Coloradans Working Together: Preventing HIV/AIDS

2007- 2009 Colorado Comprehensive Plan for HIV Prevention

As approved by the CWT Core Planning Group (CPG), August of 2006.

2007 – 2009 Comprehensive Plan for HIV Prevention
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Forward

Who are we and what do we do?

Coloradans Working Together: Preventing HIV/AIDS (CWT)

Prior to 1994 local communities were only indirectly involved in decisions regarding funding and priorities for HIV Prevention. The Centers for Disease Control and Prevention (CDC) first mandated community planning for HIV Prevention in 1993 and took effect in 1994. Colorado's community planning group was also formed in 1994 taking the name "Coloradans Working Together." The CDC's commitment to strengthen community-specific HIV prevention interventions was behind the CPG mandate. The CDC considers HIV community planning an "essential component of a comprehensive HIV prevention program" that must be conducted as a condition for federal funding. *The process must actively and meaningfully involve people from communities most heavily impacted by HIV/AIDS.* Community planning groups adhere to the CDC's "HIV Prevention Community Planning Guidance," that is the blueprint of the roles, responsibilities, and activities for community planning.

The three major goals for HIV Prevention Community Planning are:

- *Goal One — Community planning supports broad-based community participation in HIV prevention planning.*

- *Goal Two — Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.*

- *Goal Three — Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.*

Coloradans Working Together: Preventing HIV/AIDS (CWT) is the official HIV community planning group for the state of Colorado, as mandated by the CDC. CWT is a collaborative effort between the Colorado Department of Public Health and Environment (CDPHE), HIV-infected and affected communities, state and local HIV prevention providers, and other concerned parties, to improve HIV prevention in Colorado. CWT members and participants include AIDS activists, staff of the CDPHE, local health department representatives and service providers, staff and volunteers from statewide community-based organizations, and other concerned and committed citizens.

"I participate in Coloradans Working Together because we have the opportunity to guide the path of HIV prevention for the State of Colorado's future. Our process is outstanding, despite the fact that it isn't perfect. How boring it would be if it were!"*

CWT was established in 1994 with the goal of strengthening and improving the existing HIV prevention efforts and identifying priority populations and activities through a participatory process that incorporates the views and perspectives of affected persons and providers of services. Participants inform, shape, and assisted in the development of the current 2007 – 2009 *Colorado Comprehensive Plan for HIV*

Prevention. The state health department (CDPHE) than takes the information from the plan and the priority setting process and "operationalizes" it in its annual application for CDC funding, that in turn becomes HIV prevention services and programs in Colorado.

Members participate in CWT via its nine standing committees. The primary responsibility of the Core Planning Group's (CPG) standing committees is to keep community planning on track. Each standing committee drafts proposals concerning community planning and submits these proposals for consensus at meetings of the CPG. Participation in CPG standing committees is open to all CPG members and others who wish to participate.

The following is a list of the current CWT standing committees:
- Steering Committee
- Urban Planning Committee
- Rural Planning Committee

- Plan & Application Comparison Committee
- Cultural Competence Committee
- Definitions and Standards Committee
- Public Policy Issues Committee
- Membership/Orientation Committee
- Needs Assessment/Prioritization Committee

A description of the standing committee roles and responsibilities can be found in the *CWT Charter,* attached at the end of the Comprehensive Plan.

"CWT is a process to stay updated on trends, issues, barriers, public policy, interventions, etc."*

CWT received the 1998 Core Values Award from the International Association for Public Participation (IAP2), for excellence and innovation in the application of IAP2 Core Values for Public Participation.

What is the Comprehensive Plan?

The primary task of the CPG is to develop a comprehensive HIV prevention plan that includes prioritized target populations and prevention activities/interventions. CWT prioritizes target populations and prevention activities/interventions based on their potential ability to impact the greatest number of new HIV infections. The Comprehensive Plan is widely used to inform policy-makers, health care professionals, community-based organizations, and service providers at the state, county, and local level about effective HIV prevention programs, and about the populations in our community that are most at risk for becoming HIV infected.

"I believe it is my responsibility to give back to my community."*

Our Mission

To improve the availability, accessibility, cultural appropriateness, and effectiveness of HIV prevention interventions through an open, candid, and participatory process where differences in background, perspective, and experience are valued and essential.

To prevent the spread of HIV, strategies are needed that are appropriate and acceptable to diverse communities. Therefore, CWT

actively seeks the participation of every community affected by HIV: rural residents and urban residents, men who have sex with men, women at risk, Latinos, people living with HIV, African Americans, Asian Americans, Native Americans, incarcerated people, injection drug users, people with disabilities, children and pregnant women, substance abusers, people who are deaf or hearing impaired, migrant/seasonal workers, and youth.

"I came to CWT because of the unique opportunity it presented. For the first time in history, members of populations most affected by HIV had a chance to officially participate in the decision process of how HIV prevention efforts were targeted and implemented in Colorado… This process helps me stay better informed about what is happening with HIV prevention in our state and what the current needs are for service. I also believe, more than any other disease, HIV prevention provides the chance to work with the most talented and passionate people."*

How Do I Get Involved?

You can get on our mailing list to receive further information about CWT and to receive a calendar of upcoming meetings that are all open to the public. We meet four to five times a year as a full group, and we have several committees that meet at varying times throughout the year. Some committee's meet monthly, others only meet a couple times a year. However, all the committees contribute in invaluable ways to the community planning process in Colorado. We are dedicated to providing equal access and participation resources to anyone interested in participating. Just let us know what we can do to make it easier for you to get involved. Anyone is welcome to attend and speak during any of the meetings in order to express concerns or ask questions.

If you're interested in learning more about CWT or attending a meeting, contact us at:

Coloradans Working Together
4300 Cherry Creek Drive South,
DCEED-STD-A3
Denver, CO 80246-1530
Phone (303) 692-2685 or (800) 886-7689
Fax (303) 782-0904
Email: *lois.switzer@state.co.us or angela.garcia@state.co.us*
Web site: *www.cdphe.state.co.us/dc/cwt*

Important Contact Information

2006 Co-Chairs		
Craig Chapin, Rural Co-Chair PO Box 931 Laporte, CO 80535 Ph: 970-420-6407 *reikicraig@hotmail.com*	**Michael McLeod, JD, Urban Co-Chair** c/o Brothas4Ever 2615 Welton St., Suite A Denver, CO 80205 Ph: 303-292-0399 Fx: 303-292-0293 *Brothas4Ever@hotmail.com*	**Jean Finn, CDPHE Co-Chair** CDPHE-DCEED-STD-A3 4300 Cherry Creek Drive, South Denver, CO 80246 Ph: 303-692-2721 Fx: 303-782-0904 *jean.finn@state.co.us*

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Ross Barnhart, Rural Co-Chair Elect c/o Pueblo Community College 900 W Orman Ave. Pueblo, CO 81001 Ph: 719-549-3382 Fx: 719-549-3319 *Ross.Barnhart@pueblocc.edu*	**Roseann Prieto, Urban Co-Chair Elect** c/o Denver Area Youth Services (DAYS) 1240 W Bayaud St. Denver, CO 80223 Ph: 303-698-2300 Fx: 303-698-2903 rprieto@denveryouth.org

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"I participate in CWT to be a voice for Latino rural women who otherwise wouldn't be heard."*

"I participate to bring more effective interventions to drug users in Colorado."*

"I participate to bring a voice and representativeness from groups and individual on the Western Slope."*

*The above quotes were comments from CWT planning members in 2002.

Acknowledgements

The development of this plan was a coordinated effort requiring the gifts of many talented individuals. We would like to gratefully acknowledge the contributions of all the current (2006) CWT members and CDPHE staff that actively contributed to this Comprehensive Plan. There dedication to HIV prevention community planning and contribution to the field of work will be felt for many years, well beyond the 2007 – 2009 timeline proposed by this plan.

Countless other individuals contributed to the development this Comprehensive Plan, especially past members of CWT from 1994 through 2005. We greatly acknowledge the contributions of all former contributors to CWT and appreciate their contributions. We feel privileged to use their work as the basis of the new *2007 – 2009 Colorado Comprehensive Plan for HIV Prevention*.

Coloradans Working Together: Preventing HIV/AIDS

2006 Co-Chairs
Craig Chapin, Rural
Michael McLeod, Urban
Jean Finn, Health Department
Ross Barnhart, Rural Elect
Roseann Prieto, Urban Elect
Dan Garcia, Sergeant-at-Arms

2006 Participating Core Planning Group Members
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Gerald Borden
Sondra Chessare
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Gerald Ernst
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Common Abbreviations Used in Community Planning

AED	Academy for Education Development (agency that provides technical assistance to Community Planning Groups
AIDS	Acquired Immune Deficiency Syndrome
ASO	AIDS Service Agency
CBO	Community-Based Agency
CBP	Client Based Prevention
CDC	Centers for Disease Control and Prevention (Federal agency responsible for HIV prevention in the U.S.)
CDPHE	Colorado Department of Health & Environment
CIP	Community Identification Process
CLI	Community Level Intervention
CPG	Community Planning Group (Develops and adopts the Comprehensive Plan); a.k.a., Core Planning Group (the main body of CWT members who meet four to five times a year to develop the Comprehensive Plan and other planning activities
CTR	Counseling, Testing, and Referral
CTS	Counseling and Testing Site
CWT	Coloradans Working Together: Preventing HIV/AIDS (Colorado's Community Planning Group)
DCEED	Disease Control & Environmental Epidemiology Division
DIS	Disease Intervention Specialist (formerly know as partner notification/surveillance field worker)
EIA	Enzyme Immunoassay (HIV screening test)
ELISA	Enzyme-Linked Immunosorbent Assay (HIV screening test)
Epi	Abbreviation for epidemiology
Epi Profile	A description of the current status, distribution, and impact of an infectious disease or other health related condition in a specific geographic area
GLI	Group Level Intervention
HAART	Highly Active Antiretroviral Therapy
HCV	Hepatitis C Virus (HAV=Hepatitis A Virus, HBV=Hepatitis B Virus)
HC/PI	Health Communication/Public Information
HE/RR	Health Education/Risk Reduction
HIV	Human Immunodeficiency Virus
IDU/IVDU	Injecting Drug Users/Intravenous Drug User
ILHE	Individual Level Health Education
ILI	Individual Level Intervention
MSM	Men Who Have Sex With Men
NEP	Needle Exchange Programs
NGI	Non-Gay Identifying
NIR	No Reported or Identified Risk
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
PI	Public Information
PIR	Parity, Inclusion, and Representation
PLI	Population Level Intervention
PLWH	Persons Living With HIV (PLWA = People Living with AIDS)
POC	Persons of Color
POS	Partner of Opposite Sex (at risk through heterosexual contact)
RFP	Request for Proposal
STD	Sexually Transmitted Disease
TA	Technical Assistance: Direct or indirect support to build the capacity of CPG members to adequately complete the work of community planning
TATP	Technical Assistance & Training Program

Chapter One

The Integrated Epidemiologic Profile of HIV/AIDS Prevention and Care Planning (through June 2004)

What is the Epidemiologic Profile?
The intent of the Epidemiologic Profile (Epi Profile) is to describe the impact and extent of the HIV/AIDS epidemic in Colorado. The Epi Profile provides insightful information about the characteristics of populations at high risk for HIV infection, including both HIV-infected and HIV-negative persons. Sociodemographic, geographic, behavioral, and clinical characteristics are also provided, to the extent possible. The Epi Profile provides the scientific bases from which HIV prevention and care needs can be identified. Therefore we expect that this information will be of great utility to those beyond just the community planning group, Coloradans Working Together: Preventing HIV/AIDS (CWT).

What is its Significance to Community Planning?
The Epi Profile is critical to the community planning group, as it provides the scientific foundation from which the group can begin to prioritize target populations. Yet the Epi Profile is only one of the tools used by the planning group during its prioritization process. The Epi Profile helps to guide the subsequent community service assessment (CSA) process by identifying the populations at risk for HIV infection that should be targeted by the CSA. Please see chapter three through seven of this Comprehensive Plan for more detailed information about how CWT selected its target populations in 2006 and its CSA process.

The *Integrated Epidemiologic Profile of HIV and AIDS Prevention and Care Planning reported through June 2004* was compiled and edited by staff of the Colorado Department of Public Health and Environment (CDPHE) HIV Surveillance Unit.

The Surveillance Unit also publishes a quarterly report titled "HIV and AIDS in Colorado: Monitoring the Epidemic."

The information provided in the Epi Profile and most recent quarterly report was presented to the CWT Core Planning Group (CPG) at its March 31, 2006, meeting, just prior to the start of the 2006 prioritization process. Members were asked to review the current Epi Profile and quarterly report and to submit additional data questions that

would make the epi information more pertinent for community planning purposes.

The full text of the current Epidemiologic Profile is published as a separate document. Please call the CDPHE HIV Surveillance Program at (303) 692-2692 to obtain a copy of this Profile.
The Epidemiologic Profile is also available on the Internet, at:

http://www.cdphe.state.co.us/dc/HIV_STDSurv/profile3.pdf

The most recent quarterly report is available on the Internet, at:

http://www.cdphe.state.co.us/dc/HIV_STDSurv/MonitortheEpi.pdf

Chapter Two

Definitions for HIV Prevention Interventions and Standards of Practice

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What are the Definitions and Standards?
See the introduction to this chapter.

What is its Significance to Community Planning?
See the introduction to this chapter.

Introduction

HIV prevention community planning is an ongoing, comprehensive planning process that is intended to improve the effectiveness of State, local and Territorial health departments' HIV prevention programs by strengthening the scientific basis, community relevance, and population- or risk-based focus of prevention interventions. Since 1994, Colorado's community planning group entitled Coloradans Working Together: Preventing HIV/AIDS (CWT) has brought together representatives of affected populations, epidemiologists, behavioral and social scientists, HIV/AIDS prevention service providers, health department staff, and others interested in preventing HIV/AIDS. Together, CWT has analyzed the course of the epidemic in Colorado, assessed and prioritized HIV prevention needs, identified HIV prevention interventions to meet those needs, and developed a series of comprehensive HIV prevention plans that respond to the epidemic in Colorado.

This chapter of the *2007-2009 Comprehensive Plan* for HIV Prevention has three purposes. First, it is intended to acknowledge the updated "Definitions for HIV Prevention Interventions and Standards of Practice" document developed by the

Colorado Department of Public Health & Environment (CDPHE) in 2006 with the effective date of January 1, 2007. Historically, one intention of this chapter of the Comprehensive Plan for HIV Prevention was to establish best practices for programs in Colorado as well as to establish stands for evaluation and monitoring. The "spirit" of this chapter's definitions and standards were to be included in all CDPHE HIV prevention contracts.

The second purpose of this chapter is to note that CWT's Definitions and Standards committee has not met, and is not expected to meet, in 2006.

The third purpose of this chapter is to document CWT's commitment to take steps in 2007 to (1) incorporate the State's definitions and standards, (2) develop its own definitions and standards, or (3) take a third course of action to guide the work of the CDPHE STD/HIV Section, the programs contracted by CDPHE through its Technical Assistance and Training Program, and agencies not funded by CDPHE.

Chapter Three

The Resource Inventory

What is the Resource Inventory?
The intent of the resource inventory is to describe the current HIV prevention resources and activities in the Colorado that are likely to contribute to HIV risk reduction. In the following pages you will find:
• Contact information
• Funding amounts and sources
• Geographic areas served (rural or urban)
• Number of individuals served (annually)
• Targeted populations served by the programs
• Types of programs offered.
The resource inventory helps to describe the "met" needs for Colorado's target populations.

