors, and confront the stigma associated with HIV disease.

A second theme is seen in the call for increased HIV prevention efforts. Participants emphasized the need for more programs for high-risk heterosexuals in more geographic areas around the Denver metropolitan area and around the state. According to them, such programs should be tailored to a number of populations including: injection drug users; people with substance abuse problems who are not injectors; people struggling with histories of trauma and other mental health challenges; women; African Americans; Latinos; and people living with HIV. The need

for people to have the opportunity to meet in groups with others with similar backgrounds was particularly clear. Participants also underscored the need for people who are living with HIV or people who have overcome challenges related to substance abuse or mental health problems to provide prevention services to others facing similar issues. Many people who have successfully confronted such obstacles are looking for opportunities to help others, opportunities that could be provided by allowing them to work or volunteer within the prevention system.

Evident in the epidemiological data and reiterated by interview and focus group participants was the need to expand opportunities for HIV testing to prevent extensive delays in diagnosing people who are unknowingly living with HIV. Getting more health care providers to routinely offer HIV testing to their patients was considered a good way to encourage people to test who might not otherwise do so. However, such efforts are not likely to reach people who engage in high-risk activities but seldom access health care or HIV testing. Therefore, the need for outreach testing to be offered in many locations was emphasized. Several participants thought this could be facilitated by the use of a health care van that provided a number of health-related services throughout the Denver area.

A final theme emerging from the information gathered for this needs assessment is the profound interrelationship between HIV, substance abuse, mental health, and other critical life issues that people confront. The review of HARS data and DIS case reports showed that a large number of people testing positive for HIV were also confronting other difficult life circumstances related to substance abuse and poor mental health. These subjects dominated discussions about HIV risk and HIV prevention in the interviews and focus groups conducted for this study as they did in the discussions with gay and bisexual men conducted in 2006, suggesting a need for the HIV prevention system to adopt a more holistic approach and address these important interrelationships.

APPENDIX ONE: NOTES ON SPECIFIC PARTICIPANT SUGGESTIONS

OUTREACH

- Need to do outreach and get condoms to people and clean needles; need to put condoms everywhere
- Need to do outreach to drug users; try to get them to substitute other things for the drugs; something that lifts their spirits and gives them energy
- Get people in to programs through outreach
- Outreach by public health providers
- Having people do outreach that they can talk to; someone they can relate to and trust
- Should do outreach and hand out condoms and lube, etc. and talk to people about HIV and how you get it
- People need to get out there in groups and let people know about HIV, especially injectors
- People who are positive going out and doing outreach, give out condoms and talk to people; people are more likely to open up to people who open up to them
- Some people are better at outreach and handing out condoms; others could help people over My Space, tell them about HIV and give a number to call; they could then pass it on to others
- Wear t-shirts during outreach about HIV prevention with a help-line number
- Latinas need education and outreach to them for HIV prevention; need to go where they are in the communities; they have to trust you
- Do outreach twice a week and hand out condoms
- Need to do outreach and bring women together for a conference; recruit where women are getting out of jail; give them somewhere to go and talk
- Need community outreach in high risk areas
- Have former prostitutes doing outreach to current sex workers; talk to people and hand out safe sex kits and information and do referrals
- Use an outreach van; it's convenient; target high-risk areas with a van; having services on sight helps; drive around to clubs and dope houses; if people see the van they would think about protecting themselves
- Need to do outreach bringing people things they can use and education; take it to people
- Do outreach to women and young girls
- They should employ homeless people to do outreach
- Need to do outreach at clubs, especially when they're closing; pass out condoms at clubs and crack houses
- Would be good for ex users to go out and do outreach
- Do outreach on the bus
- Have tables set up at bars; do outreach testing
- Do outreach at sporting events
- Need large-scale outreach like with breast cancer
- Do outreach in African American communities with PLWH
- Can't do a one type fits all outreach; need different approaches for different types of people
- Have volunteers go out into high risk areas and take condoms and cards with a confidential number they can call for advice, offer testing
- Hand out clean syringes; it helps people to think about a safer lifestyle; it shows people you care for them and helps them to care for themselves
- You have to get down and dirty to help people who are down and dirty; need people who care about others
- You can't stay in the office and help people; you have to be in the streets

