

2011 HIV PREVENTION NEEDS ASSESSMENT

A Focus on Youth

**COLORADO HIV/AIDS
CARE AND PREVENTION COALITION**

HIV PREVENTION ADVISORY COMMITTEE

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INTRODUCTION

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) remains a major health concern in Colorado with 2,150 cases newly diagnosed in the state between 2006 and 2010.¹ Of those, 25 people have since been diagnosed with AIDS in other states, leaving a total of 2,125 that are still considered as Colorado cases. During that five-year period, the highest percentage of diagnosed HIV/AIDS cases continued to be among the diverse population of men who have sex with men (MSM) (including those with a history of injection drug use) who constituted 68 percent of the total cases. This compared to people with identified heterosexual risk (HET), who made up 14 percent of HIV cases during that period and injection drug users (IDUs) who made up six percent. Another 12 percent was made up of people with no identified risks (NIR), and one percent was pediatric cases.

In 2006, the Research and Evaluation Unit of the Colorado Department of Public Health and Environment's (CDPHE) Sexually Transmitted Infection/Human Immunodeficiency Virus (STI/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, an assessment was conducted in 2007 focusing on the needs of heterosexuals, including IDUs, who engage in high-risk behaviors. In 2009, the HIV Prevention Advisory Committee (HPAC) took the place of CWT as part of a statewide restructuring of community planning, combining both HIV prevention and HIV care and treatment groups into a single coalition. In 2010, after reviewing epidemiological and other information focusing on younger populations who were contracting HIV, the HPAC decided to include youth 12 to 24 as a priority population to better concentrate on their prevention needs. In order to understand those needs more comprehensively, the HPAC selected youth to be the focus of this 2011 needs assessment.

METHODS AND PARTICIPANTS

Three principal methods were used in gathering data for this needs assessment, including: 1) reviewing aggregate epidemiological data drawn from the Electronic HIV/AIDS Reporting System (e-HARS) and the Patient Reporting Investigating Surveillance Manager (PRISM); 2) conducting 10 focus groups with 62 representatives of high-risk youth populations and three groups with 19 service providers to high-risk youth; and 3) conducting 15 one-on-one interviews with youth, 13 of whom were living with HIV. Additionally, one key informant interview was conducted with a psychologist from the University of Denver whose work focuses on youth who have experienced physical, sexual, and psychological abuse.

Two of the three provider focus groups were held in Denver at the GLBT Community Center (The Center). The third was held in Ft. Collins at the Northern Colorado AIDS Project (NCAP). Organizations represented included:

- The Center
- CDPHE Adolescent Health
- The Empowerment Program
- Urban Peak
- NCAP

- Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
- It Takes a Village
- Addiction Research and Treatment Services (ARTS) Special Services
- Children’s Hospital
- Reflections for Youth, Inc.
- Larimer County Health Department
- Planned Parenthood of the Rocky Mountains
- Look Both Ways for Reproductive Health
- Sexual Assault Victims’ Advocates Center
- Lambda Community Center

The focus groups with youth included the following populations of people under the age of 25:

- Two groups of MSM mixed race (one group at the community-based organization [CBO] Rainbow Alley and one on the Auraria campus in Denver)
- One group of African American MSM (at It Takes a Village in Aurora)
- One group of African American women (at It Takes a Village in Aurora)
- Two groups of homeless youth (held at Urban Peak in Denver)
- One group of gay, lesbian, bisexual, and transgender (GLBT) youth (at Inside Out in Colorado Springs)
- One group of high school aged females (at the Opportunity Center School in Grand Junction)
- One group of Latina women (at Decatur Place Apartments in Denver)
- One group of Latino MSM (at Sisters of Color United for Education in Denver)

A total of 77 young people representing diverse populations participated in the youth focus groups and interviews for this need assessment. Table 1 describes the interview participants. Table 2 shows a demographic breakdown of the focus group participants based on race/ethnicity, age, and risk group.

Table 1: Interview participants by race/ethnicity, age group, and risk group

Race/Ethnicity	Males	Females	Total
African American	5	2	7
Latino	2	1	3
White	4	1	5
Age Group			
	Males	Females	Total
15 – 19	2	3	5
20 – 24	9	1	10
Risk Group			
	Males	Females	Total
MSM	11	0	11
Heterosexual	0	2	2
Pediatric	0	2	2
Total Interview Participants	11	4	15

Table 2: Focus group participants by race/ethnicity, age group, and risk group

FOCUS GROUP PARTICIPANTS				
Race/Ethnicity	Males	Females	Transgender	Total
African American	11	5	1	17
Latino	5	7	0	12
White	11	10	0	21
Mixed race	4	1	1	6
Other	4	0	0	4
Unknown	2	0	0	2
Age Group	Males	Females	Transgender	Total
15 – 19	7	11	0	18
20 – 24	27	12	2	41
Unknown	3	0	0	3
Risk Group	Males	Females	Transgender	Total
MSM	21	0	0	21
Heterosexual	14	20	1	35
Other	0	3	1	4
Unknown	2	0	0	2
Total Focus Group Participants	37	23	2	62

AGGREGATE DATA SUMMARY

Between January 1, 2006, and December 31, 2010, there were 2,150 cases of HIV newly diagnosed in Colorado. As of June 30, 2011, 2,125 of these were considered Colorado cases. Of those, 15 percent were between the ages of 13 and 25 years of age; 22 percent of whom were diagnosed with AIDS within the first 12 months of their initial HIV diagnosis. Tables 3 through 9 provide a brief demographic profile of those cases. Table 3 focuses on the geographic locations of those cases, highlighting that over three-quarters of the cases (77 percent) occurred in the Denver metro six-county area, and another 18 percent were reported in other urban areas around the state. Figure 1 shows the zip codes in the Denver area where the HIV rates among youth are highest. Table 4 breaks the cases down by age group, showing that the vast majority (85 percent) were among people ages 20 to 24 years of age. Both Tables 3 and 4 show the breakdown of cases by gender, with 87 percent of the reported cases occurring among men and 13 percent among women.

Table 3: 2006 – 2010 Youth 15-24 years of age diagnosed with HIV by area of residence and gender

	Male	%	Female	%	Total	%
Denver Metro	210	78%	31	76%	241	77%
Other Urban	50	19%	7	17%	57	18%
Rural/Frontier	10	4%	3	7%	13	4%
Total (% of row)	270	87%	41	13%	311	100%

Figure 1: Denver 2007- 2010 HIV Rates per 100,000 Among 15-24 Year Olds by Zip Code

Denver 2007 to 2010 HIV Rates per 100,000 Among 15 to 24 Year Olds by Zip Code

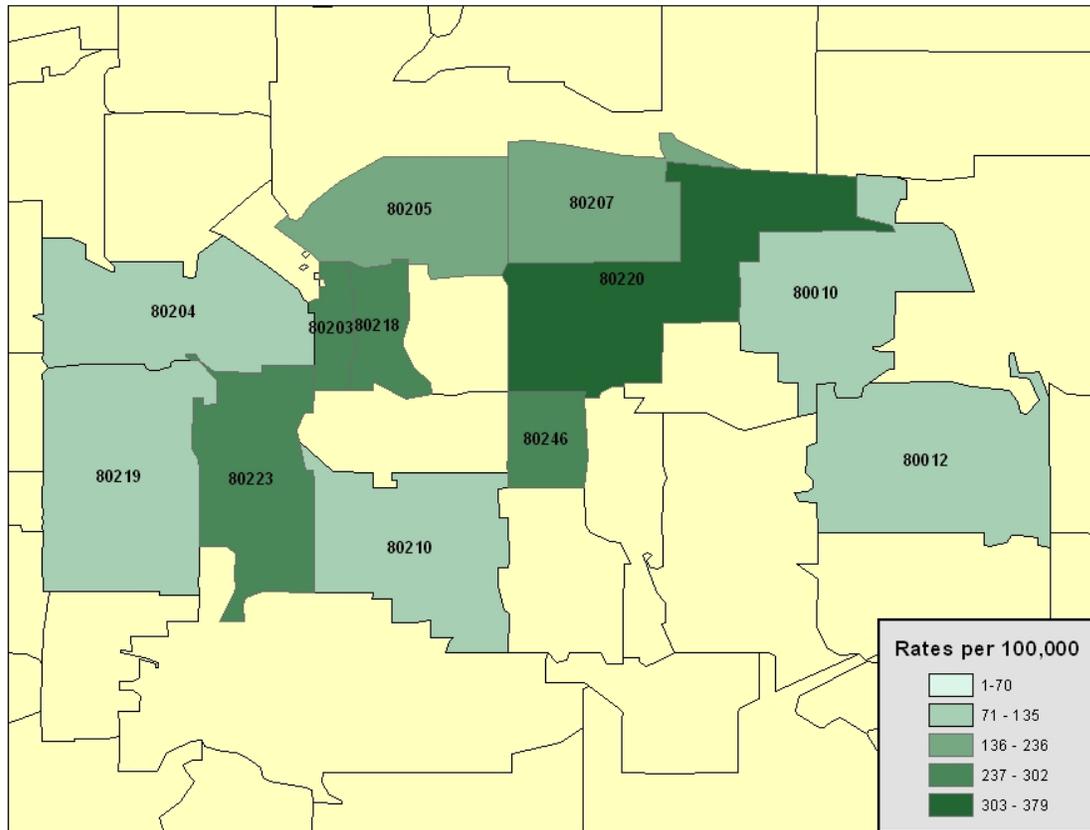


Table 4: 2006 – 2010 Youth less than 25 years of age diagnosed with HIV by age group and gender

	Male		Female		Total	
15 – 19	39	14%	9	23%	48	15%
20 – 24	233	86%	30	77%	263	85%
Totals (% of row)	272	87%	40	13%	311	100%

Tables 5 through 7 provide information related to race and ethnicity broken down by age group and gender. As shown in Table 5, there were only small differences in the age breakdown among the three major racial/ethnic groups of African Americans, Latinos, and whites, with those in each age grouping varying by less than five percent between the three groups. However, much more significant differences were apparent when broken down by gender. Tables 6 and 7 show two different perspectives on this relationship. Table 6 shows that a much higher percentage of the African American cases were reported among women at 33 percent, compared to 11 percent among Latinos and 8 percent among whites. Table 7 shows that among male cases, African Americans made up 13 percent compared to four percent of the Colorado population being African American. Latinos made up 36 percent of

male cases and 21 percent of the Colorado population. African American women made up the highest percentage of cases among women at 42 percent. Latinas made up 29 percent of the female cases. White women had the lowest proportion relative to their population numbers, among the racial/ethnic groups, making up only 27 percent of female cases. Although these differences are substantial and reflect the numbers of HIV cases among all age groups, given the overall low number of cases among females under the age of 25 during this five-year period, caution should be taken in the interpretation of these data.