What is its Significance to Community Planning?
The resource inventory attempts to answer the community planning groups question, "Who is doing what for whom and where?" More than just a list of contacts, it helps to describe a community's capability to respond to the HIV/AIDS epidemic in terms of resources and potential capacity for HIV prevention.

Introduction

The information presented on the following pages was gathered by a myriad of resources, including the "2005 Provider Survey;" the 2006 Colorado AIDS Coalition for Education (ACE) Resource Directory; the Ryan White Title I Resource list; and the Title X Family Planning Clinics in Colorado offering HIV counseling and testing services.

The "2005 Provider Survey" was distributed in August of 2005 to organizations with Colorado Department of Public Health and Environment (CDPHE) HIV prevention contracts for the current year. The purpose of the survey was to obtain information about the range of HIV prevention and education services available from these organizations, as well as to determine what populations receive those services. (See the attachments at the end of the Comprehensive

Plan to see a copy of the 2005 Provider Survey.)

The "2005 Provider Survey" was developed in combination with the Coloradans Working Together: Preventing HIV/AIDS (CWT) Needs Assessment/Prioritization (NA/P) Committee and the CDPHE Research and Evaluation Unit (R&E Unit). The committee started the process by reviewing the survey that was distributed in 2003. Strengths and weaknesses of the former survey were evaluated and the R&E Unit implemented the committee's suggestions for updating the 2005 survey. Due to the low response rate from the 2003 surveys (43%) and large amount of incomplete surveys that were returned, the committee chose to not distribute the surveys to all potential providers (as done in 2003). Instead, the surveys were sent only to

those providers that were currently receiving (or had recently received) funds via CDPHE HIV prevention contracts.

Surveys were sent to twenty organizations throughout Colorado. A total of 18 surveys were received (a response rate of 90%). Moreover, because the survey was only sent to a select number of organizations, more detailed information was obtained.

Funding information included in the Resource Inventory for providers that received CDC funding via CDPHE ("CDPHE Contractors"), was based on the contracted funding agreements recorded with CDPHE as of May 2006. The funding amounts listed are in effect through December 31, 2006. Because HIV prevention services and the delivery of those services differ greatly between urban and rural areas, the information on the following pages distinguishes between the urban and rural by means of four separate tables (organizations receiving funding via CDPHE and organizations not currently receiving funding via CDPHE, separately for urban and rural areas).

A summary of the estimated number of clients to be served by the agencies funded by CDPHE is also provided at the end of this chapter. The information is provided separately for urban and rural areas, as well as by target population and intervention method. Please note that the estimated number of clients is based on estimates done in 2005.

Another resource used to compile the Resource Inventory was the 2006 Colorado ACE Directory. ACE is comprised of over 40 public and private organizations and individuals who have interests in or activities specifically related to HIV/AIDS education, information, prevention, and care services at either local or statewide levels. ACE members volunteer their time to produce the Colorado HIV/AIDS Resource Directory. This comprehensive directory lists only Colorado-based agencies that have programs specifically focusing on some aspect of HIV/AIDS and STD prevention, treatment, or service for persons living in Colorado. It is revised every two years. Published copies of this directory are available statewide and free of cost to HIV-infected individuals and HIV/AIDS service providers.

Other resources used include the Ryan White Title I Resource list and the Title X Family Planning Clinics in Colorado offering HIV counseling and testing services. The Ryan White Title I Resource List is a list of organizations and programs providing HIV care-related services in the Denver Eligible Metropolitan Area (EMA), some of which are Ryan White Title I funded organizations.

The Women's Health Section Family Planning Program at the CDPHE conducted a survey in May of 2006 of their Title X Family Planning funded organizations to find out what agencies were offering HIV counseling and testing services.

Limitations

Although the Resource Inventory provides a significant amount of information about HIV prevention services around the state of Colorado, there were limitations to the information gathered. Though every effort was made to identify providers of HIV prevention services, and many CWT

members contributed to the effort to update the information, it is likely that some organizations were missed. It should also be noted that providers continually change the nature and scope of their services, making it difficult to maintain a "real time," accurate inventory of services.

Also, in some cases, providers completing the surveys (or other related means in which data was collected for the various resources used) were possibly unaware of the precise definitions of the services asked about in the surveys. This most likely led to some inaccurate reporting of the services provided, including some claiming to provide a service that they actually only referred people to, and some claiming to offer services they do not provide while not accurately reporting services that they do provide. Not all agencies listed on the Resource Inventory were contacted to verify accuracy of the information listed, due to limited staff resources. While there is a high amount of confidence in the resources used to create the Resource Inventory, it is likely that there is still a small margin of error.

The primary funding for direct HIV prevention programs in Colorado is supported by the Centers for Disease Control and Prevention (CDC) HIV Prevention Cooperative Agreement that is distributed to contracted agencies via the CDPHE or "prevention for positive" services through the Ryan White CARE Act. There is one HIV prevention program in Colorado that receives funding directly from the CDC, The Empowerment Program. While other funding sources are limited, CWT staff was unable to obtain information on the other funding sources and thus cannot describe their contribution to the spectrum of HIV prevention resources and services funded in Colorado. Similarly, the projected number of clients for 2006 for the organizations listed that are not receiving CDPHE HIV prevention funding could not be obtained.

It is important to note that the summary of the estimated number of clients to be served by the agencies funded by CDPHE (provided near the end of this chapter) is based on estimates done by CDPHE in the summer of 2005, and not the program's estimates as submitted to CDPHE in the fall of 2005 as part of the grant application process.

Another important limitation of the data on the following pages refers to the references of geographic areas served by the service providers. Most counties in Colorado are quite diverse from one end to another. Towns or cities within the same county may differ *greatly* in terms of socio-demographics as well community norms. Providers were asked to identify where their services were provided as precisely as possible, but responses varied from identifying individual towns or cities to entire counties. Since most counties in Colorado are also geographically quite large, it cannot be assumed that providers are able to provide the same level of services in all the towns in those counties, and in some counties the community is served on a very limited bases, if at all.

The following Colorado counties are considered urban by CWT: Adams, Arapahoe, Boulder, Denver, El Paso, and Jefferson County. All other Colorado counties are considered rural. An example of the difficulty in categorizing counties is that of El Paso County. While Colorado Springs is considered an urban city in El Paso County, the areas surrounding the city are rural. Thus, there is some overlap in the urban and rural listings based on the difficulty distinguishing such areas. In addition, the CWT Rural Committee also distinguishes rural, frontier, and suburban county designations. Please see the last two pages of this chapter for further details.

The CDPHE attempts to serve anyone in need of services, no mater where they live in Colorado, either by its staff of fieldworkers or contracted community-based agencies. But it is possible that in out-lying areas, that a service may not be provided if a person does not directly request services. This is both a reality of the service provision system

and the need to provide services within a system with limited dollars to serve all those in need.

Strengths

The major strength of this Resource Inventory is the variety of resources used to compile the Resource Inventory. In addition, the drafts of the Resource Inventory were routed to several individuals (including CDPHE staff contract monitors and case managers), three CWT committees (Rural, Urban, and Needs Assessment/Prioritization), and other CWT members via an Open Meeting. Every effort was made to assure that the Resource Inventory was as complete and accurate as possible (recognizing that there are some limitations).

Key:

ARTS	Addiction Research and Treatment Services
ASO	AIDS service organization
BCAP	Boulder Colorado AIDS Project
CAP	Colorado AIDS Project
CB	Capacity Building
CBO	Community –based organization
CDC	Centers for Disease Control
CDPHE	Colorado Department of Public Health and Environment
CM	Community Mobilization
CRCS	Comprehensive Risk Counseling and Services (may also be termed PCM)
CTR	Counseling, testing and referral
CTS	Counseling and testing site
DYC	Department of Youth Corrections
DHH	Denver Health and Hospitals
GLBT	Gay, lesbian, bisexual and transgender
GLBTQ	Gay, lesbian, bisexual, transgender, and questioning
GLI	Group level intervention
HE/RR	Health Education/Risk Reduction
HIV testing	Differs from CTR in that it may use Orasure in outreach without the full CTR component
IDU	Injecting drug user
ILI	Individual level intervention
PCM	Prevention case management (may also be termed CRCS)
PCRS	Partner Counseling and Referral
HC/PI	Health Communication/Public Information (information exchange without a behavioral adjustment or training component)
PLWH/A	Persons living with HIV/AIDS
PN	Partner notification
MSM	Men who have sex with men
MSM/IDU	Men who have sex with men and also injecting drug users
MSM-NGI	Men who have sex with men who do not identify as 'gay'
NCAP	Northern Colorado AIDS Project
SCAP	Southern Colorado AIDS Project
WestCAP	Western Colorado AIDS Project

| Resource Inventory – Urban Resources- CDPHE Contractors | | | | | | | |
Name of Agency and Contact Information	Focus	Primarily Serving Residents of (Onsite Services Provided in)	Target Population	Projected Number of Clients Annually 2006	Type of Intervention (Some services may not be offered in all locations)	Other Services Offered	CDC/ CDPHE Funding (Through 12/31/06)
Addiction Research and Treatment Services (ARTS) 2121 E. 18th Avenue Denver, CO 80206 Jodi Suckney Ph: 303-355-1014 http://www.arts.signalbhn.org/	Substance Abuse	All Colorado (Denver)	Substance Abusers ------------------------------------ PLWH/A	600 ------------------ 73 35	CTR ----------------------------------- GLI ILI	Hep C testing	CTR $2,000 ------------------ "Healthy Relationships" $42,567
Gaylord (ARTS) 1827 Gaylord Denver, CO 80206 Pamela Richards Ph: 303-388-5894 Fax: 303-388-2801	Substance Abuse	Metropolitan Denver (Denver)	MSM Substance Abusers				
Haven, The (ARTS) 3630 West Princeton Circle Denver, CO 80236 Ph1: 303-762-2193 Ph2: 303-761-7626 Fax: 303-762-2194	Substance Abuse	Metropolitan Denver (Denver)	Women, especially those who are pregnant, post-partum, or criminally involved				
Peer 1 Therapeutic Community (ARTS) 3762 W. Princeton Circle Denver, CO 80236 Ph: 303-761-2885 Fax: 303-761-1450	Substance Abuse	Metropolitan Denver (Denver)	Male Substance Abusers with significant drug/alcohol problems, often also with criminal problems				
Potomac (ARTS) 1300 S. Potomac St. Aurora, CO 80012 Ph: 303-388-5894 Fax: 303-388-2808	Substance Abuse	Metropolitan Denver (Denver)	Substance Abusers				
	Substance Abuse	Metropolitan Denver (Denver)	HIV+ drug injectors and those who smoke crack				

Resource Inventory – Urban Resources- CDPHE Contractors							
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Projected Number of Clients Annually 2006**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**	**CDC/ CDPHE Funding** (Through 12/31/06)
Project Safe (ARTS) 1741 Vine St Denver, CO 80206 Ph1: 303-315-0950 Ph2: 800-429-9240 Fax: 303-316-7697			Women of color		Strength-based case management		
	Substance Abuse	Metropolitan Denver (Denver)	Adolescent Males and Females, ages 13-19 years				
Synergy Adolescent Treatment Services (ARTS) 3738 W. Princeton Circle Denver, CO 80236 Ph: 303-781-7875 Fax: 303-762-2196	Substance Abuse	Metropolitan Denver (Denver)	Substance Abusers				
Vine Street Center (ARTS) 1741 Vine St. Denver, CO 80206 Ph: 303-315-8463							
Boulder County Health Dept. 3450 Broadway Boulder, CO 80304 Ph: 303-413-7522 Fax: 303-413-7505 Kate Storm kstorm@co.boulder.co.us http://www.co.boulder.co.us/	Health Services	Boulder County (Boulder)	General Population Those at risk for HIV	1,250	CTR-CTS	Hep C Testing	CTR $9,000

| Resource Inventory – Urban Resources- CDPHE Contractors | | | | | | | |
Name of Agency and Contact Information	Focus	Primarily Serving Residents of (Onsite Services Provided in)	Target Population	Projected Number of Clients Annually 2006	Type of Intervention (Some services may not be offered in all locations)	Other Services Offered	CDC/ CDPHE Funding (Through 12/31/06)
Colorado AIDS Project (CAP) 2490 W. 26th Ave., Bldg A Suite 300 Denver, CO 80211 Rachel Hansgen Ph1: 303-837-0388 Ph2: 1-800-333-2437 Fax: 303-861-8281 *info@coloradoaidsproject.org* *http://www.coloradoaidsproject.org/*	ASO	Metropolitan Denver and surrounding counties (Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson)	MSM PLWH/A	100 ------------------- 48 ------------------- 1,300	GLI ------------------------------------ ILI ------------------------------------ Outreach	HIV testing HE/RR Materials Food bank Transportation Housing assistance Financial assistance Health insurance assistance Counseling/ Therapy Substance Abuse Treatment	*"MPowerment"* $110,000
Colorado Coalition for STD Prevention 4300 Cherry Creek Drive South Denver, CO 80246 Ph: 303-692-2767 Fax: 303-782-0904 Angela Garcia *Angela.Garcia@state.co.us* *http://www.cdphe.state.co.us/dc/ccsp*	Education and Promoting Collaboratio-n	All Colorado (Denver)	All groups affected by STDs				
Colorado Department of Public Health (CDPHE) 4300 Cherry Creek Dr South Denver, CO 80246 Ph1: 303-692-2760 Ph2: 303-692-2777 Ph3: 800-252-AIDS *http://www.cdphe.state.co.us/dc/dceedhom.asp*	Public Health	All Colorado (Denver)	General Population		PCM/CRCS Partner Notification CTR PI PCRS Community Planning	Contract Monitoring Surveillance	

Resource Inventory – Urban Resources- CDPHE Contractors							
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Projected Number of Clients Annually 2006**	**Type of Intervention (Some services may not be offered in all locations)**	**Other Services Offered**	**CDC/ CDPHE Funding (Through 12/31/06)**
Denver Health (Denver Public Health Department) 605 Bannock St. Denver, CO 80204 Stewart Thomas Ph: 303-436-3163 Fax: 303-436-7211 *Stewart.thomas00@dhha.org* Also See "Denver Area Youth Services (DAYS)"	Health Services	Denver County (Denver)	PLWH/A MSM-NGI Latino/a IDU Those at risk for HIV General Population	45 1,000 ------------------ 13,582 ------------------ 99,150 ------------------ 219 ------------------ N/A	GLI Outreach ---------------------------------- CTR ---------------------------------- HC/PI ---------------------------------- ILI ---------------------------------- Capacity Building	HE/RR-Materials	*"Community Promise"* $59,586 ------------------ CTR: $103,221 ------------------ HC/PI $37,422 ------------------ Prevention for PLWH/A $93,165 ------------------ Capacity Building $141,608
El Centro Esperanza (Formerly ECCOS Family Center) 655 Broadway St, Suite 450 Denver, CO 80203 Chris Medina, El Futuro Program Coordinator Ph: 303-480-1920 Fax: 303-433-9627 *http://www.elcentroesperanza.org/* See "El Futuro Listed Below"	Latino Support Services	Metropolitan Denver (Denver)	Latino youth, individuals, and families		ILI GLI STD/HIV Testing Outreach (in bars and parks)	PI Counseling/ Therapy Health Education/ Risk Reduction	