GROUPS

- Groups could deal with health issues and family; need groups that include families
- Groups are better for those who are positive because it's the type of disease for which you need support; you can't talk about it with just anyone and you don't feel so alone
- Need groups for positives who are straight and opportunities to meet others who are positive
- Need more support groups for women with HIV; have others who know what you're going through; you don't feel singled out or ashamed; should be led by health professionals that can answer questions
- Groups could be for people of all ethnicities
- Need groups; people put their issues out on the table and talk
- Need programs for those with history of abuse; groups to talk about it; offer mutual support
- Don't know how to reach women with low self-esteem unless they seek help; some might be interested in support groups and some might not
- NA groups should talk about HIV or HCV or why people use
- Support groups; deal with substance abuse; talking with others with the same issues
- Groups would be helpful if they were centered on how to improve your life; rebuild; have goals for the future and talk about how to accomplish them; how to move on
- The more you trust people in a group, the more you'll get out of it
- Get support from groups; hear peoples stories; have something to do besides go out and use
- You can get people into groups by talking to them about it, advertising, fliers, let people know that everyone is welcome who wants help and wants to talk; you get people in by talking to them one-on-one
- Group doesn't care if you got high that day
- They don't look down on you because of who you are or what you have done
- Support groups are good for people with multiple issues
- People need to get into groups that have them face how they were
- Need groups with people in them that won't let you bullshit
- Group leaders need to be aware of the games users play
- Need support groups; people to help you through the tough stuff
- Need to be in groups with women who have been there and gotten through it to know that there's hope
- Should have trauma groups; need to talk to other victims and learn how to forgive ourselves
- Need to have access to mental health services, trauma groups, relapse prevention
- Need to deal with self-esteem in groups and confront societies messages about what women should look like and be like
- Could do groups that include role playing about disclosure; should talk in groups about how to be responsible and not infect others
- Groups are good with other women with HIV; good to do activities together
- Groups should talk about STDs, how to use condoms, female condoms
- Sometimes groups are good, but shouldn't have groups mixed with gay men and straight women
- Do fun things in groups and have dinners for positive women; allow women to take their kids
- There need to be classes in the jails where they allow people to get information or have a support group; talk about HIV and substance use and risks; people are often thinking about changing their lives in jail
- Substance abuse groups should give people the opportunity to talk about HIV and what it's like dealing with it; let people in the group know what can happen if they're not safe
- Have groups where people can talk about issues, STDs, communication with partners; show movies and have discussions afterwards; talk about safe sex negotiation; do role plays

- People leading groups need to be those who have been through what the people in the group have been through
- Have people who used to use go into people's homes to talk (people they know and used to use with)
- Have meetings in people's homes makes it easier for people (especially women) to participate
- Men need to have groups or be in groups with women; it would be good to know what each other thinks; what do the pimps think
- Support groups should include nutrition, mental health, staying clean, prevention, condoms, family relations, talking about feelings, living better, depression
- Have positive people talk to students; then small group discussions
- Talk about past experiences, how people are dealing with things now; talk about living with HIV; talk about how to stay sober
- Girls should get together with each other in schools to talk about issues; so should boys

NEEDLE EXCHANGE

- Need needle exchange; if someone's going to use they're going to use; it doesn't promote drug use, it promotes cleaner health; stops people from getting HIV and HCV
- They need needle exchange if they don't want to stop; there are exchanges all over the world but not here
- Users need needle exchange; Denver is probably the biggest city that doesn't have one
- Needle exchange; people wouldn't leave them around the house or get them mixed up with someone else's
- Need to get needle exchange approved; it needs to start with CDPHE
- Needle exchange should include education on STDs and HIV and prevention materials; red boxes; safe injection spots; places to go to get abscesses treated or cotton fever, etc.; instruction on how to inject safely; instruction on what to look for about different complications; supply cottons and cookers
- Needle exchange should include access to health care; non-judgmental providers; referrals
- Needle exchange isn't the answer; most HIV is transmitted through sex
- If people are going to use they need to know how to do it safely and avoid infections
- Need a place to get free needles 24 hours a day like King Soopers or Walgreens; all pharmacies and stores
- Get kits out there and clean needles
- Needle exchange should also have alcohol pads, etc.; should have counselors; if you want to quit we're ready to help you; be non-judgmental; clean kits are nice; should offer drug treatment; rehab
- NEPs should also have support, prevention information, required meetings or classes, free drug treatment
- Should have indirect exchange