Table 5: 2006 – 2010 Youth 15 – 24 years of age diagnosed with HIV by age group and race

	African American		Latino		White		Other		Total	
15 – 19	9	17%	16	15%	23	17%	0	0%	48	15%
20 – 24	43	83%	93	85%	115	83%	12	100%	263	85%
Totals (row %)	52	17%	109	35%	138	44%	12	4%	311	100%

Table 6: 2006 – 2010 Youth 15 – 24 diagnosed with HIV by gender and race

	African American		Latino		White		Other		Total	
Male	35	67%	97	89%	127	92%	11	92%	270	87%
Female	17	33%	12	11%	11	8%	1	8%	41	13%
Totals (row %)	52	17%	109	35%	138	44%	12	4%	311	100%

Table 7: 2006 – 2010 Youth 15 – 24 diagnosed with HIV by race and gender

	Male		Female		Total	
	#	%	#	%	#	%
African American	35	13%	17	42%	52	17%
Latino	97	36%	12	29%	109	35%
White	127	47%	11	27%	138	44%
Other	11	4%	1	2%	12	4%
Total (row %)	270	87%	41	13%	311	100%

Tables 8 and 9 show 2006 through 2010 male and female cases under the age of 25 based on risk categories. Overall MSM made up 90 percent of all male cases and 78 percent of all cases reported during that time period (see Table 8). This included MSM who were injection drug users (MSM/IDU) and those who also reported having sex with women (MSM/W). A somewhat higher percentage of 15 to 19 year old males were MSM at 95 percent compared to the 20 to 24 year olds at 89 percent. Among males, six percent reported having sex with women only (including one person who also injected drugs), and one percent reported IDU risk only. Three percent had no identified risk. Among female cases, all reported heterosexual risk (WSM). Nine percent of the female cases also reported injection drug use (WSM/IDU), and in 10 percent of the female cases, the women reported having sex with male partners

who were bisexual (WSBM). Again, caution must be exercised in the interpretation of small numbers.

Table 8: Males 15 – 24 diagnosed with HIV 2006 through 2010 by age group and risk group

	MSM (90 Percent)								HET (6 Percent)		IDU (1 Percent)				NIR (3 Percent)		Total	
	MSM		MSM/W		MSM/ IDU		MSM/W/ IDU		MSW		MSW/IDU		IDU		#	%	#	%
	#	%	#	%	#	%	#	%	#	%	#	%	#	%				
15-19	31	17%	5	13%	1	6%	0	0%	0	0%	0	0%	1	50%	1	11%	39	14%
20-24	155	83%	33	87%	15	94%	3	100%	15	100%	1	100%	1	50%	8	89%	231	86%
Total	186	69%	38	14%	16	6%	3	1%	15	6%	1	<1%	2	1%	9	3%	270	100%

Table 9: Females 15 – 24 diagnosed with HIV 2006 through 2010 by age group and risk group

	WSM		WSBM		WSM/IDU		WSBM/IDU		Total	
	#	%	#	%	#	%	#	%	#	%
15-19	8	24%	0	0%	1	33%	0	0%	9	22%
20-24	26	76%	3	100%	2	67%	1	100%	32	78%
Total	34	83%	3	7%	3	7%	1	2%	41	100%

A review of interview records in PRISM of women under 25 diagnosed with HIV between 2005 and 2009 showed no particular patterns in terms of risk behaviors or number of sex partners. Among the 38 women for whom such information was available, 39 percent reported one sexual partner in the previous year, including 11 percent who reported only one lifetime partner. Thirty-two percent reported two to five partners in the previous year, 11 percent reported six to 10 partners, and 18 percent reported having over 10 partners. Other data on these cases included: 27 percent with a history of substance abuse; 16 percent with a history of sex exchange; and 12 percent with a history of homelessness. Twenty-seven percent reported having HIV positive partners who did not disclose their status to them.

As noted, 22 percent of those diagnosed with HIV between 2006 and 2010 were also diagnosed with AIDS within 12 months of their initial diagnosis, suggesting that many people in this age group did not receive HIV testing until their disease had reached an advanced stage. Table 10 shows a demographic breakdown of those who did and did not have an AIDS diagnosis within one year of their initial diagnosis. The table indicates substantial differences in racial distribution and country of birth between those with an AIDS diagnosis less than a year after HIV diagnosis, and those who did not.

Table 10: People 15 – 24 diagnosed with HIV 2006 through 2010 by diagnosis type (HIV versus AIDS within 12 months of initial diagnosis) and other demographic factors

	HIV		AIDS diagnosis within 12 months		Total
	#	%	#	%	#
GENDER					
Male	210	78%	58	22%	268
Female	32	78%	9	22%	41
RACE/ETHNICITY					
African American	39	76%	12	24%	51
Latino	73	68%	35	32%	108
White	120	87%	18	13%	138
Other	10	83%	2	17%	12
AGE GROUP					
15 – 19	42	89%	5	11%	47
20 – 24	200	76%	62	24%	262
REGION					
Denver Metro	190	79%	51	21%	241
Other Urban	43	78%	12	22%	55
Rural/Frontier	9	69%	4	31%	13
COUNTRY OF BIRTH					
USA	217	81%	50	19%	267
Mexico	10	53%	19	47%	19
Other*	15	65%	8	34%	23
PRIMARY RISK GROUP					
MSM	191	79%	52	21%	243
Heterosexual Only	41	79%	11	21%	52
IDU Only	7	100%	0	0%	7
NIR	5	56%	4	44%	9
TOTALS					
Totals	248	78%	67	22%	311

*These 23 cases were among people born in 14 separate countries with no more than two cases in any one particular country.

OVERVIEW OF INTERVIEW AND FOCUS GROUP INFORMATION

The participants in the interviews and focus groups were asked to discuss a number of topics related to youth and HIV. These topics included the following: 1) youth and their risk for HIV, including which populations of youth were most at risk for HIV and why and the factors that most significantly influence risk-taking behaviors; 2) the principal life concerns of high-risk youth, including the extent to which they are concerned about HIV; 3) the most important needs of high-risk youth; 4) the assets of youth; 5) the communities of which they feel a part; and 6) the best ways to meet the HIV prevention needs of high-risk youth, including ideas for prevention strategies, public information campaigns, and the most appropriate providers of services. The following review includes some quotations from the interviews and focus groups that are displayed in italics.

Youth and HIV Risk

Youth interview and focus group participants were first asked about the populations of people under the age of 25 years who they thought were most at risk for HIV. Most commonly discussed were young gay men, for whom much of their risk was attributed to a gay culture that normalizes high levels of substance abuse, sex with multiple partners, and anonymous sex rather than relationships that were more long-term. Young gay men said that they felt pressure to conform or risk not being accepted. Others commented on how sex education in schools is not tailored to gay youth, so they may learn little about their risks. Also parents are often uncomfortable talking to their gay children about sex. Two participants mentioned that gay men were more vulnerable because of anal sex being the highest risk sexual behavior.

“And like the bar scenes are really, really bad now. I remember my first time going to the bar. I thought that people would want to get to know your name. They’re going to want to talk to you in the bar before they want to take you home. People don’t want to talk to you in the bar. They just want to take you home, and that to me is really, really promiscuous.”

“Like, with my family, all of my brothers and sisters got the sex talk but when my parents found out I was gay, they just didn’t feel like that was something that they wanted to discuss with me, and so there was no guidance, there was no role model for me on that.”

Teenagers were also commonly cited as being at high risk for HIV, much more frequently than were young adults. Explanations for this ranged significantly. Many cited the high level of drug and alcohol use among teens. Others expressed that teens did not get enough good information about HIV and risk behaviors from schools or guidance from parents. A lack of good role models for teens was also mentioned. Instead, teens are exposed to a high level of sexualized material through the media, encouraging them to be sexual before they may be intellectually or emotionally ready. Participants also frequently mentioned that many teenagers go to parties and/or have sex because there is little else offered for them to do. Peer pressure was also said to be a significant factor in encouraging sexual activity among teens as were simple curiosity and rebelliousness.

“Younger people don’t know as much about safe sex. They might be more curious and not think about safe sex.”

“There are no role models out there, and the role models that we do have are pregnant, gay or having sex at a young age. Like they have that show “Sixteen and Pregnant”. That’s the most obnoxious thing to me because it glamorizes being pregnant at an early age. You don’t see girls that are struggling at home, and they can’t go to school because they have babies. You see these upper class people whose parents are going to take care of the baby anyway and like maybe the girls get to move in with their boyfriend or their boyfriend gets to move in with them. That’s not real life, to me.”

“When there’s nothing else to do, you can always have sex. It’s the one thing you can do with no money.”

Several of those who discussed young women as being particularly at high risk for HIV attributed that to the high-risk behaviors of their male sexual partners, especially those who also had sex with other men. Others cited what they saw as women’s socialization to seek

love and find their identities in their relationships with men. One person mentioned low self-esteem in women as a factor, and another pointed to the high incarceration rate among African American men causing a lack of available men and lower levels of monogamy in the Black community. A fourth population that was frequently cited as being vulnerable to HIV were youth coming from environments of poverty, neglect, abuse, and instability.

“There are a lot of men who identify as being straight and they’re not, and it’s like really common, like I see girls with guys that I know are sleeping with other guys and they’re not telling the girls. So they might have sex with a guy, and then go back and sleep with the girlfriend and the guy was positive, and so now the girlfriend is positive too.”

“When you are on your own you get into survival mode and are not thinking of the consequences. Many who have HIV were out working the street because they didn’t have anybody to take care of them.”

Service providers who participated in the focus groups and the key informant interview developed a long and more specific list of youth that they thought were at highest risk for HIV, most of who could be considered as being part of disenfranchised populations and are facing multiple difficult life situations. These included: 1) gay males, 2) homeless youth, 3) youth with histories of trauma and mental health problems, 4) those living in poverty, 5) youth in the foster care and child welfare systems, 6) those coming from substance using families, 7) sex workers, 8) immigrants, 9) gang members, and 10) people of color.