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El Futuro Program (part of El Centro Esperanza) 1070 Bannock, Suite 150 Denver, CO 80204 Chris Medina, Program Coordinator Ph1: 303-204-9363 Ph2: 720-904-7125 Fax: 303-433-9627 *elfuturoprogram@yahoo.com* *http://www.elfuturoprogram.org/*	Latino MSM	Metropolitan Denver (Denver)	Latino MSM	24 1000 500	ILI GLI Outreach	Drop-in Center Counseling/ Therapy PI	*"Many Men, Many Voices"* $110,000
El Paso County Department of Health & Environment 301 S. Union Blvd. Colorado Springs, CO 80910 Helen Rogers Ph: 719-575-8615 Fax: 719-575-8629 *helenrogers@epchealth.org* *http://www.elpasohealth.org*	Health Services	El Paso and Teller Counties (Colorado Springs)	General Population, primarily residents of El Paso County ----------------------------------- ----------------------------------- IDU	1,506 ------------------	CTR	Hep B and C testing Outreach PI PCRS ------------------- "Safety Network Alternative Project" (McMasters Center)	CTR $52,700 -------------------
Empowerment Program 1600 York St. Denver, CO 80206 Ph: 303-320-1989 Fax: 303-320-3987 *http://www.empowermentprogram.org/*	Support Services	Metropolitan Denver (Denver)	Disadvantaged Women	30 15 280 ------------------- 1,200	ILI GLI Outreach ----------------------------------- Outreach	Health Education and Risk Reduction Hep C testing Transportation GED assistance Housing assistance Financial assistance Substance Abuse	*"Safety Counts"* $24,300 ------------------ *"Popular Opinion Leader"* $34,000

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Harm Reduction Project 775 Lipan St. Denver, CO 80204 Ph: 303-572-7800 Fax: 303-572-7800 Monique Whalen http://www.harmredux.org/	Substance abuse	Metropolitan Denver (Denver)	IDU	180 130 1,060	GLI ILI Outreach	Drop-in center Acupuncture for detox Hep C testing	*"Safety Counts"* $97,200
ISIS Inc. (Internet Sexuality Information Services) "InSPOT Colorado" PO Box 14287 San Francisco, CA 94114 Ph: 415-215-6184	Online Partner Notification System	All Colorado	Clients diagnosed with an STD that would like to notify sexual partners about possible exposure			Partner Notification	$33,510
It Takes A Village, Inc. 1532 Galena St., Suite 225 Aurora, CO 80010 Imani Latif Ph: 303-367-4747 Fax: 303-367-0227 ItTakesAVillage1@aol.com http://www.ittakesavillagecolorado.org/ Also See "Brothas4Ever"	Health Advocacy/ Services	Adams, Arapahoe, Denver Counties (Aurora)	African American High-Risk Heterosexual Females ------------------------------------ African American PLWH/A ------------------------------------ African American MSM ------------------------------------ African Americans at risk for or living with HIV. Testing and client advocacy available to individuals of all races.	50 150 ------------------ 55 75 ------------------ 24 198 ------------------	GLI Outreach ------------------------------------ ILI GLI ------------------------------------ ILI GLI ------------------------------------ CTR	Hep C testing Client Advocacy Asthma Education	*"SISTA"* $39,974 ------------------ *"Healthy Relationships"* $43,333 ------------------ *"Many Men, Many Voices"* $110,000 ------------------ CTR $0 contract, pay for lab testing

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Jefferson County Dept of Health and Environment 6303 Wadsworth By-Pass Arvada, CO 80003 Ph: 303-275-7500 Fax: 303-275-7503 260 S. Kipling (clinic) Lakewood, CO 80226 Ph: 303-239-7036 Fax: 303-239-7088 http://www.co.jefferson.co.us/health	Health Services	Jefferson County	General Population, primarily residents of Jefferson County	200 4,000	CTR- STD/HIV Testing Screening	Hep C testing	CTR $9,000
King, Wayne ManREACH	Health Education and Risk Reduction for Rural MSM	El Paso County (Colorado Springs)	MSM	50 800	GLI Outreach		*"ManREACH"* $10,910
Proyecto Nosotros P.O. Box 460695 Aurora, CO 80015 Lucy Pabon, Executive Director Ph1: 303-367-0959 Ph2: 303-204-9363 lucy-pabon@yahoo.com	Mental Health	All Colorado (Aurora)	Latino/a gay, lesbian, bisexual, and transgendered PLWH/A	300 45 24	Outreach GLI ILI	Counseling/ Therapy Substance Abuse Treatment PI	*"Healthy Relationships"* $43,333
Sisters of Color United for Education 2855 Tremont Place, Suite 125 Denver, CO 80205 Ph: 720-944-3821 Fax: 720-944-3827 http://www.sistersofcolorunited.org/	Information, Education, Advocacy, Health services	Metropolitan Denver (Denver)	Women of color and their families in underserved areas (primarily Latina) Latinas who smoke crack Latina IDU Latina High-risk Heterosexuals	20 1,120 12	GLI ILI Outreach	Hep C testing Client Advocacy	*"Hermanas"* *(version of SISTA)* $39,930

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Women's Lighthouse Project 1290 Williams St. Suite 303 Denver, CO 80218 Ph: 720-941-8200 Fax: 720-941-9011 Shannon Conn *womenslighthouse@aol.com* *http://www.womenslighthouseproject.org/*	HIV Positive Women	All Colorado (Denver)	HIV Positive Women and partners; incarcerated or recently released women	25 25 75	GLI ILI Outreach	Health Education and Risk Reduction Client Advocacy	*"Healthy Relationships"* $19,200 (Contract is with The Colorado Nonprofit Development Center)

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Acacia Counseling 1600 Downing St. #300 Denver, CO 80218 Ph: 303-861-9378 Fax: 303-839-8306	Mental health and Substance Abuse	All Colorado (Denver)	People with Mental Health Issues Substance Abusers	GLI ILI Counseling/therapy	
AIDS Coalition for Education (ACE) PO Box 18909 Denver, CO 80218 Ph: 303-830-0706 Fax: 303-315-2514 Peter Ralin, President *info@acecolorado.org* *http://www.acecolorado.org/*	Education	All Colorado (Denver)	Persons and agencies with an interest in HIV/AIDS Education, prevention, and care services.	PI	HIV/AIDS Resource Directory
AIDS Education and Training Center (AETC)- Colorado 4200 E. 9th Ave, A-089 Denver, CO 80262 Ph: 303-315-2516 Fax: 303-315-2514 MeriLou Johnson *Merilou.Johnson@uchsc.edu* *http://www.mpaetc.org/colorado.htm*	Education	All Colorado (Denver)	Clinicians, healthcare facilities or organizations, and health profession students		Skill building Clinical education
African American Unity Project 2655 Quebec St. Denver, CO 80207 Ph: 303-388-9269	Health Education and Risk Reduction	Arapahoe, Denver, Douglas, Jefferson, Boulder Counties (Denver)	African Americans Incarcerated Heterosexual men/women	HIV testing	Substance Abuse Treatment

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AIDS, Medicine and Miracles 1290 Williams St Denver, CO 80218 JoAnn Elliott Ph1: 303-860-8104 Ph2: 800-875-8770 Fax: 303-860-8105 *amm@aidsmedicineandmiracles.org* *http://www.aidsmedicineandmiracles.org/*	Health Education and Risk Reduction	All Colorado (Denver) (National Organization)	MSM PLWH/A Partners of PLWH	GLI (yearly retreat)	
Alford, William, MD 5800 E. Evans Ave., Suite 101 Denver, CO 80222 Ph: 303-759-8145	Infectious Disease	Metropolitan Denver (Denver)	PLWH/A	Medical Service Health Education/Risk Reduction	
Alternative Homes for Youth 700 W. 84th Ave, Suite 70 Thornton, CO 80260 Ph: 303-940-5540 Fax: 303-940-5542	Day and Residential Treatment	Metropolitan Denver (and some surrounding areas)	Adolescents age 12-18 and their families		
Angels Unaware 6370 Union St. Arvada, CO 80004 Ph1: 303-420-6370 Ph2: 866-420-6370 Fax: 303-456-4040 Julie Carlson *http://www.angelsunaware.net/*	Support for children affected by HIV/AIDS	All Colorado (Arvada)	Children living in families with HIV/AIDS	GLI ILI PI (monthly newsletter)	Annual Family Camp

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Apex Family Medicine 210 University Blvd. Suite 440 Denver, CO 80206 Scott, Mia, MD Mack, Paul, PA-C Mohr, Michael, DO Prutch, Peter, ANP Ph: 303-321-0222 Fax: 303-321-6683 *http://www.apexfamilymedicine.com/*	Infectious Disease	Metropolitan Denver (Denver)	PLWH/A	Medical Services Counseling/Therapy	
Arapahoe House 8801 Lipan St Thornton, CO 80260 Ph: 303-657-3700 Fax: 303-657-3727 *http://www.arapahoehouse.com/*	Substance Abuse and Mental Health	All Colorado (Thornton)	Substance Abusers and their families	PI ILI HIV testing Counseling/therapy	Hep C testing Parenting Classes Residential program
Archdiocese of Denver - HIV/AIDS Ministry 1300 S Steele St Denver, CO 80210 Al Hooper, Director of Social Min Ph1: 303-715-3287 Ph2: 303-715-3220 Fax: 303-715-2042 *alhooper@archden.org* *http://www.archden.org/*	Spiritual Support	Metropolitan Denver (Denver)	PLWH/A Partners of PLWH	PI (done through newsletter and parishes) GLI (Support group and retreats) ILI (Pastoral support)	
Arvada Counseling Center 7850 Vance Drive, Suite 280 Arvada, CO 80003 Ph: 303-420-4494 Fax: 303-420-4512	Outpatient Mental Health and Substance Abuse	Metropolitan Denver and Boulder Counties, also Larimer, Weld Counties (Arvada)		Counseling/therapy Substance Abuse treatment	

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Asian Pacific Development Center 1825 York St. Denver, CO 80206 Ph: 303-393-0304 Fax: 303-388-1172 Ivy Hontz Dr. Frank Kim 1544 Elmira St. Aurora, CO 80010 Ph: 303-365-2959 ext. 107 Fax: 303-344-4599	Multi-Human Services & AIDS Education for Asian Americans	Metropolitan Denver (Denver)	Asian Americans	AIDS Education in Asian/Pacific Ethnic Languages Counseling/therapy Peer Program PI	Employment assistance Speakers bureau Youth programs
Aurora Mental Health Center 11059 E. Bethany Drive Suite 200 Aurora, CO 80014 Ph: 303-617-2300 Fax: 303-617-2397 *http://www.aumhc.org/*	Mental Health	Adams and Arapahoe Counties (Aurora)	Children and adults with mental health issues	ILI GLI Education Counseling/therapy	Residential Program
Beacon Clinic Gantz, Nelson, MD FACP King, Mark, MD Maltzman, Alicia, NP Pujet, Heather, MD 1136 Alpine Ave., Suite 205 Boulder, CO 80304 Ph: 303-938-3167	Infectious Disease	Boulder County (Boulder)	PLWH/A		
Behavior Services Institute 1726 Downing St. Denver, CO 80218 Ph: 303-831-4500 Fax: 303-831-4499 Marjorie Lewis *ccesj@attglobal.net*	Mental Health, Substance Abuse (Dual diagnoses)	Metropolitan Denver (Denver)	IDUs Youth PLWH/A Incarcerated GLBT	GLI PI Faith-based interventions	Training and development Reintegration for formerly incarcerated

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Boulder Clinic, Inc. 1317 Spruce St. Boulder, CO 80302 Ph: 303-245-0123 Fax: 303-245-0119 *http://www.cbhclinics.com/*	Substance abuse (methadone treatment)	Boulder County (Boulder)	Individuals with heroin and other opiate addictions	Methadone treatment Assistance with related psychiatric, medical, social, occupational and legal issues clients face	Other addictive behaviors
Boulder County AIDS Project (BCAP) 2118 14th St. Boulder, CO 80302 Mark Beyer Ph: 303-444-6121 Ph: 303-444-7181 (Spanish) Fax: 303-444-0260 *http://www.bcap.org/*	ASO	Boulder, Broomfield, Gilpin, Clear Creek Counties (Boulder)	PLWH/A Partners of PLWH/A Those at risk for/affected by HIV	Public Information HIV testing Men's alliance for Safer Sex, Knowledge, and Education (MASSKE program)	HE/RR-Materials Food bank Housing Financial Assistance Counseling/therapy
Boulder County Public Health Addiction Recovery (MSO) 3450 Broadway Boulder, CO 80304 Jo Ruder, Program Manager Ph: 303-441-1281 Fax: 303-441-1286 *jruder@co.boulder.co.us*	Substance Abuse Treatment	Boulder County (Boulder)		Inpatient detox	
Boulder Valley Women's Health 2855 Valmont Rd. Boulder, CO 80301 Trisha Bozak Ph: 303-442-5160 *http://www.bvwhc.org/*	Health Services	Boulder County (Boulder)	General Population	STD/HIV testing	Health services

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Bridge Counseling Center 1552 West Alameda Ave. Denver, CO 80223 Ph: 303-937-8060 Fax: 303-433-1459 *http://www.bridgecounseling.org/*	Mental health and alcohol/drug counseling (Dual-diagnoses)	Denver, Jefferson, Adams, Arapahoe, and Douglas Counties (Denver)	PLEH/A Adolescents GLBT		
Bright Mountain Foundation 1470 Walnut St., Suite 101 Boulder, CO 80302 Ph: 303-381-2245 Fax: 303-381-2245 *cwessell@brightmtnfdtn.org* *http://www.brightmtnfdtn.org*	Community Assistance (Private philanthropic foundation)	All Colorado (Boulder)	Children/youth and their families, seniors, and persons living with HIV/AIDS and/or Hepatitis C		Make grants available to communities in the state of Colorado to assure that the target population lives in safe, healthy communities that support them.
Broomfield Health and Human Services 6 Garden Center Broomfield, CO 80020 Ph: 720-887-2220 Fax: 303-469-2110 *http://www.ci.broomfield.co.us/*	Health Services	Metropolitan Denver (Broomfield)	General Population	STD/HIV testing	
Brothas4Ever (Program of It Takes a Village) Drop-In Center 2615 Welton Street Denver, CO 80205 Ph: 303-292-0399 Michael McLeod *Brothas4ever@hotmail.com* Also See "It Takes a Village"	Health Education/ Risk Reduction, ASO	Metropolitan Denver (Denver)	African American MSM	ILI GLI Outreach	HIV testing Food bank