INDIVIDUAL INTERVENTIONS

- Need case managers; help people get the help they need; help keep you on track; help rebuild your life
- Need someone to help you through things; follow you step by step not just refer you to other places; offer encouragement; referrals suck

- Need buddy system program for those living with HIV or hep C; gives people somebody to talk to when they need it
- People with HIV need counseling because their whole life changes
- You need someone to support you that understands; someone to listen to you
- Should do an assessment on people when they test positive, for mental health, substance abuse, homelessness, etc.
- Some people need payees to help them manage their money so they don't spend it all on drugs
- Being interviewed can help people who are positive to sort through things
- Positive women need other positive women as mentors; they know what you're going through and they've survived it; it would give them some hope
- Need one-on-one counseling to get to the nitty gritty of your main problem
- PCM can help get people into substance abuse treatment
- Need to have psychiatric help available; therapists
- Need more one-on-one counseling for people with multiple issues
- Users in rehab need a lot of one-on-one attention so they can talk about their issues
- People with low self-esteem need good one-on-one counseling, someone to listen to them
- With one-on-one counseling the counselor can take the time; need counselors that understand your life experiences; they've lived it
- Counseling is really important for users
- Need help offered to couples
- People with history of trauma need counseling
- Women with history of trauma need to know they are important; need to talk to someone in confidence
- Helps to have counselors available at ID clinics for people to talk to; help with grief
- Need partner counselors to help with disclosure
- PCM can help with disclosure
- Need client-centered counseling

PUBLIC INFORMATION

- Need more resources for information; need more information out there
- Doctors should have information available to put it in people's minds
- Need to have more public information, TV, pamphlets to raise awareness and encourage people to use protection
- People need more information about HIV, risk behaviors, and how it's transmitted
- People aren't hearing enough about HIV; there needs to be more public information
- There needs to be more information out there; TV or whatever; people need to be more aware; they need to realize it can happen to them or even to a 14 year old kid
- Need to have information in the bars about HIV; when people don't see anything about it they don't think they are at risk; if you don't know you don't know what to do
- Once you have information you can do something about it; they can make a choice
- You need to give information to kids in school when they are young; by high school it's too late; doesn't mean you are giving them the OK to have sex; need realistic education; have people with HIV talk to them
- When you give kids information you need to make it fun and interactive
- Need a health and information fair; should do community events to raise awareness/provide knowledge
- Should teach more STDs and HIV in middle schools; talk to kids in school about prevention and about what's true and not true about HIV; give kids in high school information about the risks

- Put ads on My Space; billboards
- TV, Internet; get the information out there; commercials encouraging risk reduction and testing
- Mental health centers should have condoms available and information
- Put information in the unemployment office
- There needs to be more information out there; get HIV back on the front burner; get commercials out there; encourage people to acknowledge their risk behaviors; HIV needs to be in people's faces
- People need to hear about HIV from people who look like them
- Have condoms and information in bars
- People need to be reminded that their lives are precious and they need to protect themselves
- Need to get out information in different manners so it's relevant to different people
- Schools and churches need to stop limiting the information they give to people
- Information needs to get distributed better and not be white washed
- Abstinence only misses the message that needs to be given
- There needs to be more talk and education about childhood sexual abuse
- Have movies that are educational
- Many people with HIV want to talk to people, like kids in school, to help keep them from getting it
- If people were more aware, many of them wouldn't take the same risks
- Use pictures of people with diseases or the diseases themselves and what they can do
- You don't see posters or billboards on HIV now; need more public information
- Need to use role models to talk to young people about using condoms
- Provide brochures with statistics; education about HIV
- Provide education on how HIV and the drugs intermingle
- Have people who are positive talk to negatives, offer education and tell their stories; put real faces to HIV
- Need more public education to all communities to deal with ignorance and make people aware of their risks
- HIV education needs to be all over; it's not going to go away until people are comfortable talking about it
- Address stigma; get society to better understand HIV; need to be commercials that confront the stigma
- Need to advertise services better; people need to know where to go to get help
- People need to know about it before they start using; it needs to be dealt with honestly
- People need to know how important condoms are
- People need to hear messages about monogamy and safe sex if they are going to have different partners
- The schools need to be educating kids about alcohol, drugs, and sex
- People should know what positive people go through; need to know HIV can kill you; that would make them think about protecting themselves
- People need to know about STDs, complications, and that a lot of times there are no symptoms
- Need to get in people's faces and be very up front about HIV risk, that HIV is a reality, and what it's like
- They should show people statistics and tell them stories about people who got infected and how that changed their lives in bad ways; let them know that it not only affects them but the people around them
- Women need to know that they need to use protection because positive partners may not disclose or may lie about their status
- People need to know the consequences of using
- If people knew that a lot of people they know have HIV, there wouldn't be so much discrimination and rejection of those who are positive