Providers spoke of how gay youth are often subjected to stigma and discrimination in their families and communities. This can affect their self-esteem as well as a heightened fear of rejection, making them more susceptible to peer pressure and vulnerable to predators. Many remain “closeted,” especially in rural areas, often preventing them from accessing resources, and leading them to look for companionship in public sex environments and over the Internet. Youth that come from unstable family environments often face high levels of vulnerability in many areas of their lives. Many of these youth have a history of sexual, physical, and emotional abuse, which often lead to substance abuse, homelessness, and situations involving high-risk sex. History of trauma can affect their ability to establish boundaries, their level of self-esteem, their ability to self-protect, or their tendency to self-harm, all of which make them more vulnerable to older people who prey on them. Youth who run away from their homes or are thrown out of their homes often end up developing survival skills that include exchanging sex for food, a place to stay, money, or drugs.

“Many young men are easily manipulated by older partners due to lack of knowledge. Many were touched (inappropriately) when they were younger. They get information from partners, and it’s not easy to advocate for themselves.”

“Some youth come from families who use together. Some use their kids to get what they need. Their families put them to work the streets.”

“Many youth impacted by any type of trauma, who are homeless or struggling with gender identity, etc.; don’t have good boundaries. Women in jails all have a history of trauma. Many were kicked out of their homes. They don’t understand what healthy relationships are.”

Young people who end up in the child welfare system frequently do not end up in stable environments as they are moved from place to place. They often do not get consistent or any guidance from adults about healthy relationships or safer sex. Some do not understand that they have the right to consent to what they want to engage in sexually, much less condom negotiation. They are also less likely to consistently get basic health education and sex education in a school setting. For those with cognitive disabilities, even if they are getting the education, they may be unable to process it effectively. Those not getting comprehensive sex education are often getting their information from peers or other unreliable sources, leading to many misconceptions about sex and safer behaviors. Several providers also mentioned the vulnerability of young Latinas who may be more prone to follow stricter gender stereotypes of pleasing male partners or not reporting abuse in order to maintain family relations. Others discussed the difficulties faced by youth who are raised in families of substance users who see substance abuse as normal and who often end up with addictions themselves or end up forced into prostitution to support their own drug habits or those of their parents. Gang members, especially females, are subjected to violence and often find themselves in risky sexual situations.

“It’s amazing that they (girls in the child welfare system) have come this far in life where they already have children, and no one’s talked to them about the fact that they have a right to consent to what they want to engage in sexually, much less condom negotiation. They don’t get that anywhere. There are parts of adolescent development that they aren’t getting. Some are bouncing between foster homes, so maybe they aren’t in school consistently to get basic health education in a school setting or they’ve failed out of traditional schools. They might be in residential treatment centers and there’s not enough time.”

Influences on HIV Risk

As with adults, multiple factors, often occurring in combination, influence young people’s propensity to be exposed to high-risk situations and engage in high-risk behaviors. The list of influences on high-risk behaviors discussed by the youth and provider participants in the interviews and focus groups was long and complex. By far, the influence most commonly discussed by the youth participants was alcohol and drug use. Substance use was said to be very common among teens and young adults and often was associated with high-risk sexual activities. For teens, attending parties at their friends’ homes was said to be a very common activity, often occurring more than once a week. Participants described such parties as places where young people abused a large amount of substances and had sex, often with multiple partners and rarely with condoms. For older youth, the club scene also involved getting drunk or high and hooking up with someone for sex. As mentioned above, gay youth participants talked about alcohol and drug abuse and having high-risk sex as being part of gay culture. Youth were said to use a number of different drugs, but methamphetamine use was said to be particularly common among gay males.

Most frequently participants talked about how people’s judgment is impaired when under the influence, making them forget about using condoms, be more likely to have multiple partners, and leading them to be more willing to trust sex partners that may not care about their safety. Some participants discussed drug and alcohol use as their way of “self-medicating” in order to forget about abuse and other forms of trauma, and described often drinking to the point of blacking out. One of the most disturbing aspects of the discussions around substance abuse

among both gay and straight teens and young adults was how commonly drugs were used to facilitate rape, including in places where many others were around such as at house parties or clubs. Many participants described how some men would put drugs in the drinks of people they wanted to have sex with, and proceed to commit sexual assault when the person was passed out. In other cases, people described men who continued to convince someone to drink or get high to the point where they would have sex with them.

“Drug use is devastating in the gay community, especially with meth and the party and play scene. A lot of guys are doing it secretly because of the stigma of meth.”

“Mostly the parties here is where everything happens. Now that it’s summer, they can happen every single day. During school it’s mostly on the weekends. There’s alcohol there or drugs, maybe Ecstasy. Some go to the parties already messed up. Usually the sex happens at the parties. Guys will meet girls, and they’re already hyped up. They’re not really thinking. They’re just going by how they feel. They’ll eventually have sex there or go somewhere else and have sex. Some girls are even raped at some of the parties. Everybody is so messed up they don’t even know what’s going on.”

The second most discussed influence on young people’s risk behavior concerned the lack of accurate and comprehensive information about HIV, including people’s denial of their risk and misunderstandings of the potential consequences of risk behavior. In fact, young people were said to often not think that HIV would affect them, so they commonly paid little attention to the information they did receive or often relied on misinformation about risk. Such misinformation included ideas that they would be able to tell if a partner had HIV or that only gay men or, more specifically, only older gay men had it. Participants blamed the lack of information on a combination of a number of factors including: 1) lack of effective education in schools; 2) parents’ reluctance to discuss sex with their children, especially if the children are gay; 3) the fact that there is little attention paid to HIV in the media, and therefore young people rarely hear about it; and 4) because many do not know others who openly have HIV, and the reality of their potential risk has not set in. The providers participating in the needs assessment agreed that lack of proper education about HIV influenced risk. School sex education was often said to lack comprehensiveness, especially when it came to issues around sexually transmitted diseases, sexual orientation, and the risks associated with different types of sex. One provider discussed problems that young people with cognitive disabilities could have in processing the information sufficiently, and another emphasized that often people with histories of trauma are triggered by discussions of sex and safer sex and may disassociate from those discussions and not retain the information.

“Our generation is kind of dumb. People baffle you. They judge partners by looks--he ain’t got nothin’-; or when you think of the whole DL (down low) thing, they say I know he isn’t gay because he’s my baby’s daddy. Or women think the pill protects them from everything. We forget all of that. People think they’re invincible and can do whatever they want. There’s a lot we don’t know, but we do know how to protect ourselves, but often we won’t. We think we know everything. “

“There’s a lot of ignorance. Shows on TV don’t help.”

“The reality hasn’t set in for them. The younger you are, it’s less likely that you’ve experienced that. I’m not saying they haven’t, but I’m betting not a lot of 15-year-olds have had a lot of people or a lot of friends die from AIDS. “

A third major influence on HIV risk cited by the youth participants involved the impact of peer pressure on people’s behavior. As mentioned above, gay youth spoke of how having anonymous sex was seen as a norm within the community, much more so than trying to develop deeper relationships with other men. Gay and straight youth discussed the norms of both the party and club scene as involving high levels of substance use and unsafe sex as norms to which people are pressured to conform. Out of a need to be accepted or fit in, young people feel pressured to do what they see others doing, even when they may not feel comfortable with it. Some participants also mentioned that it was common for people who were virgins to be ridiculed by their peers.

“Some (gay men) use protection, some don’t. It depends on what club or bar you go to, what group you’re in, where you go to meet people. Different places have different norms. Some foster a lot of unsafe sex and it becomes the norm for the individuals. Other places may generate more responsibility.”

“Trying to be somebody you’re not. You’re trying to fit into your crew. Not sure what you really want. It’s not even for you. “

“I don’t think it’s a lack of education. Everyone already knows. It’s more of a peer thing. Peer pressure can involve smoking and drinking and sex also. You might go against your morals just to be part of the group. You forget about safety when you’re concerned with your image.”

“In high school people brag about who they slept with. If you’re not that type of person, you may do the same to fit in and be able to have the same kind of conversations. You want to be cool.”

The fourth most commonly cited influence on risk concerned mental health issues. Youth participants discussed how homophobia, other forms of discrimination, stress to succeed, neglect within families, and histories of sexual, physical, and emotional trauma can all affect how people feel about themselves and how they act on those feelings. Substance abuse was seen as a common result of such mental health problems as were low levels of self-esteem or self-respect, self-destructive behaviors, or the need to fill emotional voids such as feeling unloved or undervalued. Young people often dealt with these problems through high-risk sexual behaviors.

“I think that can be traced back to like bullying in high schools or in middle schools, and even at home and you can’t like walk around the halls without someone doing something mean to you or saying a racial slur or something about your sexuality or something, and you turn to drugs because it makes you feel better, and then that can also lead into you have sex a lot more often, and you don’t really care what happens to you because everybody else doesn’t care so you might as well not care either.”

“You can have all the condoms and education you need, but if you don’t feel good about yourself, especially if you’re a black gay male, if you don’t have confidence, you’ll let anybody do anything to you.”

“I would say depression. Sometimes people get depressed and they become promiscuous. That’s how they let it out.... They’re lonely, you know. If someone gives them attention, they just go with it. Some women have been sexually abused, and they turn to sleeping with multiple people. A couple of my friends that have been sexually abused now are very promiscuous.”

Providers participating in the study also emphasized the serious impact that mental health problems had on risk behaviors. They emphasized that youth who are impacted by trauma, homeless, or struggling with gender identity often do not have good boundaries and do not understand healthy relationships. For young people living with HIV, stigma often prevents them from disclosing their status to others out of fear of losing the support of their friends or being rejected. Gay men of color were said to be especially vulnerable to being shamed within their families and communities, and more likely to stay closeted or not disclose a positive HIV status. Women with a history of sexual violence may not know that they have a right to consent, that they should use condoms, or how to negotiate condom use, especially if they perceive that broaching the subject could cause conflict. All youth with such a history are at much higher risk for substance abuse, for participating in self-harming behaviors, and for experiencing re-victimization, which can often involve HIV risk.

“Many gay Black youth are immersed in their religion but getting negative messages about who they are. There are no positive messages about gay sex. They get shamed about it and then try to hide it.”

“A piece on behavior related to re-victimization with a history of sexual violence, you might know how to use a condom and that you should use a condom, but you might not have the interpersonal skills to negotiate condom use, or you may have cognitive biases that you’re with a partner who might say no, and you may not know what to do after that.”