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Brother jeff's Community Health Initiative 608 26th St, Executive Suite Denver, CO 80205 Jeff Fard Ph1: 303-293-8879 Ph2: 720-628-4449 *brotherjeff1@earthlink.net* *http://www.brotherjeff.com/* Also See "It Takes a Village"	Health Education/Risk Reduction	Metropolitan Denver (Denver)	African American PLWH/A	ILI GLI Outreach	HIV Testing PI Islamic information and assistance to Muslim men living with HIV, and accompaniment to Jumu'ah services
Carbone, Amy (Private Practice) 2661 Clermont St Denver, CO 80207 Ph: 303-883-9360 *acabone@earthlink.net*	Counseling/therapy	Metropolitan Denver (Denver)	MSM MSM-NGI PLWH/A	Counseling/Therapy	
Caritas Clinic (Exempla St. Joseph) 2005 Franklin St., Midtowne II Suite 390 Denver, CO 80218 Ph: 303-318-2250 Fax: 303-318-2252 Aaron Calderon, MD *http://www.exempla.org/*	Health Services	Metropolitan Denver (Denver)	Uninsured needing healthcare (charged on sliding scale)	STD/HIV testing Training	
Carolyn Gissendanner-Borrick and Associates 2217 Jasmine St Denver, CO 80207 Carolyn Gissendanner-Borwick Ph: 303-321-7130 *Charris852@aol.com*	Counseling/therapy	Denver, Adams, Arapahoe, Douglas Counties (Denver)	African Americans PLWH/A	Counseling	

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Cenikor 1325 Everett Ct. Denver, CO 80215 Ph: 303-234-1288 *http://www.cenikor.org/*	Substance Abuse	Metropolitan Denver (Denver)	Substance Abusers PLWH/A Men Criminal Justice clients	Residential 30-day treatment	
CHIP Youth Project (Children's Hospital) 1827 Park Avenue West Denver, CO 80218 Drew Hodgson Ph1: 303-837-2604 Fax: 303-837-2707 *hodgson.drew@tchden.org* *http://www.chipteam.org/*	ASO	Rocky Mountain Region (Denver)	PLWH/A (children up 24 years) Partners and Families of PLWH/A Pregnant Women	GLI (Support group open to youth with HIV/AIDS) Public Information HIV testing Outreach Peer based intervention (Peer counselors: peer program)	Partner Notification* *Must be client of CHIP, Youth up to age 24
Choosing Life Center 1626 High St. Denver, CO 80218 Carolyn Lucero, Director Ph: 303-321-6563	Substance Abuse	Metropolitan Denver (Denver)	Substance Abusers		

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Clinica Campesina 1701 W. 72nd Ave, 3rd Floor Denver, CO 80221 Ph: 303-650-4460 Fax: 303-650-4403 Lupita *http://www.clinicacampesina.org* 1345 Plaza Court N., #1A Lafayette, CO 80026 Ph: 303-665-9310 Fax: 303-665-4459 8990 North Washington Thornton, CO 80229 Ph: 720-929-1655 Fax: 720-929-1417	Health Services	Southeast Boulder, Adams, and Denver Counties (Denver and Lafayette)	Latino/a Medically underserved populations		
Colorado Anti-Violence Program PO Box 181085 Denver, CO 80218 Ph1: 303-839-5204 Ph2: 303-852-5094 24hr Fax: 303-839-5205 *info@coavp.org* *http://www.coavp.org/*	GLBT	All Colorado (Denver)	GLBT victims of bias-motivated crimes, sexual assault, and domestic violence	ILI Counseling/Therapy	
Colorado Coalition for the Homeless Stout Street Clinic 2100 Broadway Denver, CO 80205 Malia Davis Ph: 303-293-2220 *http://www.coloradocoalition.org/*	Health Services for Homeless	Metropolitan Denver (Denver)	Homeless Individuals and Families	PI STD/HIV testing Outreach Health Education and Risk Reduction	Housing Vision Dental Mental Health Substance Abuse Health services

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Colorado Department of Education (CDE) 201 E. Colfax Ave. Denver, CO 80203 Ph: 303-866-6600 Fax: 303-830-0793 Linda Tamayo *tamayo_l@cde.state.co.us* *http://www.cde.state.co.us/*	Prevention Education	All Colorado (Denver)	School age children and adolescents		
Colorado Department of Human Services 1575 Sherman St. Denver, CO 80203 Ph: 303-866-5700 Fax: 303-866-4047	Human Services	All Colorado (Denver)	Adults (18 and older) Children, youth, and families		
Colorado Infectious Disease Associates Gulison, Jordan, MD Karakusis, Peter, MD Lombardi, Carol, MD 950 East Harvard Ave Suite 690 Denver, CO 80210 Ph: 303-777-0781	Infectious Disease	Metropolitan Denver (Denver)	PLWH/A	Medical Service Health Education/Risk Reduction	
Colorado Nurses Association 1221 S. Clarkson #205 Denver, CO 80210 Ph: 303-757-7483 Fax: 303-757-8833 Paula Stearns *can@nurses-co.org* *http://www.nurses-co.org/*	Education	All Colorado (Denver)	Registered nurses in Colorado		

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Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR) PO Box 20161 Denver, CO 80220 Ph: 303-393-0382 Fax: 303-316-7772 Jacinta "Jacy" Montoya *info@colorlatina.org* *http://www.colorlatina.org/*	Education and Advocacy	All Colorado (Denver)	Latinas		Client advocacy Technical Assistance
Colorado Organizations Responding to AIDS (CORA) C/o Colorado AIDS Project PO Box 48120 Denver, CO 80204 Ph: 303-355-5665 Fax: 303-355-1923 David E. Cooper, Mdiv, Chair *raincolorado@yahoo.com*	Collaboratio-n	All Colorado (Denver)	HIV and AIDS Service Organizations and Individuals (non-profit status or affiliated with non-profit)		
Colorado Springs Community Health Initiative 301 Union Blvd. Colorado Springs, CO 80910 Monica Kirkwood, Executive Director Ph: 719-578-3158 Fax: 719-271-7147	Health Services	El Paso County (Colorado Springs)	PLWH/A	PI	
Colorado Springs Health Partners Silveria, Linda, MD 6025 Delmonico Drive Colorado Springs, CO 80919 Ph: 719-535-0648	Infectious Disease	El Paso County (Colorado Springs)		Medical Service	

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Commerce City Community Health Services 4675 E. 69th Ave Commerce City, CO 80022 Kristin Cox Ph: 303-289-1086 Fax: 303-289-7378	Health Services	Adams County (Commerce City)	General Population	PI	STD testing
Comprehensive Addiction Treatment Services (CATS) 2222 E. 18th Ave Denver, CO 80206 Ph: 303-394-2714 Fax: 303-394-2732	Substance Abuse (methadone program)	All Colorado (Denver)	Opiate/heroin users		
Connect Care (MSO) 220 Ruskin DR Colorado Springs, CO 80910 Ph1: 719-572-6133 Ph2: 888-845-2881 Fax: 719-572-6089	Mental Health and Substance Abuse	El Paso County (Colorado Springs)			Social Services
Continental Divide Management Corp 6700 E Colfax Ave Denver, CO 80220 Gary Claymon, Office Manager Ph: 303-393-7368 Fax: 303-393-7266 *gclaymon@pcisys.net* *jwhite@pcisys.net*		Metropolitan Denver (Denver)	PLWH/A	Housing/Shelter (assists with clients who are low income)	

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Council, The 1444 Wazee, Suite 125 Denver, CO 80202 Ph: 303-825-8113 Fax: 303-825-8166 *http://www.milehighcouncil.com/*	Substance Abuse (Prevention and Treatment)	All Colorado (Denver)	Substance abusers (adults and youth)	ILI GLI PI Counseling/therapy	Services for other addictive behaviors
Denver Area Youth Services (DAYS) 1240 W. Bayaud Ave. Denver, CO 80223 Ph: 303-302-3273 Fax: 303-698-2903 Maggie MacFarlane *mmacfarlane@denveryouth.org* *http://www.denveryouth.org/* Also See "Denver Health"	Human Services	All Colorado (Denver)	Youth and Families Low income Latino/a Latino/a IDU	ILI GLI PI Outreach	Residential Mentoring Vocational education Healthcare services
Denver Behavioral Health Center 6045 W. Alameda Ave., Suite 101 Denver, CO 80226 Ph: 303-922-1104 Fax: 303-922-1016 *http://www.cbhclinics.com/*	Substance Abuse (Methadone Treatment)	All Colorado (Denver)	Heroin and other opiate users	Substance abuse and related psychological, medical, social, occupational, and legal issues GLI ILI	
Denver Family Medicine McCoy, Mathew, MD 1700 Marion St. Denver, CO 80218 Ph: 303-830-6666	Infectious Disease	All Colorado (Denver)	PLWH/A	Medical Services Health Education/Risk Reduction	

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Denver Health Medical Center for Outpatient Behavioral Health Substance Treatment Services 777 Bannock, Unit 2 2nd Floor, MC-0320 Denver, CO 80204 Ph: 303-436-6393 Fax: 303-436-5071	Mental Health and Substance Abuse	Denver County (Denver)		ILI GLI	
Denver Health (STD/Infectious Disease Clinic) 605 Bannock St Denver, CO 80204 Brandy Fuess, Nursing Program Manager Ph: 303-436-7254 Ph2: 303-436-7251 (main) *brandy.fuess@dhha.org*	Health Services	Denver County (Denver)		STD/HIV testing	Medical Services to PLWH/A, including a pharmacy and dental clinic
Denver HIV Resources Planning Council 4130 Tejon St., Suite A Denver, CO 80211 Ph: 720-855-8641 Fax: 720-855-8273 Lisa Lawrence *council@DHRPC.org* *http://www.dhrpc.org/*	Community Planning for HIV care services	Metropolitan Denver (Denver)	PLWH/A		

Resource Inventory – Urban Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention (Some services may not be offered in all locations)**	**Other Services Offered**
Denver Indian Health and Family Services, Inc. 3749 S King St. Denver, CO 80236 Jen Holcomb, Clinical Director Ph: 303-781-4050 Fax: 303-781-4333 Danica Brown, Youth Prevention Services *dihfsstaff@aol.com*	Health Services	Metropolitan Denver (Denver)	Denver Native American Community (need proof of degree of Indian blood required)	STD/HIV testing Outreach Public Information ILI GLI	Dental Counseling/Therapy Substance Abuse Treatment
Denver Infectious Disease Consultants Greenberg, Kenneth, DO Hammer, John, MD Kelley, Sarah, PA-C Young, Benjamin, MD 4545 E. 9th Ave, Suite 120 Denver, CO 80220 Ph: 303-393-8050	Infectious Disease	Metropolitan Denver (Denver)	PLWH/A	Medical Service Health Education/Risk Reduction	
Denver Options 9900 E. Iliff Ave. Denver, CO 80231 Ph: 303-636-5600 Fax: 303-636-5603 Stephen Block, Ph.D., Director *info@denveroptions.org* *http://www.denveroptions.org/*	Developmental Disabilities	Metropolitan Denver (Denver)	Persons with developmental disabilities (ages 0-3 and over 18)	GLI ILI	

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Denver Psychotherapy and Consulting Services LLC P.O. Box 300265 Denver, CO 80203 Ryan Kennedy, Director Ph: 303-399-9988 Fax: 303-399-9977 *jryankennedy@earthlink.com*	Mental Health	All Colorado (Denver)	MSM-NGI MSM PLWH/A Partner of PLWH/A	GLI ILI Counseling/Therapy Health Education/Risk Reduction	
Denver Urban Ministries 1717 E. Colfax Denver, CO 80218 Ph: 303-355-4896 Fax: 303-355-3495 *info@denum.org* *http://www.denum.org/*	Spiritual Support	Metropolitan Denver (Denver)	Urban Population	Outreach ILI GLI Health Education and Risk Reduction	Food bank Clothing bank Rent and Public Service Utilities assistance
Di Leo, Peter, MA, LPC (Private Practice) Ph: 303-833-6365 ext 15	Counseling/therapy	Metropolitan Denver (Denver)			
EAGR Project Inc. PO Box 96 Denver, CO 80201 Stan Bracclon Ph: 303-860-1779 Fax: 303-860-1266 *eagrproject@aol.com*		Metropolitan Denver (Denver)	Homosexual Men		Housing Assistance Financial Assistance
Early Intervention Outreach Testing Ph: 303-851-4098		Metropolitan Denver (Denver)		HIV testing	

Resource Inventory – Urban Resources					
Name of Agency and Contact Information	Focus	Primarily Serving Residents of (Onsite Services Provided in)	Target Population	Type of Intervention (Some services may not be offered in all locations)	Other Services Offered
Eastside Health Clinic 501 28th St. Denver, CO 80205 Ph: 303-436-4600	Health Services	Metropolitan Denver (Denver)		STD/HIV testing	Health services
El Grupo 1290 Williams St Denver, CO 80218 Ph: 303-329-9379 x103 Fax: 303-329-9381 romapu@aol.com		All Colorado (Denver)	PLWH/A	GLI (Support group, open to people infected and affected to HIV/AIDS)	
Emmanuel Baptist AIDS Ministry One South Walnut St. Colorado Springs, CO 80905 Ph: 719-635-4865 Fax: 719-635-3522 health@godiswithus.org http://www.godiswithus.org/ http://www.emmanuel-cs.org/	Spiritual support	All Colorado (Colorado Springs)	African Americans PLWH/A		
Essex Growth Center, Inc. 4055 South Broadway Denver, CO 80219 Ph: 303-922-1200 Fax: 303-783-0559 essexcolorado@aol.com	Mental Health and Substance Abuse	Adams, Arapahoe, Boulder, Denver, and Jefferson Counties	Probation referred and halfway house clients or self-admits	ILI GLI	
Excelsior Youth Center 15001 E. Oxford Ave. Aurora, CO 80014 Ph: 303-693-1550 Fax: 303-693-8309	Girls age 11-18	Metropolitan Denver (Aurora)	Girls ages 11-18 years with emotional and behavior difficulties	Counseling/therapy	

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GLBT Community Center of Colorado, The 1050 Broadway (PO Box 9798) Denver, CO 80203 Art Thompson, Executive Director Ph: 303-733-7743 Fax: 303-282-9399 *info@coloradoglbt.org* *http://www.coloradoglbt.org/*	GLBT	All Colorado (Denver)	Gay, Lesbian, Bisexual, and Transgendered	HIV testing GLI	
Gallegos, Sam Private Contractor Ph: 303-316-0679	Education	Metropolitan Denver (Denver)			
Genesis Recovery & Treatment Services 3191 S. Broadway Englewood, CO Ph: 303-761-7888	Substance Abuse	Metropolitan Denver (Englewood)	Substance Abusers		Methadone treatment Detox
Hep C Connection 190 East 9th Ave., Suite 320 Denver, CO 80203 Daniel Reilly Ph1: 303-860-0800 Ph2: 720-917-3970 Ph3: 1-800-522-HEPC Fax: 303-860-7481 *dreilly@hepc-connection.org* *info@hepc-connection.org* *http://www.hepc-connection.org/*	Hepatitis C	All Colorado (Denver)	Persons infected with or seeking more information on Hep C and Coinfection	GLI (support groups) ILI (Individual Intervention done over the phone using the 800 number) Public Information	

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HIV Care Link PO Box 740305 Arvada, CO 80006 Rev. Michael D. Tucker Ph1: 303-382-1344 Ph2: 303-949-7440 Fax: 303-382-1355 *HIVCL@aol.com* *Mike@hivcarelink.org* *http://www.hivcarelink.org/*	Spiritual Support, Health Education	All Colorado (Arvada)	PLWH/A	GLI (support group held for 14 weeks) ILI (Buddy Program offers clients living with HIV/AIDS to receive support on a one-on-one level) Participant focused visitation, encouragement, and support for PLWH/A	
HIV Early Intervention Services-VA Hospital Bessesen, Mary, MD Shapiro, Lee, MD 1050 Clermont St. Denver, CO 80220 Ph: 303-393-2837	Infectious Disease	All Colorado (Denver)	Honorably discharged veterans and their spouses PLWH/A	Medical Service	
Holtby, Michael , LCSW 309 Cherokee Ave. Denver, CO 80233 Ph: 303-722-1021	Mental Health	Metropolitan Denver (Denver)	Individuals/families needing HIV specific family and relationship based counseling	Counseling	
Hope Program, The 1555 Race St. Denver, CO 80206 Ph: 303-832-3354		Metropolitan Denver (Denver)			Drop-in center
Horizon House 3601 S Allison St Denver, CO 80235-1929 Harry Lester, President Ph: 303-980-9604 Fax: 303-980-0614		Metropolitan Denver (Denver)	PLWH/A	Housing/Shelter On-site home care services to PLWH/A and assistance with everyday needs and skilled nursing care	