- People should confront other people's discrimination; they should educate others
- Married women need to know it can happen to them; have a woman who got infected from her husband tell her story
- Show videos of what really goes on in prison; women don't believe men have sex with other men there
- Need more public announcements like for breast cancer and smoking on TV, the radio, wherever people will see it a lot
- Need to be more public service announcements about safe sex; bombard people with safe sex messages
- There should be famous people talking to the public about HIV to make them more aware
- They have walkathons and rallies; sometimes people are too afraid to participate because of what people might say; you can't worry about that
- They need to do more in minority magazines and bombard people with messages
- Need to make movies and plays shown in the high schools
- Put fliers in the recreation centers; put fliers in Social Services offices; lots of time to kill

PREVENTION WORKSHOPS

- Substance abuse treatment should deal with HIV risk; deal with HIV in drug and alcohol programs
- Safe houses would be an excellent place to reach women about HIV; they could discuss issues more freely
- Could offer free health care classes for women at places like JeffCo Action Center or around churches
- Should do prevention at planned parenthood, dental clinics, homeless shelters, bus stops, on buses
- Offer classes at shelters as a requirement
- People should take classes for free and then go out and share the information with others
- Talk about HIV in the juvenile system; offer prevention classes
- Youth programs should get involved with prevention; have public health people come in
- Classes for positives that help with relationship issues and disclosure
- Six weeks is a good length for classes of about an hour and a half to two hours
- If kids are caught with drugs they should make them go to a class or to therapy
- Safe sex education would be good for sex workers
- Target high-risk men in prison for prevention
- Do prevention at housing projects and have condoms available; have people there they can talk to privately; have referrals; let people know where they can get tested
- Need workshops for individuals and couples to help deal with HIV and partners and communication

RELATED SERVICES

- Need multiple services available in one location and be affordable
- Need more services available in more places
- Need housing; if you have housing you have stability; makes you feel better about yourself
- Need to get away from the environment; need new places and new friends; get away from dealers
- Need employment; help finding jobs or getting an ID; jobs make people feel better about themselves
- More shelters; hard to get in to shelters; a lot of waiting and lotteries; need shelters for couples

- ADAP needs to provide methadone
- They need to provide methadone in jails
- Need services appropriate for straight Black men; services with other people that look like you
- Need more substance abuse treatment available; in-patient facilities; rehab; out patient
- Need medical detox
- A lot of people who are using and in recovery have psychological problems and need help
- Some men need help because of sex addictions; some of them have been sexually abused as children
- Need affordable access to health care; need free health care
- Need access to phones and fax machines, computers
- Need to go through rehab, get away from drugs and alcohol, go to school, get a job; then the self esteem will pick up
- Need more education on nutrition; classes and maybe groceries to take home (healthy foods)
- Agencies need to be better coordinated so you don't have to go to so many places to get help
- Need life skills classes; need help getting your life back together
- People need help getting to services and getting groceries etc.; need transportation
- Hard to access dental care; would help with self-esteem
- Just because services are available doesn't mean they are the right ones (counselors not always a good fit)
- Treatment programs need to be respectful
- Those with multiple problems need counseling, groups, HIV prevention; HIV prevention should deal with all of those subjects
- Women who don't have money should be able to access multiple services, maybe starting with counseling to see what they need; also need access to health care
- Substance abuse treatment can help come to terms with HIV as well
- Kids need to not be so sheltered in some things; people need to talk to them honestly about things like childhood sexual abuse and let them know it's not their fault
- People with multiple problems need immediately accessible mental health care, drug treatment, free condoms, and free needles
- It's easy to find drugs; it should be just as easy to get help to not use
- Teenagers that don't want to do drugs need a place to go; they feel left out; they feel bored
- Rehab can give you tools to quit
- There needs to be more literature available on drug addictions and places where you can get help for free; treatment should not just be available to those with money
- There needs to be more counseling available for addicts; many people need help to get their priorities straight and stay clean
- When users start thinking they don't want to use anymore and live like that, there needs to be treatment available to them right away
- Mental health treatment needs to be free and open to everyone; it shouldn't be available just to those who have the money
- If a person gets sexually abused they should have access to mental health care in the same way someone in an accident gets taken to a hospital
- Everyone deserves mental health treatment; those who go untreated may do horrible things
- People need some place to go to talk openly about their drug problem
- Need to have multiple services available, including assistance with housing, food, drug problems, doctors appointments, job counseling and services, nursing services, etc.
- People need programs to quit and a support system
- There are a lot of types of addictions out there; people need help with the core issues causing them
- Need more drug prevention
- Need more drug programs for women