Other influences on HIV risk behavior discussed by the youth and providers participating in this assessment included the following:

- Many participants discussed the prevalence of coercion on the part of sex partners who would take advantage of vulnerable youth and their need for love and acceptance. Their strategies included: convincing the youth that they loved them and would take care of them no matter what happened; convincing them that they were “clean” and that nothing bad could happen; or convincing them that condom use would diminish the experience. Participants commonly spoke of older people that preyed on younger ones. This was said to be especially common in the gay community, as older gay men frequently pursued younger, more vulnerable men. Participants also discussed that homeless youth, both male and female, were often coerced into having sex with older partners in exchange for food, a place to stay, drugs, money, or other needs.
- Another set of influences on HIV risk concerned what participants described as the propensity for youth to act carelessly without thinking of or caring about potential future consequences or their tendencies to want to rebel against what adults and society tell them they should do. Unsafe sex was seen as fun, pleasurable, and not something to be

interrupted in the heat of the moment by dealing with condom use. Some talked about the desire to experience things as they grew older, including sex (sometimes with both males and females) and drug and alcohol use.

- As mentioned, many participants thought that the media had a huge impact on young people. They talked about how much sexual content youth were exposed to on TV and the Internet, making casual sex seem normal and expected. The potential consequences of casual sex were rarely portrayed through the media, and the virtual lack of any mention of HIV kept the subject from people's minds.
- Others discussed the difficulties that many young people had in accessing prevention materials. Condoms were considered as very expensive for those with little income, and many did not know where to access free condoms. The lack of needle exchange programs was also discussed as limiting access to sterile syringes by injection drug users.
- Participants in the group also discussed how many people may not think that their behaviors are high-risk because they do not have multiple partners or because they discuss HIV status with partners. However some of those partners were said to not disclose high-risk behaviors or HIV positive status.

Concerns of High-Risk Youth

Youth and provider participants in the interviews and focus groups were asked about the principal life concerns of young people. By far, the most common set of answers related to their emphasis on gaining the acceptance and approval of others. This most commonly meant acceptance by their peers, but it also included their parents, other adults, and society at large. Pressure to conform to what other young people were doing, especially during the teenage years, was powerful, dictating how people looked and dressed, who they hung out with, the cars they drove, and participation in certain behaviors. This often involved using drugs and alcohol and having sex, even when people did not feel comfortable with such activities, but they feared rejection or being teased.

"Image, peer pressure - you have to look a certain way, be a certain size, etc., etc., conform.... Pressure can involve smoking and drinking and sex also. You might go against your morals just to be part of the group."

"There's a big sense of I have to fit in.... We'll spend our last money just to stay relevant."

"Being accepted. I remember when I first started having sex. It wasn't something that I necessarily wanted to do. I just wanted to be accepted. I kind of felt that if I gave that part of me to somebody that they would appreciate it and then I would be accepted from that. And then, like just being seen with a cuter person or something like that, it's just going to make people accept me more. So, I think that's really all they want - somewhere to feel accepted, whether it's in somebody's arms or whatever it is. It's usually what they're targeting - self-esteem and just wanting to feel love."

Gay participants spoke of identity and acceptance being at the forefront of their concerns. They spoke of feeling pressure to decide where they fit in terms of defined roles and the feelings of isolation that came with not fitting well into those roles. For some, that meant appearing to be straight to the outside world. For others it was figuring out where you fit on a masculine/feminine spectrum or whether to be defined as a "top" or a "bottom."

“It’s not like you really have a chance to make a choice if that’s the mindset you’re in and if you’re not strong enough to really be like, “No. I may be gay, but I’m still my own person.” And it’s really hard to be your own person in the gay scene because being your own person could be the one thing that stops you from being able to live in the gay scene and to be happy.... It’s a lot of stress.”

Several participants talked about issues related to acceptance by their families and being able to live up to their parents’ expectations. For others it was acceptance by society at large. Gay Mexican immigrants were especially concerned about what their families and communities thought of them, to the point where they claimed knowing very few that were out in Mexico about their sexual orientation. Many of the participants talked of feeling less concerned of what others thought of them as they got older. Instead their concerns focused more on the increasing responsibilities that come with adulthood such as getting jobs, finding a place to live, and paying bills.

Another set of concerns discussed by the participants focused on the pressures of getting through school, getting a good education, and preparing for one’s future. For those who did not fit well into educational environments with high expectations, such environments could prove to be quite stressful. Some mentioned the difficulties involved in finding a job with a living wage if a person did not have a degree beyond high school. Youth and provider participants alike spoke of the concerns of many youth for meeting basic needs. This was especially the case for youth who were homeless or living in poverty. Concerns were about housing, food, providing for children, and accessing health care. Several spoke of the disrespect they often have to confront from service providers as they try to meet those needs. Others spoke of potential high-risk situations that youth often confront.

“I think if you’re in a high-risk situation, I think you’re just kind of fighting to get through the day, and finding food for the table. And depending on if you have children or not, a lot of it goes to them, and the less you have, the more you go back to your basic needs, and whatever you have to do to get there kind of comes into play.”

“For youth who don’t go on to college, they can be pretty marginalized. They are suddenly adults but don’t have services directed at them. They are particularly vulnerable. They have big economic concerns, don’t have insurance, and seem marginalized in a lot of ways.”

Other concerns discussed by the focus group participants included: 1) being able to provide for their children, set a good example, and keep them safe; 2) stress that often comes from trying to live up to people’s expectations, which can lead to using substances or having sex in order to relieve stress; 3) the impact of trauma and abuse; 4) substance abuse; 5) relationships, including family, friends, and partners; 6) civil and legal rights; and 7) mental health issues such as self-esteem and depression. Youth living with HIV also discussed concerns about not infecting others and about the stigma and discrimination surrounding HIV.

Perceptions of HIV

Responses ranged significantly when participants were asked what youth think about HIV and how concerns about HIV compared to other types of concerns. By far, the most common

set of responses from both youth and providers was that young people do not think about HIV very much if at all. Many respondents talked about how most young people really do not think they could ever be infected with HIV. In related comments, many participants discussed how young people just do not care about HIV or take it seriously. Some thought that many young people do not know enough about HIV to understand their risks and therefore do not consider it an issue. Others mentioned how young people especially did not think about HIV when they are drunk or high. Several participants emphasized how young people do not think about HIV because they rarely hear about it in the media. Some pointed out that many people do not think about HIV until it affects them personally, by finding out that they have it or that they have been exposed or by finding out that someone they know or care about is infected.

“You never really think you’ll get it. It doesn’t cross your mind. You know it’s there, you know you could get it, but you don’t think about it in the spur of the moment kind of thing.”

“When you’re young you don’t think about HIV; you don’t care about it.”

“I’ve always thought it was a legitimate risk. There are times in the heat of the moment or the heat of the alcohol or drugs it becomes not as serious or a joke. It’s gotten to the point that to the people who aren’t surrounded by it or don’t know people who are dying from it, it becomes kind of a joke.”

“A lot of people don’t think about it until they actually get it or know somebody that has it. It’s not real to them.”

Though this lack of concern about HIV seemed to be much more prevalent among straight youth, some participants mentioned that lack of knowledge or concern about HIV could also be seen among gay and bisexual men as well. Some were said to think that it was more of an older gay men’s disease. Others just assumed they would probably get it someday.

“Some gay/bi men think that getting HIV is inevitable. They see themselves at risk, but maybe it doesn’t matter that much.”

“I’m 24 now. I’ve been positive since I was 18. In all of these years, I have never had one person turn me down (for sex) because I was positive.”

Although fewer than those thinking HIV was not a concern for high-risk youth, many youth and provider participants discussed that some youth were in fact concerned about HIV, including those who found it scary. Some highlighted how many people become more concerned about HIV or take it more seriously the more they learn about it. For some the concern was just enough to be aware of their risks and to take precautions accordingly. Others described themselves as highly concerned about HIV or described themselves and others as more “paranoid”, frequently seeking testing. One youth participant discussed how HIV was still important to the gay community and was often stressed. Another, who worked in HIV prevention, warned young gay men against forgetting the history of HIV and its destruction in the gay community.

“It might have taken the 1,001 time to actually sink in, but at some point I actually started to realize that HIV can, you know, seriously kill you. You might want to be safe about it.”

“HIV is the only disease (gay) men will think about. They don’t think about syphilis and other STDs. HIV has been pumped into us. It’s our boogie man.”

Two other sets of responses to questions about what high-risk youth think about HIV concerned the stigma surrounding HIV and the fact that, in many settings, it is a taboo subject. Two gay men pointed out that gay men who are positive are often “shunned” by negative men. One provider participant emphasized that stigma around HIV can often perpetuate risk, causing some to keep high-risk behaviors a secret and to avoid safer sex so as not to raise suspicion. Several participants said that some people will not even talk about HIV because they are afraid of what others will think. Others pointed out that people generally are uncomfortable talking about HIV or even about sex in this country or within certain communities. One gay man said that it was taboo to bring up HIV in sexual situations.

“HIV is easier to talk about if you have more education; but if you’re just meeting someone on the Internet, they may not want to talk about it, so you don’t.”

“Latinos keep the topic of sex hidden. Parents may give you the talk, but after that it isn’t mentioned. As Latinos, we’re not ready for HIV. We think it’s a terrible disease.”

Several of the youth participants who were living with HIV talked about how afraid they were when they first learned that they were infected, describing how they thought their lives would soon end. This was more the case for those who knew little about the disease. Though some still admitted to occasional feelings of depression and regret, all of the HIV positive respondents currently thought of HIV as manageable. Due to receiving good medical and other care and expanded education about the virus, some described it as being very similar to other chronic diseases for which people must take medicine and maintain healthy behaviors. Two mentioned that there were worse diseases one could have. Three stressed that they did not think about HIV very much.

“I’m still on the fence about it because some days, I look in the mirror, and I just start crying.... I’m mad at myself. I get mad at myself for not protecting myself. But then, I stop and I think about it. I’m like, you know it could be worse.... You’re at the stage where you can still keep it under control.”

“Of course, there are a lot worse things that could happen to you.”

“I’m thinking of what I’m going to do on Friday. HIV is not on my list of things to think about. I mean, I’m affected by it every single day of my life, (but) I don’t think about it until it’s time to take my medicine, or until it’s mentioned.”

The participants who were living with HIV did emphasize the impact that HIV-related stigma has had on them. Although some were very open about their HIV status, outside of intimate relationships, most had only disclosed to a limited number of people. One had disclosed to no one outside of her family for fear of being judged. They mentioned the ignorance about HIV that was prevalent among the general public which influenced discrimination and often led to hurtful situations with people to whom they were close. These included incidences such as friends not wanting to drink from the same glass or a partner not wanting to kiss because of a cut in the mouth. Disclosing to potential sex partners could also lead to rejection, rumors being spread, and being treated like a pariah.