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Idea Infusion Consulting PO Box 12322 Denver, CO 80212 Ph: 303-918-7700 Fax: 303-986-3812	HIV Prevention consulting and contracting services	All Colorado (Denver)	General Population	Health Education and Risk Reduction	
Infectious Disease Consultants Blum, Ray, MD Gass, Rebeka, MD 1601 E. 19th Ave., #3650 Denver, CO 80218 Ph: 303-831-4774	Infectious Disease	Metropolitan Denver (Denver)	PLWH/A	Medical Service Health Education and Risk Reduction	
Infectious Disease Specialists Gates, Robert, MD Hackenberg, Thomas, MD Hofflin, Jesse, MD Strandberg, Donald, MD Weber, Robert, MD 721 North Tejon, Suite 100 Colorado Springs, CO 80903 Ph: 719-578-5176	Infectious Disease	El Paso County (Colorado Springs)	PLWH/A	Medical Service Health Education and Risk Reduction	
Intermountain Harm Reduction Project 775 Lipan St. Denver, CO 80204 Ph: 303-572-7800 Fax: 303-572-7800 (call first)	Substance Abuse	Metropolitan Denver (Denver)	Substance Abusers IDU	Outreach Health Education and Risk Reduction ILI GLI PI	Hep C testing
Jeffco Action Center 8755 W 14th Lakewood, CO 80215 Ph: 303-237-7704 x206 operations@jeffcoac.org		Jefferson county only (Lakewood)	PLWH/A	Food Bank Financial Assistance	

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Jewish Family Service 3201 S. Tamarac Dr. Denver, CO 80231 Ann Reilly, Program Coordinator Ph: 303-597-5000 x315 Fax: 303-597-7700 *areilly@jewishfamilyservice.org* *http://www.jewishfamilyservice.org/*	Medical Services	Metropolitan Denver (Denver)	PLWH/A	Hearts and Hands Program offers house cleaning, meal preparation, and other support services	
JSI Research and Training Institute 1860 Blake St., Suite 320 Denver, CO 80202 Ph: 303-262-4309 Fax: 303-262-4395 Patrice Zink *pzink@jsi.com* *http://www.jsi.com/*	HIV Prevention Training	All Colorado (Denver)	Public health organizations/providers	Health Education	
Kaiser Permanente Medical Group- Infectious Disease Emily Bruce, HIV/AIDS Case Manager 2045 Franklin St 4th Floor Dept. 1964 Denver, CO 80205 Ph: 303-861-3154 Fax: 303-831-3772	Infectious Disease	All Colorado (Denver)	PLWH/A Kaiser Permanente insurance carriers	HIV testing	Medical Service
La Clinica Tepeyac 3617 Kalamath St. Denver, CO 80211 Ph: 303-458-5302 *http://www.clinicatepeyac.org/*	Health Services	Metropolitan Denver (Denver)	Latino/a PLWH/A Uninsured, working poor	CTR-STD/HIV testing	Health services

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Latin American Research and Service Agency (LARASA) 309 W. 1st Ave Denver, CO 80223 Ph: 303-722-5150 Fax: 303-722-5118 *larasa@larasa.org* *http://www.larasa.org/*	Latino/a	All Colorado (Denver)	Latino/a community		
Mayor's Office of HIV Resources 201 W. Colfax Dept 1009 Denver, CO 80202 Ph: 720-865-5402 Fax: 720-865-5533 *http://www.denvergov.org/mohr*	Monitor Title I and Title II funds	Metropolitan Denver (Denver)			
Mental Health Corporation of Denver (Living and Learning w/ HIV) 1555 Humboldt Denver, CO 80218 Ph: 303-504-1650 Fax: 303-504-1660 Craig Iverson civerson@mhcd.org 4353 East Colfax Ave. Denver, CO 80220 Ph: 303-504-1200 TDD: 303-320-8526 Fax: 303-320-4830 *http://www.mhcd.org/*	Mental Health	Denver, Adams, Arapahoe, Jefferson, and Douglas Counties (Denver)	PLWH/A Partners of PLWH	GLI ILI Health Education and Risk Reduction	Mental Health

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Mental Health Center of Denver 1555 Humboldt Denver, CO 80218 Ph: 303-504-1650 Fax: 303-504-1660 Craig Iverson civerson@mhcd.org	Mental Health	Metropolitan Denver (Denver)	Adults with serious mental illness	Mental Health	
Metropolitan Community Church (MCC) of the Rockies 960 Clarkson St Denver, CO 80218 Rick Smith, Support Services Ph: 303-860-1819 x12 Fax: 303-860-1594 *rsmith@mccrockies.org* *jburns@mccrockies.org* *http://www.mccrockies.org/*	Spiritual Support	Metropolitan Denver (Denver)	Lesbians and Gays and their families and friends	HIV/AIDS Ministry Counseling/Therapy GLI	Food bank
Metro Community Provider Network 3701 S Broadway St Englewood, CO 80110 John Kuenning Ph: 303-761-1977 x145 Fax1: 303-761-2787 Fax2: 303-761-2085 *jkuenning@mcpn.org*	Health Services	Adams, Arapahoe, Jefferson, Park Counties (additional sites in Englewood, Aurora, Bailey, and Lakewood)	Uninsured	STD/HIV testing PI- community and schools ILI	Hep C testing Health services

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Mi Casa Resource Center for Women, FENIX Program 360 Acoma St. Denver, CO 80223 Ph: 303-573-1302 Fax: 303-595-0422 Carmen Carillo, Director *info@micasadenver.org* *http://www.miscasadenver.org/*	Support Services	Metropolitan Denver (Denver)	Youth and young adults, predominantly Latino youth	Health Education and Risk Reduction (through Wellness Project)	Career development
Milestone Counseling 8533 West Colfax Ave. Denver, CO 80215 Ph: 303-234-9130 Fax: 303-234-0760	Substance Abuse	Metropolitan Denver (Denver)	Denver drug court, DUI, and voluntary addiction problems	ILI GLI Education	
Montbello Health Clinic 4685 Peoria St. Montbello, CO 80239 Ph: 303-375-4200	Health Services	Denver County (Montbello)	General Population	STD/HIV Testing	Health services
Mt. Resource Center (at Safeway Shopping Center) 10875 US Highway 285 Suite D202 PO Box 425 Conifer, CO 80433 Ph: 303-838-7552	Health Services	Jefferson County (Conifer)	General Population	HIV referrals	STD testing
Multi Services Clinic, Inc. 2001 Federal Blvd. Denver, CO 80211 Ph1: 303-480-0693 Ph2: 303-480-0693 Fax: 303-480-0695	Drug/Alcohol Abuse for Hispanic & Latino populations	Jefferson, Denver, Adams, Arapahoe, and Gilpin Counties (Denver)	Hispanic/Latino		

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National Pediatric AIDS Network (NPAN) PO Box 1032 Boulder, CO 80306 Ph1: 303-527-0185 Ph2: 800-646-1001 Gary Gale *Gary@npan.org* *http://www.npan.org/*	Resource Information	All Colorado (Boulder)	Children and Adolescents with HIV/AIDS		
North Denver Behavioral Health Center 1701 W. 72nd Ave., Suite 140 Denver, CO 80221 Ph: 303-487-7776 Fax: 303-487-7868 *http://www.cbhclinics.com/*	Substance Abuse	All Colorado (Denver)	Heroin and other opiate addictions	GLI ILI HIV testing Substance Abuse Treatment	Related psychological, medical, social, occupational, and legal issues
OASOS (GLBTQ youth program) PO Box 1018 Boulder, CO 80306 *http://www.boulderpride.org/oasos.htm*	GLBTQ Youth	Boulder County (Boulder)	GLBTQ Youth	STD/HIV testing	

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Only One Inc. (Aurora) 2396 Galena St Aurora, CO 80010 Dora Esquibel, Assistant Ph: 303-360-8553 Fax: 303-360-8553 Only One Inc. (Boulder) PO BOX 7523 Boulder, CO 80306 Ph: 303-444-9009 *dbyoung@comcast.net* SEE ALSO "Two-Spirit Society"		Adams County (Aurora) and Boulder County (Boulder)	MSM MSM-NGI PLWH/A Partners of PLWH/A	GLI CLI	
Pan African Arts Society 911 Park Avenue West 2nd Floor Denver, CO 80205 Ashara Ekundayo Ph: 303-298-8188 Fax: 303-299-9064 *BluBlakwomyn@yahoo.com* *http://www.panafricanarts.org/index.htm*		Denver, Adams, Arapahoe, Douglas, Boulder counties (Denver)	PLWH/A MSM	GLI ILI Public Information HIV testing Other HIV related support Peer Based Intervention	
Parents, Families, and Friends of Lesbians and Gays (PFLAG) PO Box 18901 Denver, CO 80218 Sarah Winter Ph: 303-388-1002 *winternye@sprintmail.com* *http://www.pflag.org/*		All Colorado (Denver)	Parents, Families, and Friends of Gays and Lesbians Partners of PLWH/A	ILI GLI Counseling/therapy Outreach	

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Peak Vista Community Health Centers Brooke, James, MD 340 Printer's Parkway Colorado Springs, CO 80910 Ph: 719-632-5700	Infectious Disease	El Paso County (Colorado Springs)		Medical Service	
People's Clinic, The 3303 N. Broadway Boulder, CO 80304 Ph: 303-449-6050 *info@peoplesclinic.org* *http://www.peoplesclinic.org/*	Health Services	Boulder County (Boulder)	Residents of Boulder County who do not have health care insurance or have difficulty receiving medical care elsewhere	STD/HIV testing	Mental Health Substance Abuse Health services
Persons Living with HIV Action Network of Colorado PO Box 9926 Denver, CO 80209 Daniel Garcia Ph: 303-722-3083 Fax: 303-722-2532 *danielgarcia@comcast.net*	PWLH/A	All Colorado (Denver)	PLWH/A, Service Providers, Elected officials	Public Information Health Education and Risk Reduction	Food bank Transportation
Planned Parenthood 950 Broadway Denver, CO 80203 Call for nearest location Ph: 303-321-7526 *www.ppfa.org*	Health Services	All Colorado (Denver)	General Population	STD/HIV Testing	Information and Referrals for sexual health services
Positive Project, The 1221 South Clarkson St., #302 Denver, CO 80210 Tony Miles, Ph.DExecutive Director Ph: 303-733-0545 *tmilesphd@aol.com* *http://www.thepositiveproject.org/*	Education and Advocacy	Metropolitan Denver (Denver)	PLWH/A Partners of PLWH	Public Information	

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Project Angel Heart 4190 Garfield #5 Denver, CO 80216 Ph1: 303-830-0202 ext 13 Ph2: 800-381-5612 Fax1: 303-830-1840 Fax2: 800-731-5622 *http://www.projectangelheart.org/* PO Box 7597 Colorado Springs, CO 80933 Phone: (800) 381-5612 Fax: (800) 731-5622	Home delivered meal program	People within 700+ square miles of Metropolitan Denver	PLWH/A and other life threatening diseases		
Queer People of Color (Q-POC) Liz Andrews, Coordinator Andrews.me@gmail.com *http://www.myspace.com/qpoclounge*	GLBTQ Youth of Color	Metropolitan Denver (Denver)	GLBTQ Youth of Color		
Rainbow Alley 1050 Broadway Denver, CO 80203 PO Box 9798 Denver, CO 80209 Ph: 303-831-0442 *rainbowalley@glbtcolorado.org* *http://www.glbtcolorado.org/*	GLBT Youth	Metropolitan Denver (Denver)	GLBT youth, ages 12-21 years and their friends	STD/HIV testing Peer-to-Peer Support and Education	Drop-in center for youth age 21 and under
Rainbow House - Volunteers of America 3400 Bruce Randolph Blvd. Denver, CO 80205 Laura Wildt, Program Manager Ph: 303-355-9581 Fax: 303-355-3450 *rainbow@earthnet.net*	Day program for children affected by HIV/AIDS	Metropolitan Denver (Denver)	Children with HIV/AIDS or family members with HIV/AIDS	GLI (Monthly support groups for families affected by HIV/AIDS) ILI (services are available to people and children affected by HIV/AIDS, Play Therapy available) Public Information	Clothing bank Hot meals for children

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Regional AIDS Interfaith Network (RAIN) 1290 Williams St, Suite 102 Denver, CO 80218 David Cooper Ph: 303-355-5665 Fax: 303-355-1923 *raincolorado@yahoo.com*	Health Education and Risk Reduction	Metropolitan Denver (Denver)	PLWH/A Partners of PLWH	GLI (support group) ILI Public Information	
Rocky Mountain Association of Nurses in AIDS Care (ANAC) c/o The Children's Hospital Emily Barr 1056 E. 19th Ave B055 Denver, CO 80218	Education	Rocky Mountain Region (Denver)	Anyone in the field of HIV services		
Semmler, Pam, MA, LPC, CACIII (Private Practice) 309 Cherokee Ave. Denver, CO Ph: 720-280-9085	Mental Health	Metropolitan Denver (Denver)	Individuals/families needing HIV specific family and relationship based counseling	Counseling/therapy	
Servicios de La Raza 4058 Tejon St Denver, CO 80211 Maria Lopez Ph: 303-477-3817 Fax: 303-455-1332 Maria Lopez *maria@serviciosdelaraza.org* *http://www.serviciosdelaraza.org/*	Latino/a	Metropolitan Denver (Denver)	Latino/a PLWH/A	ILI GLI Substance Abuse Treatment Counseling/Therapy Outreach CLI	Hep A, B, and C prevention issues related to drug use Food bank Financial assistance Housing assistance Legal issues

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Signal Behavioral Health Network, Inc. (MSO) 1391 Speer Blvd., #300 Denver, CO 80204 Bill Wendt Ph: 303-639-9320 Fax: 303-639-9241 *signal@signalbhn.org*	Substance Abuse Treatment	Jefferson, Denver, Adams, Arapahoe Counties (Denver)		Treatment Referrals	
Sobriety House, Inc. 107 Acoma St Denver, CO 80223 Ph: 303-722-5746 Fax: 303-777-7601 *http://www.sobrietyhouse.org/*	Substance Abuse	Metropolitan Denver (Denver)	Low income alcohol and/or drug addicted persons		
Southern Colorado AIDS Project 1301 W. 8th St #200 Colorado Springs, CO 80906 Ph1: 719-578-9092 Ph2: 800-241-5468 Fax: 719-578-8690 *info@s-cap.org* *http://www.s-cap.org/*	ASO	Southern Colorado (Colorado Springs)	PLWH/A Partners of PLWH/A Those at risk for HIV/AIDS	Outreach GLI ILI	HE/RR-Materials Food bank Maternal health services Financial assistance Mental and physical health
South Denver Infectious Disease Specialists Cimafranca, Carol, MD Golub, Burton, MD Kutolf, Rudolph, MD Messa, Jacqueline, MD Williams, Josephine, MD 601 E Hampden, Suite 340 Englewood, CO 80110 Ph: 303-788-5900 Fax: 303-788-5922 *reception@sdids.com*	Infectious Disease	All Colorado (Englewood)	PLWH/A	Counseling/Therapy Medical Services	