- Need more things for women to do; activities for yourself or the community
- People need access to treatment when they're ready; shouldn't have to wait; a lot of bad things can happen while people are waiting to get into treatment
- Multiple issues should be dealt with as a package
- Train health care providers to deal with multiple issues
- Need more activities that are free (zoo, movies, rec centers, church activities); poor people need places to have fun
- Need more drop in centers where you can get tested, do your laundry, eat, watch TV, etc.
- Deal with domestic violence, drug use, and STDs too
- Kids need more places to go; someplace where there are people they can talk to
- Need to provide awareness and programs to help users get back on their feet
- Free methadone
- Treatment centers need to have condoms available

APPROACHES

- Need to have people leading who have gone through a situation and know how to deal with it; interventions with people who have been through something similar that can be a role model
- You have to have someone with qualifications to help people handle these issues
- Users need to be treated with respect by providers since they often already feel bad about themselves
- Get people in through word of mouth
- People need to not be pushy or judgmental; make it about being safe and if people want to quit they are there to help
- People providing services need to check on people
- Need harm reduction programs; people can change and come to terms with things at their own pace
- Addicts more likely to listen to other addicts in recovery
- Help people realize they are still beautiful; pamper people with things like make up and hairdos
- Helps to have an ex user talk to people about using and consequences; have them talk to kids
- Users need to hear about how much better life can be when you stop and they need to hear it from someone who has quit and made it
- Whether it's through rehab or therapy, you need to get people to look at what they are doing, look at themselves; getting better takes a lot of soul searching; decide if they really want to live their lives like this
- People need to know they can get help, that they have options other than drugs or suicide
- Need counselors that treat people respectfully
- Really need to get to know somebody through counseling to find out about multiple issues; need to be able to have open discussions with counselors not just screening
- Referrals need to be made thoughtfully
- Need team effort approach to care; need to have an all around system of care
- Social workers should be involved with people from the beginning when they find out they're positive, assess what you need, and help you access appropriate services
- To help people you need to get to the root of their problems, not just treat the symptoms
- You can't baby people and keep bailing them out of the situations they get themselves into
- People with addictions need support to be able to heal
- To address substance abuse among Latinas, need to be honest about it; talk openly about the issues