"... the bar environment isn't exactly the best place for a girl with HIV to go try and pick up guys because the second you drop HIV, they don't talk to you again, and rumors spread, people talk. There's actually a couple of bars that I have stopped going to because, I mean, people talk. "Oh, God, I shouldn't drink with her. I might get AIDS." Or "I don't want to talk with him. I don't want to look at him. I'm going to contract it." And so, it's that ignorance. It's just ignorance."

History of HIV Education

When asked how they first learned about HIV, most of the youth participants in the needs assessment said that they had first learned about it in school. However, many of the youth participants and a few of the providers had negative things to say about the quality of HIV education offered in schools. Most commonly, the youth complained that the education they received was very insufficient. They discussed how the coverage of the topic was often very brief and not at all in depth, often combining it with other topics such as sexually transmitted infections and human reproduction. The participants described teachers using techniques that generated little interest, such as simply showing a video or giving a short lecture. Many said that the teachers did not try to generate discussion, or they did so in ways that many found awkward and embarrassing. Consequently, several youth remembered that many of their classmates did not take the subject matter seriously. Some complained about the misuse of scare tactics, exaggerated information, or the lack of realistic approaches that accepted that many youth were already sexually active. Several of the gay youth spoke of how sexual orientation or sex among same sex partners was not discussed. Others noted how they may have learned about diseases, but very little about prevention. Some described the approaches as being almost anti-sex or overly abstinence heavy. Also, several of the participants, including three of the youth living with HIV, said they did not receive any HIV-related education until after their diagnosis. Some participants emphasized how parents commonly did not talk to their children about topics related to their sexual health, including HIV. Others pointed out how young people often learn information from each other that is often inaccurate, however they will internalize it as fact.

"The sex ed portion ... they explicitly showed a PowerPoint of all the various sexually transmitted infections you can get, and that was more just shock and awe, and people, they didn't really educate they just said this will happen to your body if you have unsafe sex. And there wasn't much dialogue going on. It was more just this could happen to you."

"And I mean my middle school education was literally one day of 30 minutes of slides of a lot of different STIs that you could get. So it was really quick and that was all I got, so..."

"In school, education about sex and drugs was all "don't do this." Or they would beat around the bush about it."

"Some sex education is very stupid. It's insensitive to gays. If you're just learning that unsafe sex can lead to pregnancy, gay men think they have nothing to worry about."

"Last year (ninth grade) was the first I learned about it. It was good but we weren't paying that much attention. We didn't think it was anything we would go through. Now I wish I'd had more information on how to prevent it. The teachers were really trying but we weren't listening."

Many other youth participants described getting good education about HIV and sexual health through their schools. In these cases, the classes were described as much more comprehensive, longer-term, and interesting, with teachers showing genuine interest and knowledge in the subject matter. They used more varied teaching techniques including the use of interactive activities, visual aids, research assignments, guest speakers, and discussions. One person spoke of the teacher using a questions box so that students could ask their questions anonymously, avoiding embarrassment. Some mentioned that they not only learned about prevention, but also were able to access condoms at the school or learn where they could access them. By far the most powerful technique used by teachers that was highlighted by the participants was the use of guest speakers who were living with HIV. People spoke of how listening to people's stories brought a sense of reality of HIV to students, raising awareness about the disease, dispelling some stereotypes about who can get HIV, reminding them that they too could be at risk, and encouraging them to take precautions. One person described how their teacher brought in a very diverse group of people living with HIV to bring home the point that any type of person can be at risk.

"We had a health lab my freshman year of high school and they had all of these pictures of STDs and what they looked like. Then we had a lot of research we had to do about it, and it grossed me out. So, even though I had already started having sex at that point, it gave me some kind of way of saying, "No." It wasn't just that I had seen the STD things but my teacher went above and beyond and she said, "Okay, this is what you can get from having sex and this is what you can tell people when you're in (risky) situations to help you get out of them.""

"Some kids were dumb, in my opinion, really immature and kind of giggly about some of the things... Other kids were really scared, and I think it actually got their attention... It's really different once you actually meet someone (living with HIV) and talk to someone about it versus hearing about it."

Other participants described getting good HIV education from family members, including parents, grandparents, aunts, uncles, and older siblings. Some said they learned through doing research on their own, especially over the Internet. Others said they learned from health care providers. This was especially the case for the young participants living with HIV, who emphasized how much better they felt about their diagnosis once they truly understood what they were dealing with. A few people discussed learning about HIV from various community-based organizations, from friends, and from partners.

"Well, I learned from school, too, but when I was 11, I came home from school one day because I didn't want to use the restroom because a kid told me don't sit on the seat or whatever, you'll get AIDS. So I came home and asked my sister what is AIDS, and that's when I learned all of it. I don't know if I really comprehended at 11, but I knew about it."

"When I sat down and they (health care providers) went through everything, they educated me more, so it was like, "HIV is not the death sentence that it was in the 80's. Definitely treatable but it's something you can live with and can go about a pretty normal, everyday, average, happy-go-lucky life with HIV.""

Those making suggestions about how to improve HIV education among youth most commonly recommended facilitating situations where youth can meet other young people who are living with HIV. Others emphasized how important it was for HIV education in schools to be much more comprehensive. This would involve: 1) consistent education over longer periods of time throughout middle school and high school; 2) added information on STIs; 3) content on prevention, including condom use and safer sex negotiation; 4) information on all of the different types of sex both gay and straight people have and the risks involved in each; 5) local statistics to raise awareness about the presence of disease in the area and the people most impacted; and 6) sufficient opportunities for discussion. Several participants emphasized the importance of education on sexual health being presented in a way that accepts that many youth are already sexually active or soon will be.

“Make it not so embarrassing for those having sex. Sex isn’t a bad thing, but there are bad things that can happen from it if you’re not being careful. Promote safe sex in high schools.”

“If you take five youths that are HIV positive and they look perfectly healthy, the other kids are going to find them to be remotely attractive, and you’re going to set them in front of those kids and have each of them say that “I’m HIV positive because I was doing that.” Then, it’s a little bit more of a shocker. I’d have people flirting with me while I’m talking into the mike, and the second that I say “I’m HIV positive” the room gets completely silent, and at that point in time, everybody’s phone goes in their pockets, everybody puts up whatever they were playing with, and it’s like “I have to hear this because that’s too real for me.””

“Just a little bit more based on like how important it is to use a condom. “You’re sexually active now. Your body is going through changes. You’re going to feel things that you never felt before and experience things that you’ve never experienced before, but there is this one thing - if you think you’re ready to get to that point, just use a condom. Use a condom.” I think they should reiterate how important that little piece of plastic is. Like, use it, use it.”

The Needs of High-Risk Youth

When asked what high-risk youth need most, the youth participants in the interviews and focus groups most commonly answered that they needed someone to talk to, someone with whom they could discuss difficult life issues. This could include professional counselors, teachers, family, friends, or mentors. Some thought it was especially important that youth be able to talk to people that could relate to their situations or who had lived through similar circumstances to their own. Most important were that these people would listen to them, support them, treat them with respect, and not judge them or try to tell them what to do. Some thought that having such support could prevent young people from dealing with their problems through substance abuse or looking for attention and emotional connection through high-risk sexual situations.

“Maybe like a place or a person that they can share things with and not be afraid of judgment, because a lot of times younger people are afraid of people passing judgment on them, and when they have that support, they don’t, they’re more likely to talk about it and get educated on it.”

“They need counselors that can understand where they’re coming from.”

“At the parties a lot of kids are talking about their problems at home and with their boyfriends. And they’re all drunk; that’s why they go drink at a party. Counseling could help them get things off their mind and feel like someone is actually listening to them. The counselor could give them more advice about what to do besides drinking to help them solve their problems. Maybe then they wouldn’t go to parties as much.”

Providers stressed the need for culturally competent counselors who could help youth build life skills and who would respect people’s confidentiality. It was especially important that such counselors improve young people’s sense of safety and lessen their feelings of marginalization.

“I think it’s just all summed up by them wanting to feel safe, and that’s the bottom line. If they feel safe, everything else kind of falls in line... and supported, too... and belonging.”

Youth participants also thought that education was a key need for high-risk youth. Such education would include: frank and honest discussions about HIV, its risks, and consequences. They needed to have misconceptions about HIV, risk, and people living with HIV addressed. As mentioned above, youth especially thought it was important for people living with HIV to provide education to others, especially in helping to clear up misconceptions and raise people’s awareness about risk and prevention. Other types of education discussed included: more awareness raising through the media; information on where to access HIV testing and free condoms; and comprehensive sex education in schools. Good education was said to help high-risk youth to make more informed decisions.

“I needed more education about it. I would have educated myself, but I was too young. Young people don’t even know that it can happen just that fast.”

“They need to know.... it’s the information that’s gonna make the difference. If you don’t know, then you just make decisions based on knowing nothing, and you don’t want to make decisions based off ignorance.”

A third principal need of high risk youth discussed by the youth and provider participants was the wide-spread availability of free condoms and lubricants. Another need emphasized was for more recreational things for young people to do and more safe places for youth to hang out. Some stressed the need for youth to have more opportunities for personal growth and to learn life skills. Others mentioned the need for high-risk youth to have their basic needs met. Needs for fighting HIV and homophobia-related stigma, for mentors, and for increased support for immigrants were also discussed.

“I think their important need is really protection..., because even if somebody sits down and has a conversation with a person and tells them they’re at risk for this and this and that, it’s still not going to help unless you just really give them a condom, like “Well, I’m not playing, and I want you to protect yourself.””

“They need to know where to get free condoms. There needs to be more condoms in public places. They should advertise where to get them.”

HIV Testing Among Youth

Youth and provider participants in the needs assessment were asked for their opinions about several topics related to young people and HIV testing. The first topic concerned the extent to which young people were getting tested for HIV. Most of the participants thought that testing among youth was not at all common, especially among females and heterosexual males. Testing was said to be somewhat more common among gay males, especially if they were already accessing organizations that regularly offered testing, such as GLBT community centers or other community-based organizations. Young people were also more likely to test if they found themselves in a high-risk situation such as finding out a sex partner had HIV or was at high risk.