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Special Services Clinic (ARTS) 2121 E.18th Ave Denver, CO 80206 Bob Dorshimer Ph: 303-355-1014 Fax: 303-355-0899 *robert.dorshimer@uchsc.edu*	Outpatient Substance Abuse and primary medical care of PLWH/A	All Colorado (Denver)		GLI (Living and Learning with HIV support group) ILI (Mental Health Consultation, Individual substance abuse treatment, Therapy for clients and their partners) Substance Abuse Treatment HIV testing	
Spot, The 2100 Stout St. Denver, CO 80205 Ph: 303-291-0442 *http://www.thespot.org/*	Youth	Metropolitan Denver (Denver)	Urban "at-risk"youth ages 14-24 years	STD/HIV testing Health Education and Risk Reduction Outreach	Youth Drop-in Center Career Development
Treatment Alternatives to Safer Communities 2490 West 26th Ave, Suite 300A Denver, CO 80211 Bishop Robinson, TASC Specialist Ph: 303-480-7041 Fax: 303-477-3857	Substance Abuse	Denver County (Denver)	MSM MSM-NGI PLWH/A Partners of PLWH/A May be for youth only	GLI Public Information Substance Abuse Treatment STD testing and treatment	

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Tri-County Health Department (5 sites) 4301 E. 72nd Ave Commerce City, CO 80022 Ph: 303-288-6816 10190 Bannock St., Suite 100 Northglenn, CO 80260 Ph: 303-452-9547 15400 E. 14th Pl., Suite 123 Aurora, CO 80011 Ph: 303-341-9370 4857 S. Broadway Englewood, CO 80110 Ph: 303-761-1340 101 3rd St. Castle Rock, CO 80104 Ph: 303-663-7650	Health Services	Adams, Arapahoe, Douglas Counties	General Population	STD/HIV testing	Health services
Two-Spirit Society Inc. PO Box 18566 Denver, CO 80218 Joey Criddle Ph: 303-832-4296 Fax: 303-938-0299 *wenakuo@jumo.com* *joeynco@hotmail.com* *http://www.denvertwospirit.com/* SEE ALSO "Only One, Inc."	GLBT Native Americans	All Colorado (Denver)	GLBT Native Americans and their partners	Health Education and Risk Reduction Public Information GLI	

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United Way (of Mile High) 2505 18th St. Denver, CO 80211 Ph: 303-433-8383 Fax: 303-455-6462 http://www.unitedwaydenver.org/	Referrals	All Colorado (Denver)	General Population	Referrals	
University of Colorado Hospital-HIV/AIDS Primary Care (UCHSC) 4200 E 9th Ave Box B163 Denver, CO 80262 Danielle Archunda, LSCW Dr. Steven Johnson Ph: 303-315-1540 Fax: 303-372-8230	Infectious Disease	All Colorado (Denver)	PLWH/A	ILI Mental health assessment and counseling HIV testing	Medical services
Urban Peak 1630 Acoma St. Denver, CO 80223 Susan Boyle Ph: 303-777-9198 Fax: 303-777-9438 http://www.urbanpeak.org/ 423 E Cucharras Colorado Springs, CO 80903 Ph: 719-630-3223 CoSpringsinfo@urbanpeak.org	Youth	All Colorado (Denver and Colorado Springs)	Runaway and homeless, and at-risk youth ages 15-20	STD/HIV testing PI	Youth Shelter Hep C testing

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Visiting Nurse Association 390 Grant Street Denver, CO 80203 Ph: 303-698-2121 Fax: 303-698-6433 1520 N. Union Blvd. Colorado Springs, CO 80909 Ph: 719-577-4448 *http://www.vnacolorado.org/*	Health Services	All Colorado (Denver & Colorado Springs)	General Populations PLWH/A	STD/HIV testing	Referrals Home Care
Walter S. Jackson Community Alcohol-Drug Rehabilitation and Education Center 3315 S. Gilpin St. Denver, CO 80205 Ph: 303-295-2521 Fax: 303-295-2326	Substance Abuse for Young Adults and Basic HIV/AIDS Education	Metropolitan Denver (Denver)	Young Adults		
Western Infectious Disease Consultants Cullinan, Mary Lou, MD DesJardin, Jeff, MD Fujita, Norman, MD Mason, Susan, MD Robertson, Katherine, MD 3885 Upham St, Suite 200 Wheatridge, CO 80033 Ph: 303-425-9245	Infectious Disease	Metropolitan Denver (Wheatridge)		Medical Service	

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Westside Family Health Center 1100 Federal Blvd. Denver, CO 80204 MaryAnn Bolkovatz Ph1: 303-880-5747 Ph2: 303-436-4200 Cell: 303-891-9360 Fax1: 303-436-4479 Fax2: 303-436-4360		Metropolitan Denver (Denver), unless they have Medicaid or Medicare then they can be residents of any county.	PLWH/A MSM	STD/HIV testing	
Youth HIV Advocacy Coalition (YHAC) Ph: 303-837-2604					

Resource Inventory – Rural Resources- CDPHE Contractors							
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Projected Number of Clients Annually 2006**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**	**CDC/ CDPHE Funding** (Through 12/31/06)
Colorado Department of Corrections ALSO SEE URBAN RESOURCE INVENTORY	Corrections	All Colorado (Canon City)	Incarcerated	300	GLI		*"Reach One, Teach One"* $25,000
Ingram, Michael ManREACH	Health Education and Risk Reduction for Rural MSM	Southeastern and Southcentral Colorado (Salida)	Rural MSM	80 80	GLI Outreach		*"ManREACH"* $8,060
Northern Colorado AIDS Project (NCAP) 400 Remington St, Suite 100 Fort Collins, CO 80524 Andrew Thomasson Ph1: 970-484-4469 Ph2: 800-464-4611 Fax: 970-484-4497 *info@ncaids.org* *http://www.ncaids.org/*	ASO	Larimer, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma Counties (Fort Collins)	PLWH/A ----------------------------------- Rural MSM ----------------------------------- Rural IDU ----------------------------------- CTR	24 45 ------------------- 16 60 1,300 ------------------- 30 150 500 ------------------- 610	ILI GLI ----------------------------------- ILI GLI Outreach ----------------------------------- ILI GLI Outreach ----------------------------------- CTR	PI HE/RR-Materials Job Placement Food Bank	*"Healthy Relationships"* $23,902 ------------------- *"ManREACH"* $39,668 ------------------- *"Community Promise"* $26,692 ------------------- *CTR* $ 5,000

Resource Inventory – Rural Resources- CDPHE Contractors							
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Projected Number of Clients Annually 2006**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**	**CDC/ CDPHE Funding** (Through 12/31/06)
Northern Colorado AIDS Project - High Plains 700 Columbine Sterling, CO 80751 Pam Lindenthal Ph1: 970-522-3741 x246 Ph2: 970-580-4498 Fax: 970-522-1412	ASO	Morgan, Logan, Washington, Yuma, Phillips, Sedgewick Counties (Sterling)	See above	See above	See above	See above	See above
Western Colorado AIDS Project (WestCAP) 805 Main St Grand Junction, CO 81501 Jeff Basinger, Prevention Services Ph1: 970-243-2437 Ph2: 800-765-8594 Fax: 970-243-5791 *jeff@westcap.info* *http://www.westcap.info/*	ASO	Archuleta, Delta, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Miguel, San Juan, Summit Counties (Grand Junction)	Rural MSM ------------------------------------ Rural IDU ------------------------------------ CTR	10 70 ------------------- 12 75 100 ------------------- 200	ILI GLI ------------------------------------ ILI GLI Outreach ------------------------------------ CTR	HE/RR- Materials	*"ManREACH"* $33,333 ------------------- *"Community Promise"* $17,500 ------------------- CTR $3,000

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Adams State College Richardson Hall #220 208 Edgemont Blvd. Alamosa, CO 81102 Ph: (719) 587-7746	Health Services	Alamosa County (Alamosa)	Students of Adams State College, Alamosa residents	STD/HIV testing	General Health Services
Alamosa County Nursing Service 8900 Independence Way Alamosa, CO 81401 Ph: 719-589-5157	Health Services	Alamosa County (Alamosa)	General Population	STD/HIV testing	Hep C testing Health services
Colorado West Regional Mental Health 436 South 7th Grand Junction, CO 81501 Ph: 970-245-4213 Fax: 970-243-7297 Ken Eielson keielson@cwrmhc.org	Mental Health, Substance Abuse	Delta, Eagle, Garfield, Grand, Mesa, Montrose, Pitkin, Rio Blanco, Routt, Summit Counties (Grand Junction)	Substance Abuse	HIV testing PI GLI	Hep C testing Substance Abuse Treatment Mental Health
Community Health Services 0405 Castle Creek Rd, Suite 6 Aspen, CO 81611 Ph: 970-920-5420	Health Services	Pitkin County (Aspen)	General Population, primarily residents of Pitkin County	STD/HIV testing	Health services
Connect Care (MSO) 220 Ruskin Drive Colorado Springs, CO 80910 Annette Fryman, Executive Director Michael Allen, Associate Director Ph: 719-572-6133 Fax: 719-572-6097 annettef@ppmhc.org	Substance Abuse	Lake, Park, Teller, Chaffee, Fremont, Custer Counties (Colorado Springs)	Substance abusers	Treatment Referrals	

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Croce, Theresa D., MD Saliman, Al, MD Internal Medicine 1905 Blake Ave. Glenwood Springs, CO 81601 Ph: 970-945-8503	Infectious Disease	Garfield County (Glenwood Springs)	PLWH/A	Medical Service	
Crossroads Managed Care 509 E 13th St Pueblo, CO 81001 Marc Liebert, Vice President Ph: 719-546-6666 x134 Fax: 719-543-7764 *mliebert@crossroadsmcs.org*	Health Services	All Colorado (Pueblo)	General Population MSM-NGI	GLI ILI	
Currie, James, MD 7251 W. 20th St., Unit K Greeley, CO 80634 Ph: 970-353-4322	Infectious Disease	Weld County (Greeley)	PLWH/A	Medical Service	
Delta County Health and Human Services 255 W. Sixth St. Delta, CO 81416 Pat Sullivan Ph: 970-874-2165 Fax: 970-874-2175	Health Services	Delta County (Delta)	General Population, primarily residents of Delta County	STD/HIV testing PI	Hep C testing Health services
Four Corners Infectious Diseases and Internal Medicine Salka, Charles, MD 1800 E. 3rd Ave., Suite 203 Medical Arts Building Durango, CO 81301 Ph: 970-382-1808	Infectious Disease	San Juan Basin (Durango)	PLWH/A	Medical Service	

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Grand Junction VAMC Meyers, Steven, MD 2121 North Ave. Grand Junction, CO 81501 Ph: 970-242-0731	Infectious Disease	Mesa County (Grand Junction)	PLWH/A	Medical Service	
Gunnison County Public Health 225 N. Pine St., Suite E Gunnison, CO 81230 Ph: 970-641-0209	Health Services	Gunnison County (Gunnison)	General Population	STD/HIV testing	Health services
Hicks, Paul, MD 1115 Second St. Fort Lupton, CO 80621	Infectious Disease	Weld County (Fort Lupton)	PLWH/A	Medical Service	
Island Grove Treatment Center 1140 M Street Greeley, CO 80631 Ph: 970-356-6664 ext 1176 Fax: 970-356-1349 Jerrod McCoy *http://www.islandgrove.net/*	Substance Abuse	Larimer and Weld Counties (Greeley)	Substance abusers	Substance Abuse Treatment GLI PI	Hep C testing
Kennedy, Christopher, MD 2420 16th St. Greeley, CO 80634 Ph: 970-353-7668	Infectious Disease	Weld County (Greeley)	PLWH/A	Medical Service	

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Larimer County Dept of Health and Environment 1525 Blue Spruce Dr Fort Collins, CO 80525 Nettie Underwood, Nursing Supervisor Ph: 970-498-6700 Fax: 970-498-6772 *nunderwood@larimer.org* *http://www.larimer.org/health*	Health Services	Larimer County (Ft. Collins)	General Population, primarily residents of Larimer County	STD/HIV testing Partner notification PI GLI	Hep C testing Health services
Las Animas-Huerfano County Health Dept. 412 Benedicta Ave Trinidad, CO 81082 Ph: 719-846-2213 119 E. 5th St. Walsenburg, CO 81089 Ph: 719-738-2650	Health Services	Las Animas-Huerfano County (Trinidad, Walsenburg)	General Population	STD/HIV testing	Health services
Lieberman, John, MD 1925 E. Orman Ave, Suite 410 Pueblo, CO 81004	Infectious Disease	Pueblo County (Pueblo)	PLWH/A	Medical Service	
Marillac Clinic 2333 N. 6th St. Grand Junction, CO 81501 Ph: 970-255-1782	Infectious Disease	Mesa County (Grand Junction)	Low income, no insurance, Mesa County residents PLWH/A	Medical Service	
Martinez, Julie, MD Samora, Patrick, MD 607 Berkley Ave. Alamosa, CO 81101 Ph: 719-256-4025	Infectious Disease	Alamosa County (Alamosa)	PLWH/A	Medical Service	

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Mass, Ann, MD Internal Medicine 400 W. Main St. Aspen, CO 81611 Ph: 970-925-1180	Internal Medicine	Pitkin County (Aspen)	PLWH/A	Medical Service	
Mawharter, Linda, MD 2115 Stuart Alamosa, CO 81101 Ph: 719-589-3000	Infectious Disease	Alamosa County (Alamosa)	PLWH/A	Medical Service	
Mesa County Health Department 515 Patterson Rd. Grand Junction, CO 81506 Rene Landry, HIV Clinic Coordinator Ph: 970-248-6906 http://www.mchealth.com/	Health Services	Mesa County (Grand Junction)	General Population, primarily residents of Mesa County	STD/HIV testing Outreach	Health services
Montezuma County Health Dept. 106 W. North St. Cortez, CO 81321 Ph: 970-565-3056 John Godbey http://www.co.montezuma.co.us/	Health Services	Montezuma County (Cortez)	General Population, primarily residents of Montezuma County	STD/HIV testing Outreach	Health services
Montrose County Nursing Services 1845 S. Townsend Montrose, CO 81401 Ph: 970-252-5000 851 Main St. PO Box 39 Nucla, CO 81424 Ph: 970-864-7319	Health Services	Montrose County (Montrose and Nucla)	General Population, primarily residents of Montrose County	STD/HIV testing	Health services