- Need to show people what drugs do to you over time; to your appearance and body functions (incontinence; ability to get aroused, etc.)
- People need to be taught to love themselves; learn that they're worth something, that they are important
- Need to be able to access clothes and hygiene products; need something to look forward to; need food
- Need more education for health professionals on the nature of addiction
- Helping others is really good for self-esteem; it feels good if people can benefit from your story
- People should go door to door to talk to people about drugs
- Offer incentives
- Personal interventions on the part of loved ones can help; someone that cares telling you there's a problem
- Health care providers should ask about abuse
- People need to have their self esteem built and education; maybe learn a trade
- Should treat addictions as a brain disease
- Teachers need more training in recognizing mental health problems
- Schools and churches need to teach people how to care about themselves
- To help self esteem, need mentors, good role models; need someone who believes in you
- Friends talking to friends; teach people to teach others; people need to talk to their kids more
- Need to have the condoms available; make free condoms available; put them in bars (very visible) and put something that makes them look enticing ('free' sign, colors, blown up condom)
- Get people into programs by offering food, have social events and entertainment
- Offer incentives to people like downloads for their MP3 player or give away an MP3
- Scare tactics can be effective; show pictures of meth mouth
- Can get people into programs with fliers explaining what it's going to be like, what they are going to talk about, what could be helpful
- Put condoms in health care places, planned parenthood, schools
- Could encourage women to use condoms as birth control
- Positive people can teach others about HIV, teach new positives, and can teach doctors about how to treat patients so they will want to go to the doctor; hearing from positive people makes it more real
- Talking to kids may make them more selective when they have sex or use condoms
- Give women the opportunity to talk openly, give condoms, give crack kits, give information on the dangers of getting a virus
- There should be more places where people can get condoms, like bus stops
- There should be someone there to talk to women about female condoms
- Should give out more free condoms; give them out in stores, clinics, gas stations (have a bucket)
- Get buy-in from local business owners
- You need to get messages to people at younger ages
- Make sure programs are publicized
- Need to impress upon people that they don't want to get other people sick and it's better to tell and be embarrassed than not tell and feel guilty
- Show videos of people telling their stories about disclosure
- People need to realize that if someone rejects you because you have HIV then they weren't worth it
- People need support to disclose, someone to help them do it
- Agencies need to be open when people need them (including weekends)
- Need to not send straight people to organizations that are for gays
- There should be a comfortable place for kids to come and someone talks to them about HIV and make sure they have condoms; needs to be a caring environment and offer other services such as transportation

- Need to have fliers and condoms in the straight bars; most bisexual guys go to straight bars
- Need to provide transportation
- Positive people need a place to go that doesn't include negatives
- Public schools need to play a public health role; they need to have counselors that will listen to kids and not tell their parents
- School needs to confront cultural stereotypes about sex
- People who are positive need to get on others about their behavior
- Unless you address substance abuse, housing issue, social interactions, self-esteem, personal stability, etc. nothing's going to change in terms of behavior
- Need to look at successful models in other countries and adapt them to the US
- Working within your community makes you feel better
- Help people figure out their risks, barriers, triggers to prepare them for situations
- Raising women's self esteem would be huge in preventing HIV and being happier
- Parents should get together once a week and have a community thing with the girls; get people in the neighborhood together to talk about STDs and educate young girls of color
- Need to have a faith dimension
- Offer retreats
- Give female condoms
- Need programs to help with self-esteem, hygiene, depression, substance abuse, risk behavior, avoiding risk; one programs should cover all of this
- Need programs to help you understand HIV and what it does, best meds, best clinics
- Make bleach kits more available; don't see them anymore
- Prevention needs to offer child care
- Black women need opportunities to reach out to the community; they can spread the word
- Providers should shadow clients to see what they go through in a day (addicts, prostitutes)
- Have free condoms available at schools, colleges (student union, library, etc)
- Have speakers who are drug users and have HIV to tell their stories; people would relate to them
- Have prisoners with HIV talk to other prisoners and explain the linkages between drug use and HIV
- Deal with multiple issues; physical and mental wellness; exercise, good diet, playing sports
- Women need to be empowered on how to protect themselves, negotiate safe sex
- People need behavioral tools; need to learn ways to change their habits
- The more programs available the better off people will be; people need something pleasant to be doing other than doing drugs;
- Men need more education; they need to hear what the prostitutes have to say
- Need hotlines for women in crisis
- Put the needs assessment to use to create more services
- Prominent people with histories of addiction need to be out there talking about it, what happened to them and their drug use
- Providers should look like people on the streets; it takes someone who has been in jail to motivate some
- HIV and substance abuse need to be addressed at the same time
- Should have opportunities for positive men and women to meet each other
- Family orientation is important
- Put condoms at the food stamp office; put them in other places
- Put condoms and fliers at the shops where they sell pipes
- Need to make other condoms available for those allergic to latex
- They need a center for people with HIV where they can get together and have a meal, swimming, picnics, trips to the mountains, etc.; they could exercise, volunteer, or help out with groups; need a social place
- Sell burritos and give out condoms