The most mentioned barrier to testing proposed by the participants was fear of possibly finding out that they had HIV. Rather than seeing the benefits of finding out if one is infected, participants thought that many people would rather not know because HIV is a scary disease and because of all that being positive might involve. Participants also commonly thought that people often did not get tested for HIV because they were afraid that their confidentiality would be breached by a provider. Some also said people were embarrassed to seek testing because someone they know might see them, question why they are there, make assumptions about their behaviors, and possibly start rumors. Young people were said to often be concerned of what others might think, including health care providers.

“They’re afraid they might have it and don’t want to deal with it.”

“It’s embarrassing to get tested. They’re afraid friends will find out, or they think the doctor will tell somebody.”

As mentioned above, many young people do not think about HIV or know much about it, even if they are at high risk. Such lack of knowledge or concern about HIV therefore keeps many from even considering getting tested, especially if they are showing no signs of anything being wrong. A fourth set of barriers discussed by the participants focused on issues of access to testing. These issues included: 1) the cost of testing in some areas which could be prohibitive to young people; 2) not knowing where to go to get a test; 3) the time that it takes to get tested, especially in clinics where waits can be long; 4) lack of transportation to testing facilities; 5) providers not offering testing or even discouraging people from testing if they do not think they are at risk; 6) the lack of consistent availability of testing; 7) disrespectful treatment at clinics; and 8) lack of documentation, making immigrants think they cannot access testing.

“On our campus, we have free HIV testing once or twice a year, and I’ve seen them around and a lot of times they’re just kind of standing around waiting for someone. I guess like a lot of people just, you know, it’s not on their top ten list of STIs I could get, so they don’t really worry about it.”

“They have to schedule an appointment like two weeks in advance, instead of just going in and just getting it then. And, being done. And, I think that that’s probably kind of a drawback to some people because some people just want to get in, get out.”

“They (health care providers) said, “you don’t look like you have anything” and I was like, thank you, but that doesn’t mean anything.”

Some of the youth participants thought that testing was readily available, especially in larger cities, but people may not know that or make the effort to find out. They mentioned a number of community-based organizations and clinics that offered free or low cost testing. For those living outside of Denver and Colorado Springs, access was much lower. Participants had many ideas about improving the level of testing among high-risk youth. The most common suggestion was that organizations offer incentives for young people to test. These could include free condoms, small gifts, basic needs, or school credit. Others stressed the need for more public information encouraging people to test for HIV. Such information should include: the locations where people can access free testing; increased normalization of testing, making it more acceptable to people; emphasis on the importance of knowing one’s status so one can receive timely treatment and not expose others to the disease; and awareness raising. Increasing access to testing in more locations, including schools, public events, and public facilities was also suggested. Two participants thought that having young people living with HIV telling their stories and encouraging people to test would be very effective as it would lead more people to consider their potential risk. Others suggested that doctors should be offering testing to their patients on a regular basis, and several suggested that testing should be mandatory for everyone, even though they admitted that would likely be impractical. Several providers mentioned the importance of test sites being comfortable, with trusted staff that is consistently accessible. They emphasized the importance that young people feel confident that their confidentiality will not be breached.

“Sometimes young people need incentives to get tested or do things they should do anyway. Some need an excuse to get tested rather than admitting they need it.”

“I think it’s worth a try to have somebody actually testing in the schools. I think that every school nurse should be certified for testing. You’re there. You’re with the kids every day, and people trust the school nurse. She’s not an authority figure in the school.”

“Show someone positive having a good life as role models. Show it in a positive light. It would be inspirational, and people may be less afraid to get tested.”

Assets, Strengths, and Communities

One smaller part of the needs assessment focused on a better understanding of the greatest strengths or assets of young people that should be built upon or tapped into in the development of HIV prevention programming. Youth and provider participants offered many ideas, but most commonly described the intelligence of youth, particularly those who have survived especially difficult circumstances. Participants pointed out young people’s ability to problem-solve and their ability to access and communicate information through their facility with and widespread use of technology.

“Something I give our generation is when we have a problem, we are so stubborn and really good about solving it.... Maybe that sounds cocky, but I think if you [expletive] our generation off enough with a problem, it’s a really bad mistake, because we have no problem finding a way to solve it. And I find that incredible.”

“Our generation is the near future. We will soon be controlling everything. We need to be the role models. Everybody in the room is going through the same circumstances (homelessness). We’re not the only ones. Those like us who are going through a lot have a lot more knowledge to offer to the next generation.”

“Youth are an asset to us and our programs. They are the experts, and, when seen that way, good partnerships can occur.”

Participants also discussed the resilience, strength, and independence of youth. Providers who had worked with high-risk youth showed a special admiration for their resilience. Some youth participants focused on how much more accepting their generation is. This was especially the case as it related to the acceptance of gay youth. Related to this was a sense that youth today had more freedom to express who they are, being less confined by societal dictates of what is acceptable and expected. Other assets of youth discussed included their stubbornness, their honesty, and their tendency to be social.

“You can throw the worst things at them, and they figure out a way to deal with it.”

“I think our age group and our generation is a lot more accepting towards things that they don’t understand. I mean because I’m a gay teenager. I see a lot of people who don’t agree with it, but I also see a lot more people who are like, okay, it’s just another part of you, I don’t really care. I like you, so I’m gonna be friends with you.”

Another question posed to the youth and provider participants concerned the communities of which youth felt a part. The responses were numerous and showed few patterns. Mostly the conversations highlighted the fluidity of people’s identification with others. The most common suggestions by both youth and provider participants included identifications with communities based on: 1) sexual orientation for those who were gay or lesbian; 2) common interests around sports, art, substance use, and partying; and 3) ethnicity for youth of color. Although many of the gay participants said that they felt part of the gay community, a few reported feeling part of the straight community as well, and one gay youth expressed feeling part of neither. One gay youth, who said he was more comfortable in the straight community, said that it was taking him longer to feel comfortable first with being gay and second with the gay community. Another said he was afraid to hang out within the gay community because of the potential for gay-bashing and violence. Some gay men expressed feeling a conflict between their identification with the gay community and other communities of which they felt a part, including the African American and Latino communities and the rural community. One gay Latino man expressed that gay Latinos were not very united and were often highly critical of each other. One provider spoke about this conflict saying many gay youth of color are subjected to a lot of discrimination and therefore will separate themselves from their ethnic communities. Other bases for community identification included: school, neighborhoods, religion, work environments, and gang affiliation. Many expressed that their communities consisted only of their group of friends, and some homeless youth expressed feeling community with each other.

“Well, first and foremost, the homosexual community because it’s so different from all the other communities. A lot of like the heterosexual community sometimes pushes you away so you immediately go to people who are gay and lesbian. You’re like, okay, these are my type of people, I’m happy here.”

"I have a lot of friends who felt like that they have to choose between being gay and being black."

"In high school you have your cliques, which sounds bad, but they're sort of your communities, like you have the group of people who are on drugs, and then you have the thespians who are like the all-out actors, and technical brainiacs, and then you have like your group of friends that you sit with at every lunch and you just, that's sort of your community because you feel like you belong."

HIV Prevention Strategies

Public Information. Youth and provider participants offered many suggestions for HIV prevention strategies appropriate for young people who are at higher risk for HIV. Most of the participants agreed that people needed to pay more attention to HIV, and recommended that more aggressive measures be used to bring the subject to the forefront. Therefore, the most discussion in the interviews and focus groups was around ways to raise more awareness about HIV and provide information widely to the public. People suggested the use of many types of media, including TV, radio, billboards, pamphlets, posters, newspapers, and the Internet. Participants especially suggested extensive use of the Internet to get information about HIV to young people.

Ideas for the content of public information included providing accurate and straight-forward (not exaggerated) information about HIV. This would involve: 1) providing detailed and realistic information about risk and the multiple factors that influence risk; 2) addressing misconceptions about HIV, its transmission, and those who are most at risk; 3) including local statistics to remind people that HIV is a local issue affecting multiple populations, and not just a disease affecting gay men and people in large cities; 4) explaining multiple approaches to preventing HIV beyond abstinence and 100 percent condom use; 5) providing information about relevant events in the area and about where people can access services, HIV testing, and free condoms; 6) including information about the realities of living with HIV that is hopeful for those living with the virus or those who are afraid to test but also oriented toward discouraging those who are negative from putting themselves at risk; and 7) addressing other STIs and sexual health in general.

"We need to have a more prevalent sense of HIV... people knowing how easy it is to get and what leads to getting it. We need to get better information out there and clear up misconceptions."

"I like to hear this many people in Denver. I like to hear stuff like that so you're kind of like, wow, you know, that's pretty crazy. I mean I guess my knowledge before I was positive was, it wasn't very popular. I mean you think of San Francisco, New York when you think of things like HIV.... You don't think of Denver, Colorado, you know, meeting someone at the bar and getting HIV. You don't think of someone you dated. You don't think of that, because you just think little town and that it's not gonna be there. I mean you hear that stuff, and you hear those common slogans, but you never think it's gonna happen to you, or in the town you live in, or the people that you're with, or the clique you're in, or the community you're in. So I just feel like, just letting people know that it is real life."

“Tell our stories to people, and let ‘em know, “You know, I made this mistake here, I made this mistake here, but I’m dealing with it now by doing this and by doing that.” just explaining to people...”

Another set of suggestions for public information content included encouraging people to seek out information to better understand their risks, to seek out HIV testing to know their status, and to disclose their status to others. Others emphasized the importance of addressing the stigma that not only surrounds HIV but discussions of sex in general. They spoke of the need to normalize discussions of sex and safer sex that are free of judgment and to confront discrimination against those living with HIV and those that are disproportionately affected. Ideas included: openly promoting safer sex and general sexual health; having people living with HIV tell their stories to help dispel stereotypes and myths; and displaying and promoting healthy gay relationships.

“If you don’t know about it, go ask people who do know about it. Encourage people to ask questions. Get people to personalize their risk. Get people to think about themselves and their behavior.”

“Give people hope, even for those with HIV. Remove the stigma around HIV, sex, having the conversation, etc.”