	Resource Inventory – Rural Resources				
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Mountain Family Health Centers *http://www.mountainfamily.org* 562 Gregory Street Black Hawk, CO 80422 Ph: 303-582-5277 Fax: 303-582-3929 1905 Blake Ave., Suite 203 Glenwood Springs, CO 81601 Ph: 970-945-2840 Fax: 970-945-2893 20 East Lakeview Drive Nederland, CO 80466 Ph: 303-258-3206 Fax: 303-258-7302	Health Services	Gilpin, Garfield, and Boulder Counties	General Population, special consideration to medically underserved and uninsured population	STD/HIV testing	Health services
Northeast Colorado Health Dept. 700 Columbine Sterling, CO 80751 Ph: 970-522-3741 Fax: 970-522-1412	Health Services	Morgan, Logan, Washington, Yuma, Phillips, Sedgewick Counties (Sterling)	General Population	HIV Referrals PI	STD Testing Health services
Northwest Colorado VNA 940 Central Park Drive Suite 101 Steamboat Springs, CO 81487 Ph: 970-871-7618 745 Russell St. Craig, CO 81321 Ph: 970-824-8233	Health Services	Northwest Colorado (Steamboat Springs and Craig)	General Population	STD/HIV testing	Hep C Testing Health services

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Otero County Health Dept 13 W. 3rd St. Room #111 La Junta, CO 81050 Ph: 719-383-3040 Fax: 719-383-3060	Health Services	Otero County (La Junta)	General Population	PI	Health services
Pikes Peak GLBT Center 716 ½ N. Tejon Colorado Springs, CO 80903 Ph: 719-471-4429 *http://www.ppglcc.org/*	GLBT	Pikes Peak Region (Colorado Springs)	GLBT		
Planned Parenthood Call for nearest location Ph: 1-800-230-PLAN *http://www.ppfa.org/*	Health Services	All Colorado (various locations throughout state)	General Population	STD/HIV testing PI	Health services
Pueblo City/County Health Dept. 151 Central Main St. Pueblo, CO 81003 Sarah Ruybalid Ph: 719-583-4380 Fax: 719-583-4375	Health Services	Pueblo County (Pueblo)	General Population, primarily residents of Pueblo County	STD/HIV testing	Health services
Pueblo Community Health Center Park Hill (EIS) 1302 E. 5th St Pueblo, CO 81003 Analee Beck, EIS Program Coordinator Ph: 719-543-8718 x725 Fax1: 719-542-1639 Fax2: 719-543-5430 *analee.beck@pueblo.chc.org*	Health Services	Pueblo, Baca, Bent, Chaffee, Crowley, Custer, Fremont, Huerfano, Las Animas, Otero, Prowers Counties (Pueblo)	PLWH/A	STD/HIV testing Substance Abuse Treatment	Health services Psychiatric Services

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
RAD Education Programs PO Box 9059 Aspen, CO 81611 Ph: 970-925-2488 Fax: 970-920-7833 Deborah Schoeberlein *info@preventaids.net* *http://www.preventaids.net/*	Education	All Colorado (Aspen)	Adolescents, teachers, and HIV educators		
Red Ribbon Project, The PO Box 6058 Avon, CO 81620 Ph: 970-827-5900 Fax: 970-827-4176 Paula Palmateer	CTR	Eagle County (Avon)	Latino/a Youth Seasonal Workers	HIV testing PI	Hep C testing
Rocky Mountain Infectious Disease Consultants Cobb, David, MD Peskind, Robert, MD Ong, Jacob Lee, MD 2121 E. Harmony Rd, #300 Fort Collins, CO 80528 Ph: 970-224-0429	Infectious Disease	Larimer County (Fort Collins)	PLWH/A	Medical Service	
Rural Center for AIDS/STD Prevention (RAP) Campus Box 188 Denver, CO 80217 Ph: 303-556-9796 Fax: 303-556-8501 Susan Dreisbach *Susan.dreisbach@cudenver.edu* *http://www.indiana.edu/~aids*	HIV/STD prevention in rural America	Rural Colorado	Rural, Latino/a, youth		

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Saguache County Public Health Dept. 220 S. Worth St. Center, CO 81125 Ph: 719-754-2773 *scphdns@fone.net*	Health Services	Saguache County (Center)	General Population	STD/HIV testing	Health services
Salud Family Health Center Ph: 303-892-6401 *info@saludclinic.org* 30 S. 20th Ave., Suite A Brighton, CO 80601 Ph: 303-659-4000 6075 Parkway Drive, Suite 160 Commerce City, CO 80022 Ph: 303-286-8900 Aspenwood Professional Bldg. 600 S. St. Vrain #2 Estes Park, CO 80517 Ph: 970-586-9230 FAX: (970) 586-0292 1635 Blue Spruce Drive Fort Collins, CO 80524 Ph: 970-494-4040 Fax: 970-494-4076 1115 Second Street Fort Lupton, CO 80621 Ph: 303-857-2771 Fax: 303-892-1511	Health Services	Northcentral and Northeast Colorado	General Population MSM, MSM-NGI PLWH/A Partners of PLWH/A Seasonal and migrant workers	STD/HIV testing ILI PI	Health services Mobile van Dental services

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Salud Family Health Center (continued) 909 E. Railroad Ave. Fort Morgan, CO 80701 Ph: 970-867-0300 Fax: 970-867-7607 5995 Iris Parkway Frederick, CO 80530 Ph: 303-833-2050 220 E. Rogers Road Longmont, CO 80501 Ph: 303-776-3250 Fax: 303-682-9269 1410 South 7th Avenue Sterling, CO 80751 Ph: 970-526-2589 Fax: 970-526-0244					
San Juan Basin Health Dept. 281 Sawyer Dr., Suite 300 Durango, CO 81303 Ph: 970-247-5702 Fax: 303-247-9126 Deb Banton *db@sjbhd.org* *http://www.sjbhd.org/*	Health Services	Archuleta, La Plata, San Juan Counties	General Population PLWH/A	STD/HIV testing PI PCM	Hep C testing Home Care Health services

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
San Luis Valley Area Health Education Center 1560 W. 12th St. Alamosa, CO 81101 Ph: 719-589-4977 Fax: 719-589-4978 Charlotte Ledonne, RN *info@slvahec.org* *http://www.slvahec.org/*	HIV/AIDS Resource Materials and Speakers	San Luis Valley Region (Alamosa)	Healthcare providers and consumers	PI	
San Miguel County Nursing Services 333 W. Colorado Ave.#315 PO Box 949 Telluride, CO 81435 June Nepsky Ph: 970-728-4289	Health Services	San Miguel County (Telluride)	General Population, primarily residents of San Miguel County	STD/HIV testing	Health services
Signal Behavioral Health Network, Inc. (MSO) 1391 Speer Blvd. #300 Denver, CO 80204 Bill Wendt Ph: 888-607-4462 Fax: 888-607-4462 *signal@signalbhn.org*	Substance Abuse	Larimer, Weld, Morgan, Logan, Sedgwick, Phillips, Washington, Yuma, Douglas, Elbert, Lincoln, Kit Carson, Cheyenne, Pueblo, Crowley, Otero, Bent, Prowers, Kiowa, Saguache, Mineral, Rio Grande, Alamosa, Conejos, Huerfano, Costilla, Las Animas, Baca Counties	Substance Abusers	Treatment Referrals	
SKITTLES 149 West Oak St., Suite 9 Fort Collins, CO 80524 Ph: 970-221-3247 *http://www.lambdacenter.org/*	GLBTQ Youth	Larimer County (Fort Collins)	GLBTQ Youth		

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Southeastern Colorado Area Health Education Center 503 North Main, #422 Pueblo, CO 81003 Ph1: 719-544-7833 Ph2: 866-330-7100 Fax: 719-544-7955 Randy Evetts info@secahec.org http://www.secahec.org/	Continuing education	Southeastern Colorado Region (Pueblo)	Healthcare professionals		
Southern Colorado AIDS Project (SCAP) Southern Colorado AIDS Project 1301 W. 8th St #200 Colorado Springs, CO 80906 Ph1: 719-578-9092 Ph2: 800-241-5468 Fax: 719-578-8690 info@s-cap.org http://www.s-cap.org/	ASO	Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, El Paso, Elbert, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Mineral, Otero, Park, Prowers, Pueblo, Rio Grande, Saguache, Teller Counties (Colorado Springs)	PLWH/A Partners of PLWH/A	GLI (Support groups for HIV+ men and women, second support group is in Spanish) Public Information (Speaker's Bureau) Outreach CLI ILI HIV Testing	Immunization Transportation Food bank
Southern Colorado Family Medicine St. Mary Corwin Hospital 1008 Minnequa Ave. Pueblo, CO 81004 Ph: 719-560-5855	Infectious Disease	Pueblo County (Pueblo)	General Population PLWH/A	Medical Service	
Southern Ute Health Center PO Box 988 Ignacio, CO 81137 Ph: 970-563-4581 Fax: 970-563-0206	Health Services	Ute Territory (Ignacio)	American Indians (proven degree of Indian blood required or tribal documents required)	STD/ HIV testing	Health services

			Resource Inventory – Rural Resources		
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Spanish Peaks Regional Health Center 129 Kansas Ave. Walsenburg, CO 81089 Ph: 719-738-2718	Health Services	Las Animas and Huerfano Counties (Walsenburg)	General Population, primarily residents of Huerfano county	STD/HIV testing	Health services
St. Mary's Family Medicine Specialty Care Clinic 1160 Patterson Rd Grand Junction, CO 81506 Lucy Graham, HIV Program Manager Ph1: 970-255-1735 Ph2: 1-866-448-8383 Fax: 970-255-6289 Lucy Graham *lgraham@stmarygj.com* *http://www.stmarygj.com/*	Health Services	Archuleta, Clear Creek, Delta, Dolores, Eagle, Garfield, Gilpin, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Miguel, San Juan, Summit Counties (Grand Junction)	PLWH/A Partners of PLWH/A	ILI STD/HIV testing	Hep B and C testing Mental Health Dental
Summit County Nursing Services 0037 County Rd, #1005 PO Box 2280 Frisco, CO 80443 Ph: 970-668-5230	Health Services	Summit County (Frisco)	General Population, primarily residents of Summit County	STD/HIV testing	Health services
Sunrise Community Health Center 1028 5th Ave. Greeley, CO 80631 Ph: 970-395-2365	Infectious Disease	Weld County (Greeley)	PLWH/A	Medical Service	
Teller County Public Health 11505 Highway 24 PO Box 928 Divide, CO 80814 Ph: 719-687-6416	Health Services	Teller County (Divide)	General Population, primarily residents of Weld County	STD/HIV testing	Health services

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
Tom Thom Club PO Box 251 South Fork, CO 81154 Tom Chenault Ph: 719-873-5980 Fax: 719-873-5537 (call first) *tomthomclub@fone.net*	Support Group	Conejos, Costilla, Alamosa, Mineral, Rio Grande, Saguache Counties (South Fork)	PLWH/A Persons at risk for/affected by HIV	CLI (for MSM) Public Information (speaking engagements supply local newspapers with articles and press releases) HIV+ support group	
Valley Wide Health System 128 Market Street Alamosa, CO 81101 Ph: 719-589-5161 Fax: 719-589-5722 *info@vwhs.org* Numerous clinics throughout Southern Colorado	Health services	Southern Colorado: Alamosa, Bent, Conejos, Costilla, Crowley, Fremont, La Plata, Mineral, Montezuma, Otero, Rio Grande, and Saguache Counties	Medically underserved populations		Health services
Weld County Health Department 1555 N 17th Ave Greeley, CO 80631 Debbie Pettit Ph1: 970-304-6420 Ph2: 800-464-4611 Fax: 970-304-6412 4209 Weld County Rd. 24 ½ Longmont, CO 80504 Ph: 720-652-4238 *ltovar@co.weld.co.us* *http://www.co.weld.co.us/*	Health Services	Weld County (Greeley)	General Population, primarily residents of Weld County	STD/HIV testing ILI	Health services

Resource Inventory – Rural Resources					
Name of Agency and Contact Information	**Focus**	**Primarily Serving Residents of (Onsite Services Provided in)**	**Target Population**	**Type of Intervention** (Some services may not be offered in all locations)	**Other Services Offered**
West Slope Casa (MSO) PO Box 234 Hot Sulphur Springs, CO 80451 Sandy Roberts, Clinical Director Ph: 970-725-3614 Fax: 970-725-3614 *sroberts@cwrmhc.org* PO Box 40/6916 Highway 82 Glenwood Springs, CO 81601 Kenneth Stein, President Ph: 970-945-2241 Fax: 970-945-5523 *kstein@cwrmhc.org*	Substance Abuse Treatment	Moffat, Routt, Jackson, Grand, Rio Blanco, Garfield, Eagle, Summit, Mesa, Pitkin, Delta, Gunison, Montrose, San Miguel, Ouray, Hinsdale, Dolores, San Juan, Montezuma, LaPlata, Archuleta Counties	Substance Abusers	Treatment Referrals	
Women's Center of Larimer County 424 Pine St., Suite 201 Fort Collins, CO 80524 Jen Lowe Ph: 970-407-7040 Fax: 970-484-0218 *jlowe@womens-resource.org* *http://www.womens-resource.org/index.html*	Collaboratio-n	Larimer County (Fort Collins)	Women	CLI GLI PI Outreach	Health services Dental services
Yampa Valley Medical Center 1024 Central Park Drive Steamboat Springs, CO 80487 Ph: 970-871-2430 Fax: 970-871-2571	Health Services	Routt County (Steamboat Springs)	General Population	STD/HIV testing	Hep C testing Health services
Zimet, Susan, MD Internal Medicine 100 E. Main #201 Aspen, CO 81611 Ph: 970-925-5440	Internal Medicine	Pitkin County (Aspen)	General Population PLWH/A	Medical Service	

.2006 Intervention Provider Summary Report

(Number of clients projected to be served by CDPHE HIV Prevention Contractors)

Injection Drug Users (IDU)

	URBAN							RURAL						
	GLI	ILI	Outreach	PCM	PCRS	HC/PI	CTR	GLI	ILI	Outreach	PCM	PCRS	HC/PI	CTR
HIV Positive	-	3	-	12	5	-	9	-	-	-	-	1	-	-
HIV Positive and their Partners	9	8	-	4	10	-	-	3	2	-	-	2	-	-
HIV Negative/Unknown	6	138	336	22	42	-	1,215	-	-	-	-	7	-	385
Mixed	415	896	4,491	-	-	23,040	-	200	160	1,000	-	-	1,800	-
TOTAL	430	1,046	4,827	38	57	23,040	1,223	203	162	1,000	-	10	1,800	385
Hispanic or Latino	141	345	1,525	10	11	8,412	231	51	41	250	-	2	450	30
Not Hispanic or Latino	289	698	3,302	27	41	14,628	843	152	121	750	-	7	1,350	339
Ethnicity Not Targeted	-	-	-	-	-	-	150	-	-	-	-	-	-	15
TOTAL	430	1,043	4,827	36	52	23,040	1,223	203	162	1,000	-	9	1,800	385
American Indian or Alaska Native	18	44	215	1	1	979	49	4	3	20	-	-	36	28
Asian	4	14	69	0	1	161	6	-	-	-	-	-	-	-
Black or African American	75	261	1,059	10	9	4,384	140	4	3	20	-	2	36	7
Native Hawaiian or Other Pacific Islander	6	14	84	0	-	161	4	-	-	-	-	-	-	-
White	323	709	3,400	25	41	17,356	819	195	155	960	-	7	1,728	320
Race Not Targeted	4	1	-	-	-	-	205	-	-	-	-	-	-	28
TOTAL	430	1,043	4,827	36	52	23,040	1,223	203	162	1,000	-	9	1,800	385
<13 years	-	-	-	-	-	-	-	-	-	-	-	-	-	-
13-18 years	56	51	571	1	1	1,452	15	-	-	-	-	-	-	-
19-24 years	63	143	678	5	7	3,226	175	10	8	50	-	1	90	121
25-34 years	91	383	1,368	16	19	7,020	364	61	49	300	-	3	540	136
35-44 years	135	281	1,288	9	16	6,997	336	102	81	500	-	3	900	106
45+ years	86	184	922	6	9	4,345	332	30	24	150	-	2	270	15