TESTING

- Counseling is very important with testing; some people flip out or use drugs/alcohol when test positive
- Counseling is pretty helpful; it makes you relax a little more; you find out who to see if you end up positive (counselor, case manager, etc.) and how to find out how sick you are
- Counseling is important when you find out you're positive; need someone to talk to
- People need to know that there's hope; need to know the health department will be notified
- If they're high risk and negative they need to hear that it's a miracle; they're not immune; some day their luck will run out if they don't change behavior; need to be scared into changing behavior
- Counseling can help people to understand it better; can help people know how not to give it to others; can help people to know where to get help
- Doctors need to be trained to give results in a constructive, helpful way
- People should be counseled before the test
- Nurses should be trained on HIV counseling
- If they are positive there should be mandatory counseling by a doctor or counselor
- Counseling is very important; people need to learn how to take care of themselves so they don't get HIV
- Good to have counseling with testing and give people information they need; but you need to follow up to see if the person followed through with referrals, etc. and how that went
- Counseling messages should encourage people to be honest with their partners, talk about risk, and use condoms
- Should give people information about HIV transmission and STDs, etc
- Telling people to protect themselves can make them think you care about them
- Need to encourage people to stay safe and understand their risks and how to change risk behaviors
- Should tell people statistics, give information on what HIV is and how it's transmitted, symptoms, how to prevent it, where to get medical care, etc.
- High risk people need to be asked if they use protection; need to know they could still be positive; need to know they should keep testing
- Nurses, counselors, and doctors should encourage people to get tested
- Good to not have to draw blood
- Commercials and education are important to get people to test
- Need to have more testing facilities; have it available right on the street
- Should offer incentives for people to get tested
- There should be free testing in a lot of places; places people aren't afraid to go
- Rapid tests are better because it's good to find out right away
- When someone who is positive talks to women about HIV, many want to get tested
- They should test people when they go into and out of jail
- People up on drug charges should be tested
- They should test in substance abuse treatment centers and places where users hang out
- There should be more news programs about testing and about HIV; newspaper ads
- Give out free coupons to get tested
- Should set up tables outside of clubs and offer free HIV testing; also bars, concerts, football games, etc.
- HIV needs to be more in people's faces so they understand their risks and get tested
- Offer testing in places where people sell drugs

- People need to know things like you can test anonymously or about the rapid test
- Need to reinforce why it's important for people to know
- Testing should be mandatory
- Testing needs to be encouraged by those with HIV, in the family, and in the church
- Good to offer to go with someone to get tested; offer support
- Need to advertise testing locations
- Do outreach testing and testing in people's homes
- Have parties and offer testing and condoms
- Have testing available at CBOs
- Need outreach testing from a health van
- People don't test due to lack of money
- Make testing available in stores
- It's good for couples to get tested at the same time; some test sites won't allow that
- Peers, PLWH, other qualified people should provide testing
- Need more testing at Stout Street Clinic
- Need testing on campuses, homeless shelters, public events
- Need to make testing attractive; make it easy; market it
- Have victim's advocates encourage people to get tested

ROLE OF HEALTH CARE PROVIDERS

- Doctors and med students need to learn more about HIV; and they should talk to their patients
- Doctors should talk about prevention to positive patients
- Health care providers should do prevention talks
- Doctors should talk to patients about condoms and risks
- Health care providers can play a big role in prevention; they should counsel their patients no matter what they come in for
- Doctors need to learn to talk to their clients about sexual and other risk behaviors
- Doctors should have counseling available
- Should follow up with patients who don't come in
- Doctors should talk to partners so they understand HIV and know that they should test
- They should be providing syringes and condoms with no questions asked
- Doctors need to take more time with patients and know their history; get on them about unsafe behaviors
- Doctors need to encourage people to have an active life and not seclude yourself from others
- Doctors should teach you how to take care of yourself, understand your own risks, how to prevent it
- Need to have condoms in the clinics, especially infectious disease clinics
- Doctors should talk to pregnant women who are not married or women going in for birth control about being safe and making good choices
- If women go in with STDs, talk to them about safe sex
- All of your doctors need to communicate and be on the same page
- Should provide information at doctors' offices and clinics about where women can get help with mental health issues and histories of trauma; doctors should talk to their patients about it