Ideas for disseminating HIV-related information to the public included the following:

- Develop radio talk show and videos for TV and the Internet of young people talking about sex, safer sex, HIV, and risks
- Develop blogs or websites where people can go to post topics, questions, and comments and generate dialog
- Place ads, pop-up information, and information pages on the Internet with links to further information about HIV, testing locations, and services; ensure that ads will draw attention using humor or sexy images
- Distribute pamphlets and posters about HIV and its prevention in gay bars, bathhouses, schools, agencies, bus stops, and other public places
- Disseminate HIV-related information through mass texts
- Utilize public service announcements on TV and radio
- Develop songs and music videos that tell the story of someone living with HIV and that address HIV prevention, stigma, and acceptance
- Facilitate the development of community-produced public information
- Disseminate information through peers and through people living with HIV
- Hold HIV-related health fairs and consistently provide information at other public functions including concerts, sporting events, and festivals
- Make condoms more visible through the media, including through condom commercials and pornography

“I think if you were to get four individual young people who don’t know each other.... You can get somebody who dresses Gothic, the hip-hoppers, somebody that looks country and then somebody that just doesn’t look like they’re from here at all. You sit them down and you have them talk about these things in front of The View, somebody is going to watch it. Each youth is going to pick a personality out of that they connect to, and they’re going to want to watch them, and they’re going to want to see how they debate with other

people. I've always thought that would be a really, really good piece for social media, especially for prevention."

"A lot of people have Facebook, and you have those little ads on the side of your Facebook.... Why not have like a permanent one that says "use a condom" or you can click on it, and it'll bring you to this page that says what you can get and what it does to you and how you can protect yourself. Because I mean a lot of people have a Facebook, and that will hit hard sometimes."

"Safe sex promotion.... Use condoms in porn. Have ads about condoms. Get more advertising, and put it in people's faces."

"I've always thought it would be a perfect idea to have a TV show that followed somebody who is HIV positive and put it on a network that most kids watch because it's a lot different for me to go into a school and talk to people about being positive because I can't really portray to them what life is really like....If there was a camera following me around, they get to go to my doctor's office, they get to see those mornings that I wake up and I just don't feel good for any reason but I'm positive...or the days that my meds give me some type of symptom that just doesn't work for me. They don't see that."

"We have to put aside prevention as we know it. Messages have been very black and white and sex negative. They don't address the complex realities of risk, and they lack harm reduction orientation. There's too much judgment and shame. We need to have all steps to risk reduction be praised and the judgment needs to be taken out."

Education. The second most commonly discussed set of strategies for HIV prevention involved providing comprehensive and accurate information to young people, especially in school settings. Both youth and provider participants had many ideas about what such education should involve. These fell into three general categories and are included in the sets of bullet points below.

Suggestions for where to provide HIV education included:

- Require comprehensive sexual health classes throughout middle and high schools
- Provide seminars in schools, work sites, and CBOs
- Give information during assemblies and pep rallies; talk about STIs, HIV, and prevention
- Provide classes in casual settings rather than classrooms

Suggestions about the content that should be covered included:

- Ensure students know basic health information and information about their bodies as a foundation for understanding sexual health
- Teach both males and females about boundaries, healthy relationships, the right to consent, and empowerment; dispel sex-based stereotypes
- Speak honestly with teens about sex, accepting that many are sexually active; give them informed options and allow for them making their own decisions
- Provide a thorough understanding of risk behavior and address misconceptions about risk and people who are at risk
- Address factors that influence risk-taking behaviors

- Include information about all types of sexual activities, sexual orientation, and gender identity
- Provide statistics, including local ones
- Emphasize the importance of using condoms
- Encourage HIV testing
- Teach young people the signs of a predator

Suggestions on effective strategies to use in providing HIV-related information included:

- Provide prevention demonstrations and allow people to practice skills; make lessons fun and interactive
- Train youth to provide peer education including youth living with HIV
- Offer information in ways that allow for different types of learning
- Encourage parents and offer them skills to talk to their children about sex and HIV
- Facilitate youth meeting youth living with HIV and hearing their stories
- Make literature available
- Encourage discussions; normalize conversations about sex to avoid feelings of shame and embarrassment
- Show pictures of STI and HIV symptoms and complications
- Provide safe ways to ask questions such as anonymous question boxes
- Utilize a diverse set of scenarios and examples to extend the relevance to more people
- Bring in experts
- Encourage safer sex pledges over abstinence pledges
- Promote gay pride through discussing gays in history

Condom Distribution and Outreach. Youth and provider participants strongly agreed that condom use needed to be promoted among high-risk youth, and that condoms needed to be more readily available. Several youth participants expressed that the benefits of condom use in the prevention of HIV, other STIs, and unwanted pregnancy needed to be promoted. They also emphasized that condoms were way too expensive when bought in stores, and therefore needed to be made available for free or at low cost in many more places. Some youth thought that if young people had condoms readily available, more would use them, and they spoke highly of places that did make condoms available, such as local clinics, GLBT community centers in Denver and Colorado Springs, and certain CBOs. One provider spoke of filling the condom bowls at a Denver-based community center on a daily basis and being pleased to see more people taking them. Other participants added that varieties of condoms should be available and that the quality needed to be high. Some condoms were said to be more appealing to young people based on factors such as looks, size, comfort level, and the amount of sensation they allowed.

“The simple answer is condoms. Increase access to condoms.”

“I really, really wish that there would be more importance bestowed upon this beautiful invention called a condom.”

“I just think condoms - throw them out there, you know, every chance you get. If they have it, they’ll use it. If they have one, they’ll use one. You don’t have to worry about catching

an STD, and it's also about not getting pregnant, having a baby when you don't want one."

Multiple suggestions were made as to where free condoms should be made available, essentially encompassing all places where young people may congregate. These included: schools and colleges, clubs and bars, community and recreation centers, parks, malls, concerts, raves, festivals, stadiums, beaches, gas stations, supermarkets, pharmacies, hotels, housing complexes, and public bathrooms. Some especially emphasized ensuring that condoms were available in places where gay men were meeting and having sex such as gay bars, bathhouses, parks, and arcades. Participants thought that condoms could be made available in many places via dispensers or discreetly made available for people to pick up. One participant, who suggested that condoms be available for free at clubs, thought that people could then be encouraged to take and use them by the DJs at the clubs. Participants also emphasized the importance of distributing condoms and safer sex kits via outreach in many of the places mentioned above so that people would also be getting information as well. Outreach to sex workers and gay men were especially seen as important. One HIV positive participant thought that it would be very effective if he and others living with HIV in his community would do outreach in their neighborhood.

Other HIV Prevention Strategies. Several other types of HIV prevention strategies were recommended by the needs assessment participants as effective approaches for working with high-risk youth. Given that the participants cited support or "someone to talk to" as the most important need of youth, providing for that support was one recommended strategy. Although few details were discussed on how this should happen, providing access to mentors, counselors, support groups, or other trusted individuals were suggested. One participant who was living with HIV discussed the importance of directing prevention interventions at people who are HIV positive, making sure they have condoms and the services they need and helping them with issues around disclosure. Another participant emphasized the need for parents to show more support to their children and share their own past experiences with them. Several highlighted that within these interventions there was a need to show young people respect and to trust them to make their own decisions. One youth participant who has worked in HIV prevention emphasized the need for client-centered interventions, working one-on-one with a person as a mentor using a harm reduction approach. Through such an intervention the counselor would work with individuals to discover the roots of their biggest issues, map out the stages of how they can get to where they want to get in life, and then help them work through those stages. Throughout this process, people have someone that they can rely on and someone they know has their interest at heart and who is not judgmental.

"If you give them the power to make a decision, they're going to make a good decision. I think that's the case with most kids. Because if they feel like they're trusted, they're going to want to keep that trust. Those kids that run off and do bad things, they're not being trusted as they want to be trusted...."

"I see a lot of middle schoolers who step up and say they want to make a difference in the world, but in those groups I see a lot of positive relationships forming where they're turning to support each other in their identities and in having healthy relationships, and wanting this information, wanting this communication.... They want to be supportive peers for each other."

“Yes, it’s one-on-one and you have to be able to meet that person where they’re at. They might be at a place where you could really talk to them about disclosing their HIV status and ... they’re going to take something from it. Whereas other people, they’re still getting comfortable with waking up thinking that they’re positive every morning, so you have to get them to the point where they’re even comfortable saying the word HIV out loud before you can get them to tell somebody else that out loud. It’s specific to every single person. I think that really, really works because then it’s like more of a personal interest in somebody. Like I was saying earlier, every kid wants to feel like they belong and like someone loves them and cares for them.”

Participants also recommended offering opportunities for young people to meet together in informal groups to learn information as a group and to discuss issues related to sex and sexual health and express their opinions openly. Giving people the opportunity to express themselves, rather than just feeding them information, was seen as essential. Such groups could take place in schools, at organizations, and through public forums. Groups could be lead by counselors or educators and involve guest speakers including doctors, people living with HIV, or people who have survived difficult circumstances similar to those the youth are facing. Such conversations could help to get information across, clarify misconceptions, recognize and clarify some of the complex context surrounding risk behaviors, strategize ways to deal with high risk situations, and offer mutual support. They could also help to confront issues of stigma and discrimination. Filming the discussions was recommended so that others could benefit.

“Let them express theirselves. You can’t give them all that information and then expect them to not talk about how they feel. Have discussions. Don’t just tell people what to do.”

“We need more discussions... discussion groups in schools, in public, at organizations. Let people talk about it.”

“Like right in the park or something or like a situation like this, like if we just added a couple more people while we’re just sitting here talking about these particular questions and basically showing it on YouTube or something like that, you know, where we’re all sitting up here telling the truth about what’s going on. I think people would understand better.”

In discussions of HIV prevention, many of the youth participants, and some of the providers, emphasized the need for young people to have more to do. Some stressed that many of the youth who go to parties or clubs, use drugs and alcohol, and have unsafe sex do so because there are no good alternative things to do. Free places to go where young people could hang out, such as community centers, seemed especially important. Such places could offer recreational activities such as sports and games and opportunities to participate in art, music, theater, or media projects. Involving them in prevention projects was also suggested, and one person mentioned that it could be a place where young people living with HIV could come and talk to each other. They would also be places where youth could access counselors, HIV and STI information and testing, and free condoms. One youth participant emphasized that it does no good to just educate people and then send them back to their normal lives. They need more positive environments through which they can interact with others. One other participant recommended that there should be places to hang out that were open all night.

Similar ideas included: having schools open in the evenings where young people could hang out and do activities; and having more social events, outings, and activities in which people could participate.

“I just think, if there was really, really something for kids to just go out and do, I think it would be way different - way, way different.”

“For the longest time, I’ve always thought that we have to find a way of getting like a real community center. Like growing up, I remember we had after-school activities, and we’d go to the rec center and play Little League sports. There was always something going on in the neighborhood or in the city, and there’s just not that anymore.... I know that, prevention-wise, like a lot of people say, “That’s not a prevention effort.” But to me it’s a prevention effort because if you’re playing basketball, you’re not having sex. If you’re swimming, you’re not having sex.”

