

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

**2007 HIV PREVENTION
NEEDS ASSESSMENT REPORT**

**Susan Luerssen, PhD
Kelly Voorhees, MSPH
George Ware, MS**

**Research and Evaluation Unit
STD/HIV Section
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, Colorado 80246**

June 2007

For further information call: Susan Luerssen (303-692-2792) or George Ware (303-692-2762)

ACKNOWLEDGMENTS

This needs assessment was conducted by the Research and Evaluation Unit at CDPHE in collaboration with the community planning group, Coloradans Working Together: Preventing HIV/AIDS (CWT). We would like to thank the former CWT planning group coordinator, Lois Switzer; Richard Weinert, the current coordinator; Angela Garcia, Planning Liaison; and members of the CWT Needs Assessment Committee for their contributions to this project.

We would also like to thank the following individuals for their assistance in gathering information used in this document and accessing participants for the interviews and focus groups:

Bernadette Berzoza
Debbie Berzoza
Mary Ann Bolkovatz
Gerald Borden
Dale Britt
Stephanie Carrol
Shannon Conn
Letoynia Coombs
Allison Crutchfield
Jennifer Donnelly
Laura Ginnett
Marshall Gourley
Rachel Hangsen
Rebecca Jordan

Ruth Kanaster
Imani Latif
Mary Beth Luedtke
Teresa Martinez
Claire Mearns
Marsha Miller
Crystal Noel
Antonio Olmos
Silvia Ramey
Tonya Rozencwajg
Juana Soto
Mariska Osbourne-Wells
Monique Whalen
Lisa Wheeler

Special thanks go out to Solwazi Johnson for facilitating and assisting with three of the focus groups and to Susan Snook for coordinating the transcription of recordings of interviews and focus groups and for her hard work transcribing recordings. We are also grateful to Roseann Prieto for facilitating a focus group and recruiting participants for another; to Maria Jackson for her facilitation of a group; and to Angela Garcia, Jo Palma, Colette Schantz, and Marsha Miller for their hard work transcribing recordings.

Finally, we would especially like to thank the men and women who participated in the focus groups and one-on-one interviews for sharing their stories and ideas.

2007 HIV PREVENTION NEEDS ASSESSMENT

INTRODUCTION

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

Needs assessments conducted prior to 2006 relied heavily upon the statewide distribution of surveys to individuals who were considered to be at high risk for getting or transmitting HIV as the primary approach for gathering data. Over the last several years, the data from these surveys were supplemented with some information gained through more qualitative methods. For the 2006 and 2007 assessments, once again a combination of quantitative and qualitative methods of data collection were used. However, the primary emphasis was placed on information gathered through the use of qualitative methods such as interviews and focus groups in order to elicit more complete information about the circumstances surrounding high-risk behaviors and to better understand how such behaviors fit into the complex context of people's lives. Another critical element of this approach was the effort to gain input from people who were at high-risk for HIV about the most effective and appropriate approaches for addressing key issues and needs as they related to HIV prevention. Additionally, it was meant to determine effective ways to get high-risk people involved in prevention programming. This information will aid CDPHE, its contractors, other providers of HIV prevention and related services, and other CWT members in gaining a more complete understanding of what elements should be present in HIV prevention and related programming and the most effective and appropriate ways to assist program participants through referrals to needed services.

METHODS

Four principal methods were used in gathering data for this needs assessment including: 1) reviewing aggregate epidemiological data drawn from the HIV/AIDS Reporting System (HARS), the Supplement to HIV/AIDS Surveillance Project (SHAS), and the 2003-2004 Needs Assessment Survey (NAS); 2) reviewing HIV case reports of heterosexual clients diagnosed over

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

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

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

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

SUMMARY OF AGGREGATE DATA AND HIV CASE REVIEW

SHAS

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

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

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

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

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

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

Needs Assessment Survey

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

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

- Women heterosexual respondents were more likely than heterosexual men to have reported both physical and sexual abuse, low self-esteem, depression, feelings of hopelessness, mental illness, and substance abuse.

HARS and HIV Case Reviews

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OVERVIEW OF INTERVIEW AND FOCUS GROUP INFORMATION

Participant Demographics

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

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

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

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

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

Discussions Topics

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

Issues and Concerns

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

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

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

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

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

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

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

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

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

Reasons for Risk Behaviors

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

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

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

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

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

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

HIV and Vulnerability

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

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

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

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

Disclosure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Approaches to HIV Prevention and Meeting Multiple Needs

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

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

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

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

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

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

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

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

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

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

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

HIV Testing

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

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

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

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

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

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

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

LIMITATIONS OF THE DATA

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

Data from the quantitative sources described above were drawn from convenience samples. Although HARS contains a more complete sample than the others, it only encompasses HIV cases that have been reported to CDPHE. The Supplement to HIV/AIDS Surveillance Project (SHAS) survey data were collected from people living with HIV who were accessing care services at Denver Public Health. The 2003-2004 Needs Assessment Survey (NAS) respondents were recruited by service providers and peers throughout Colorado, and were not randomly selected and cannot be considered representative samples. Despite this, a large amount of rich data was collected from a diverse sample of people that can be used with a high level of confidence for HIV prevention program planning and development.

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

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

SUMMARY AND CONCLUSIONS

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

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

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

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

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