“I would want in my community center if I were to build one would be a cooperative media-thing for the kids, like a place for the kids where they could make their own music, they can make their own dances, they could give performances, but it’s like every single piece of it would be the youth doing it and it would be stuff that could go together so if you had a young person who wants to be a play writer, they can write the plays, and the kids that want to act can act, the kids who want to make the music can make the music - just stuff that ties the kids in together where they can have their little interests, and it’s all a big collaborative effort.... Basketball tournaments at the park would be fine. I think it would be good to have competition-type stuff, like I know most kids like competition.”

“...have your little comfortable counseling office that doesn’t feel so counseling office-like, with condoms readily available. Have condoms in a bowl at the door when you walk in. Just have it be discreet but appealing enough for you to be like, “This is discreet. This is my decision.” This is the place where you don’t have to sign anything. You don’t have to fill out any forms. You can just go in at your own will, talk to someone if you feel like you need to talk someone.”

Appropriate Providers

When asked about the most appropriate people to provide HIV prevention services to youth, the majority of both the youth and provider participants thought that young people or peers should play a large role in designing and implementing prevention strategies. Participants thought it was important for young people to hear information from people they could relate to rather than those who would traditionally have authority over them. Some mentioned the importance of bringing the adult voices and youth voices together in partnership. The types of peers who were said to be most appropriate included: 1) those who were well-trained in the subject matter, 2) those who were outgoing, 3) people who were popular or well-respected by their peers, 4) people who had experienced similar life difficulties and managed to overcome them, 5) young people who were just a little older than those they are working with, 6) people from diverse backgrounds, 7) youth with the passion and desire to educate others; 8) youth that others feel comfortable talking to, and 9) people of the same gender or sexual orientation. Young gay men of color especially emphasized that they wanted to see more men like themselves involved in prevention.

“Other youth.... People feel more comfortable with people their own age.”

“Peer education that is diverse and does not look the same... people coming from different backgrounds... different faces. Then people can’t say, oh that won’t affect me.”

“I would like to see more Black gay men doing things like this.”

“We need leaders in the Latino gay community. Someone has to do something. A lot of people are getting infected.”

The youth participants thought it would be especially important and powerful to have young people living with HIV providing prevention services. Such people were said to be able to bring the reality of the disease to people’s attention and remind them that they too could be at risk. Youth would be more likely to take the subject seriously. Young people with HIV could also be able to dispel some of the myths and misinformation about the virus and address much of the stigma that affects those who are positive. Other types of people that were recommended as appropriate prevention providers included: 1) celebrities, including local celebrities, 2) adults that young people can relate to, 3) role models, 4) teachers, 5) health professionals, and 6) gatekeepers such as people well known within communities and bartenders or DJs at popular bars and clubs frequented by youth.

“They would be able to explain their own life experiences. People learn from other people’s life experiences as well their own. So if they have an example in front of them, this is what it means to be positive, then they can gather more, and they can absorb more. I mean when you’re looking at a piece of paper, you’re looking at a piece of paper. You can’t identify with that.”

“It needs to be something or someone they can relate to. Most people talking about HIV are in their forties. If it was someone like me who talked to a class, they would more likely listen. It would be more real. It would have a great impact. If I would talk at an assembly at school, they would leave feeling a lot different and would want to go get tested.”

“I think like hearing it from someone that you idolize or someone that you place on a higher pedestal than yourself is... I think that has far more of an impact to have someone that you appreciate fully.”

Providers reiterated the importance of young people being involved in the design and implementation of HIV prevention activities for youth, expressing genuine appreciation for their wisdom and creativity. However, they were all very aware of the vulnerability and the lack of empowerment of youth, emphasizing the need for adults to act as their advocates, mentors, and educators. Providers working in collaboration with youth in the development of programming was said to be key to successful efforts.

“There are certain things they want to learn from peers and other things from adults because they have more credibility. We should work in combination and have youth be part of the solution and helping to create the solutions.”

“More agencies need to get input from youth about what the services should look like, the language to use, etc. They need a youth voice in learning how to market this stuff. The more you can bring youth voices into programming the better.”

“It’s a different generation. Identities are more fluid. Adults may know a lot, but they (young people) are really the experts. They need partnerships where there is a place for the grown up voice and what we know and what they know.”

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 youth in Colorado. This needs assessment was designed to address HIV-related issues of a broad and diverse range of people, however, it was inevitable that adequate representation for all appropriate groups would not be obtained, despite the efforts of the Planning and Evaluation Unit staff and colleagues at partnering agencies. Staff especially thought that the involvement of more Latino and white young gay men in the interviews and focus groups would have provided important information about how to best meet the prevention needs of the highest risk groups. The information would also have been richer if more women from the United States and male and female Latin American immigrants who were living with HIV had been interviewed. To fill some of these gaps, evaluation staff intends to conduct more interviews with people living with HIV or those at very high risk over the next several months. The Planning and Evaluation Unit is also considering the development of a survey in 2012 to distribute among selected high-risk populations in order to obtain a broader range of information around specific topics.

SUMMARY AND RECOMMENDATIONS

Since it was first identified, HIV has disproportionately affected disenfranchised populations or people confronting an array of difficult life issues. Such populations include gay and bisexual men, people with substance abuse and mental health problems, people of color, and people living in poverty. In this sense, there is little difference between those most affected by HIV among people under the age of 25 and those who are older. However, the manifestations of difficult life circumstances within younger populations is in some ways qualitatively different, often affecting a higher level of vulnerability among young people, and often necessitating different approaches to preventing HIV. Some possible reasons for this greater vulnerability include: lower levels of maturity, life experience, and education; fewer civil rights, especially for those under the age of 18; societal discrimination against youth; and lower levels of empowerment and fewer opportunities for self-determination.

Several themes emerge from the vast amount of information gathered for this needs assessment. The first is that HIV is virtually “out of sight, out of mind” for most teenagers and young adults. We have heard from many different populations over the last several years that HIV has “fallen off the radar screen.” This was reiterated in our discussions with young people, as they stressed that they almost never hear about HIV. HIV education in school was often said to be lacking, if it was presented at all, and many stressed learning little about the disease and its prevention in ways that had much impact. They stressed how HIV did not seem real to them or seem like something that they needed to be concerned about or take precautions against. Many youth participants also stressed that they are exposed to a very

high level of sexual content from the media through which they see casual sex as common and acceptable. However, they never hear anything about the possible consequences of unprotected casual sex and especially about HIV through the media. Even condom commercials were rarely seen, and condom use was almost never mentioned in the sexual encounters displayed. This lack of exposure to HIV information combined with the feelings of many young people of invincibility and their tendencies toward rebelliousness was said to frequently influence unsafe behaviors and very low rates of HIV testing. Even some young gay men said that they did not take HIV as seriously as they should and ignored potential risks since the subject was rarely raised. The high percentage of AIDS cases among people under the age of 25 can be seen as a testament to the lack of visibility of HIV.

The second theme to emerge in this assessment is the necessity to better address the needs of young gay men. Eleven percent or one out of every nine cases of HIV diagnosed in Colorado from 2006 to 2010 was among gay and bisexual men under the age of 25. Although this younger generation was described as more accepting of homosexuality, homophobia still was described as having a large impact on the lives of young gay and bisexual men, especially men of color. Some gay male participants spoke of being bullied in school, degraded and rejected by family members, and thrown out of their homes because of their sexual orientation. Others described having to hide their sexual orientation in their homes, schools, work environments, and communities. They spoke of seeking acceptance and love within the gay community in environments that often involved high levels of substance abuse and older gay men trying to prey on them. Some of these young men spoke very highly of the GLBT community centers in Denver and Colorado Springs, but stressed that these centers catered better to teenagers, and that there needed to be equivalent places available to young adults within the gay and wider community. Over the last several years, many Colorado agencies serving the HIV prevention and related needs of gay men have emphasized the lack of participation in programs by younger gay men, underscoring the need for the incorporation of new programming and strategies tailored to younger men's needs.

Many people at high risk for HIV from all populations and age groups are those that are dealing with multiple and interrelated life difficulties including mental health problems, substance abuse, poverty, and discrimination. This trend is clearly evident in the discussions about young people by youth and provider participants in the needs assessment and is presented here as the third theme emerging from the data. Gay youth, runaway and throwaway youth, young people growing up in the foster care system, and young people with histories of abuse, neglect, and other types of trauma often suffer from mental health problems such as depression, low self-esteem, and high levels of stress. This is also often the case for people living in poverty who are often treated with disrespect as they try to meet their needs. This can make them more vulnerable to peer or partner pressure as they seek love and acceptance, to developing substance abuse problems as they learn to self-medicate, and to coercion and sexual assault by predators. Homeless youth often end up in situations where they are trading sex for a place to stay and other basic needs. The wide prevalence of substance use and abuse among young people, often in social environments such as parties or clubs, was also often associated with high-risk sexual behaviors as well. Participants commonly spoke of older people living with HIV taking advantage of young people in these vulnerable situations and not disclosing their HIV status to them.

The youth and providers participating in the interviews and focus groups shared numerous ideas about how to address the HIV prevention needs of high-risk youth, and they most

commonly recommended that HIV prevention strategies directed toward youth be heavily informed and implemented by youth whenever possible. According to participants, programming developed for youth needed to:

- 1) Address issues of mental health and substance abuse
- 2) Heed the call to provide young people with access to support (someone to talk to)
- 3) Assure that free condoms are readily available in many locations where young people congregate
- 4) Improve the quality and quantity of the HIV-related education they receive.

Such programming also needed to involve increasing awareness and knowledge about HIV to young people and to society at large as well as addressing issues of stigma, homophobia, and other forms of discrimination. Additionally, those providing prevention services to youth needed to “think outside the box” as to what prevention should look like and develop more safe environments where young people can go to access help, to learn, and to socialize. Youth participants in the needs assessment expressed very creative ideas about ways to meet the prevention needs of other young people, and many expressed enthusiasm for being part of the process of creating and implementing programs. A large number saw the importance of youth meeting young people who are living with HIV to evoke a better sense of the reality of the disease and of risk as well as to confront stereotypes and stigma. Many of the young participants living with HIV expressed a desire to be part of that process, in spite of the further stigma they could face by revealing their HIV status to so many others. It is clearly up to agencies that provide or seek to provide HIV prevention services to high-risk youth incorporate young people into the design, implementation, and evaluation of programming and provide opportunities for HIV positive youth to contribute to prevention efforts.

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ⁱ CDPHE STI/HIV Surveillance Program, 2011.