Not age focused	-	-	-	-	-	-	2		-	-	-	-	-	-	8
TOTAL	430	1,043	4,827	36	52	23,040	1,223		203	162	1,000	-	9	1,800	385
Male	295	823	3,447	31	44	17,254	684		136	109	670	-	7	-	204
Female	133	207	1,350	5	8	5,626	539		67	53	330	-	2	-	181
Transgender	3	13	30	0	-	161	-		-	-	-	-	-	-	-
TOTAL	430	1,043	4,827	36	52	23,040	1,223		203	162	1,000	-	9	-	385

Men Who Have Sex With Men (MSM)

	URBAN							RURAL						
	GLI	ILI	Outreach	PCM	PCRS	HC/PI	CTR	GLI	ILI	Outreach	PCM	PCRS	HC/PI	CTR
HIV Positive	-	29	-	58	41	-	103	-	-	-	-	6	-	15
HIV Positive and their Partners	117	89	-	32	82	-	-	39	23		-	12	-	-
HIV Negative/Unknown	22	660	1,232	165	368		3,118	-	-	-	-	55	-	897
Mixed	453	2,266	9,481	-	-	50,910	-	297	-	3,240	-	-	8,100	-
TOTAL	592	3,045	10,713	255	491	50,910	3,221	336	23	3,240	-	73	8,100	912
Hispanic or Latino	212	906	3,154	57	99	12,198	657	81	4	810	-	15	2,025	158
Not Hispanic or Latino	380	2,110	7,559	182	351	38,712	1,914	242	11	2,430	-	52	6,075	686
Ethnicity Not Targeted	-	-	-	-	-	-	650	-	-	-	-	-	-	68
TOTAL	592	3,016	10,713	239	450	50,910	3,221	322	15	3,240	-	67	8,100	912
American Indian or Alaska Native	8	124	351	7	10	1,698	34	7	0	65	-	1	162	23
Asian	2	56	145	3	4	643	55	-	-	-	-	1	-	15
Black or African American	178	922	2,789	53	85	24,953	191	7	0	65	-	13	162	8
Native Hawaiian or Other Pacific Islander	2	52	145	1	-	643	8	-	-	-	-	52	-	-
White	251	1,824	6,809	175	351	22,973	2,478	323	22	3,110	-	-	7,776	814
Race Not Targeted	151	37	475	-	-	-	455	-	-	-	-	-	-	53
TOTAL	592	3,016	10,713	239	450	50,910	3,221	336	23	3,240	-	67	8,100	912
<13 years	-	-	-	-	1	-	-	-	-	-	-	-	-	15
13-18 years	31	117	519	3	2	3,033	118	-	-	-	-	-	-	23
19-24 years	66	407	1,356	33	65	6,865	672	17	1	162	-	8	405	347
25-34 years	171	1,324	4,181	96	165	20,993	937	101	7	972	-	24	2,430	264
35-44 years	220	686	2,876	65	132	12,314	826	168	12	1,620	-	18	4,050	158
45+ years	104	482	1,781	42	85	7,706	654	50	4	486	-	12	1,215	106
Not age focused	-	-	-	-	-	-	15	-	-	-	-	5	-	-
TOTAL	592	3,016	10,713	239	450	50,910	3,221	336	23	3,240	-	67	8,100	912
Male	582	2,969	10,527	238	450	49,839	3,210	336	23	3,240	-	58	8,100	905

Female	-	-	-	-	-	-	-		-	-	-	-	9	-	-
Transgender	11	47	186	1	-	1,071	11		-	-	-	-	-	-	8
TOTAL	593	3,016	10,713	239	450	50,910	3,221		336	23	3,240	-	67	8,100	912

Men Who Have Sex With Men/Injection Drug Users (MSM/IDU)

	URBAN							RURAL						
	GLI	ILI	Outreach	PCM	PCRS	HC/PI	CTR	GLI	ILI	Outreach	PCM	PCRS	HC/PI	CTR
HIV Positive	-	-	-	7	3	-	21	-	-	-	-	1	-	-
HIV Positive and their Partners	-	-	-	-	6	-	-	-	-	-	-	2	-	-
HIV Negative/Unknown	6	108	336	3	42	-	212	-	-	-	-	7	-	8
Mixed	33	367	1,259	-	-	6,610	-	33	-	360	-	-	900	-
TOTAL	39	475	1,595	10	51	6,610	233	33	-	360	-	10	900	8
Hispanic or Latino	21	150	563	3	11	2,446	24	8	-	90	-	2	225	-
Not Hispanic or Latino	18	324	1,032	7	37	4,165	182	25	-	270	-	7	675	8
Ethnicity Not Targeted	-	-	-	-	-	-	28	-	-	-	-	-	-	-
TOTAL	39	475	1,595	10	48	6,610	233	33	-	360	-	9	900	8
American Indian or Alaska Native	1	20	60	1	1	278	4	1	-	7	-	-	18	-
Asian	0	9	27	0	1	107	-	-	-	-	-	-	-	-
Black or African American	9	148	442	3	9	2,529	13	1	-	7	-	2	18	-
Native Hawaiian or Other Pacific Islander	0	9	27	0	-	107	2	-	-	-	-	-	-	-
White	19	285	950	6	37	3,589	189	5	-	58	-	7	144	8
Race Not Targeted	10	2	90	-	-	-	25	-	-	-	-	-	-	-
TOTAL	39	475	1,595	10	48	6,610	233	7	-	72	-	9	180	8
<13 years	-	-	-	-	-	-	-	-	-	-	-	-	-	-
13-18 years	2	19	62	1	1	343	4	-	-	-	-	-	-	-
19-24 years	4	62	198	1	7	888	41	2	-	18	-	1	45	-
25-34 years	12	204	639	5	17	3,018	81	10	-	108	-	3	270	-
35-44 years	14	110	421	2	14	1,440	77	17	-	180	-	3	450	-
45+ years	7	80	275	1	9	922	30	5	-	54	-	2	135	8
Not age focused	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	39	475	1,595	10	48	6,610	233	33	-	360	-	9	900	8
Male	38	467	1,572	10	48	6,480	233	33	-	360	-	7	900	8

Female	-	-	-	-	-	-	-	█	-	-	-	-	2	-	-
Transgender	1	7	23	0	-	130	-	█	-	-	-	-	-	-	-
TOTAL	39	475	1,595	10	48	6,610	233	█	33	-	360	-	9	900	8

Heterosexual and Not Risk Focused

	Urban Heterosexual							Urban Not Risk Focused	Rural Heterosexual							Rural Not Risk Focused
	GLI	ILI	Outreach	PCM	PCRS	HC/PI	CTR	PCRS	GLI	ILI	Outreach	PCM	PCRS	HC/PI	CTR	PCRS
HIV Positive	-	-	-	10	5	-	36	15	-	-	-	-	1	-	15	2
HIV Positive and their Partners	54	14	-	-	10	-	-	30	18	11	-	-	2	-	-	4
HIV Negative/Unknown	6	108	336	5	49	-	10,787	139	-	-	-	-	7	-	1,855	19
Mixed	228	641	4,468	-	-	8,040	-	-	-	-	-	-	-	-	-	-
TOTAL	288	764	4,804	15	64	8,040	10,823	184	18	11	-	-	10	-	1,870	25
Hispanic or Latino	65	231	1,688	5	13	2,412	3,117	37	4	3	-	-	2	-	339	5
Not Hispanic or Latino	223	532	3,116	11	46	5,628	5,822	132	14	8	-	-	7	-	1,237	18
Ethnicity Not Targeted	-	-	-	-	-	-	1,884	-	-	-	-	-	-	-	294	-
TOTAL	288	764	4,804	15	59	8,040	10,823	169	18	11	-	-	9	-	1,870	23
American Indian or Alaska Native	5	32	119	1	1	402	188	3	1	1	-	-	-	-	22	1
Asian	3	15	74	0	1	161	247	32	-	-	-	-	-	-	29	-
Black or African American	158	247	949	5	11	2,653	2,134	2	-	-	-	-	2	-	14	4
Native Hawaiian or Other Pacific Islander	3	15	55	0	-	161	19		-	-	-	-	-	-	-	-
White	73	436	2,488	9	46	4,663	6,289	132	17	10	-	-	7	-	1,588	18
Race Not Targeted	46	19	1,120	-	-	-	1,945	-	-	-	-	-	-	-	217	-
TOTAL	288	764	4,804	15	59	8,040	10,823	169	18	11	-	-	9	-	1,870	23
<13 years	-	-	-	-	-	-	19	-	-	-	-	-	-	-	15	-
13-18 years	13	31	75	1	1	402	823	-	-	-	-	-	-	-	75	-
19-24 years	42	106	738	2	8	1,126	3,373	25	1	1	-	-	1	-	611	4
25-34 years	95	336	2,054	8	22	4,020	3,590	63	5	3	-	-	3	-	573	9
35-44 years	102	178	1,394	3	17	1,447	1,670	50	9	5	-	-	3	-	339	7
45+ years	36	114	543	2	11	1,045	1,283	31	3	2	-	-	2	-	234	3
Not age focused	-	-	-	-	-	-	64	-	-	-	-	-	-	-	23	-
TOTAL	288	764	4,804	15	59	8,040	10,823	169	18	11	-	-	9	-	1,870	23
Male	116	600	1,512	13	51	6,754	6,203	146	14	9	-	-	7	-	784	20

Female	167	148	3,262	2	8	1,126	4,603		23	4	2	-	-	2	-	1,086	3
Transgender	5	15	30	0	-	161	17		-	-	-	-	-	-	-	-	-
TOTAL	288	764	4,804	15	59	8,040	10,823		169	18	11	-	-	9	-	1,870	23

County Designations

As mentioned earlier in this chapter, CWT has distinguished the counties in Colorado as urban and rural. In addition, the CWT Rural Committee also distinguishes frontier and suburban county designation.

- Urban: Shall be a term applied to counties that fall within the standard definition of Metropolitan Statistical Areas, having within the county boundaries one or more population centers of 50,000 persons or more, AND which according to Colorado HIV surveillance data have a preponderance of HIV/AIDS cases, that is 250 cases or more. These counties are: Adams, Arapahoe, Boulder, Denver, El Paso, and Jefferson. In Colorado these counties are both urban by definition and account for 89 percent of the known AIDS cases in the state.

- Suburban: Larger than "rural" with more significant infrastructure and good access to the services and resources in urban areas (examples would be Douglas and Broomfield County).

* Note: Larimer County is considered "rural" although the city of Fort Collins would be considered Suburban.

- Rural: While not "urban or suburban," is a larger geographic area that has established HIV prevention infrastructure, county health departments, and/or health clinics (examples would be Weld and Mesa County)

- Frontier: (Smallest distinction) smaller than rural with extremely limited, if any, HIV prevention, mental health, or substance use providers or infrastructure. Considered "remote" and/or a long distance from services (travel time to services is measure in hours, not minutes)(examples would be Mineral and Jackson County).

The following is a list of the counties is Colorado and their designation.

Urban

Adams (Brighton)
Arapahoe (Littleton)
Boulder (Boulder)
Denver (Denver)
El Paso (Colorado Springs)
Jefferson (Golden)

Suburban

Douglas (Castle Rock)
Broomfield (Broomfield)

Rural
Alamosa (Alamosa)
Chaffee (Salida)
Clear Creek (Georgetown)
Delta (Delta)
Eagle (Eagle)
Fremont (Canon City)
Garfield (Glenwood Springs)
Gilpin (Central City)
Gunnison (Gunnison)
La Plata (Durango)
Lake (Leadville)
Larimer (Fort Collins)*
Mesa (Grand Junction)
Moffat (Craig)
Montezuma (Cortez)
Montrose (Montrose)
Morgan (Fort Morgan)
Pitkin (Aspen)
Pueblo (Pueblo)
Routt (Steamboat Springs)
San Miguel (Telluride)
Summit (Breckenridge)
Teller (Cripple Creek)
Weld (Greeley)

Frontier
Archuleta (Pagosa Springs)
Baca (Springfield)
Bent (Las Animas)
Cheyenne (Cheyenne Wells)
Conejos (Conejos)
Costilla (San Luis)
Crowley (Ordway)
Custer (Westcliffe)
Dolores (Dove Creek)
Elbert (Kiowa)
Grand (Hot Sulphur Springs)
Hinsdale (Lake City)
Huerfano (Walsenburg)
Jackson (Walden)
Kiowa (Eads)
Kit Carson (Burlington)
Las Animas (Trinidad)
Lincoln (Hugo)
Logan (Sterling)
Mineral (Creede)
Otero (La Junta)
Ouray (Ouray)
Park (Fairplay)
Phillips (Holyoke)
Prowers (Lamar)
Rio Blanco (Meeker)
Rio Grande (Del Norte)
Saguache (Saguache)
San Juan (Silverton)
Sedgwick (Julesburg)
Washington (Akron)
Yuma (Wray)

Chapter Four

The Needs Assessment

What is the Needs Assessment?
A needs assessment is a process used to obtain and analyze information to determine the current status and service needs of a population at risk for HIV infection or geographic area. The needs assessment builds on the data provided in the Epi Profile to elaborate on the behaviors, assets, and prevention needs of the populations at risk of HIV infection. The data provided contains both qualitative and quantitative information about Colorado's target populations, both from the perspective of the communities themselves and the providers who serve them. Barriers that make it difficult to reach and involve specific target populations in those prevention activities, and suggestions to overcome those barriers should also be identified.

What is its Significance to Community Planning?
The results and analysis of the needs assessment provides the majority of the data the community planning members need to prioritize target populations at greatest risk for HIV and identify the interventions needed to reduce the greatest number of new HIV infections for those target populations. The data provided in the report should help the community planning group determine the extent to which target populations are aware of HIV transmission methods and high-risk behaviors, are engaging in high-risk behaviors, have been reached by HIV prevention activities, and the likelihood that the communities would participate in HIV prevention activities or interventions.

Introduction

Coloradans Working Together: Preventing HIV/AIDS (CWT) works on a three-year planning cycle, and has traditionally performed its needs assessments every three years (prior to CWT prioritizing target populations and interventions). The past needs assessments attempted to identify a wide range of at-risk population needs, as well as services delivered to address those needs. However, its comprehensiveness proved to be limited. Therefore, CWT decided to focus the 2006 Needs Assessment efforts on men who have sex with men, and in 2007 conduct needs assessments for the injecting drug use and high-risk heterosexual populations. CWT believes that this approach will provide the opportunity for the needs assessment projects, using both

qualitative and quantitative approaches, to allow for a more complete assessment.

The Research and Evaluation Unit (R&E Unit) at the Colorado Department of Public Health and Environment (CDPHE) was charged with the main research and analysis components of the project, while CWT's Needs Assessment and Prioritization Committee helped guide and oversee the process.

The needs assessment report was formally presented by the R & E Unit at the July 21, 2006 CPG meeting. The presentation also included the findings from the past (2002-2003 and 2003-2004 Needs Assessment Reports). The information gleaned from the needs assessments, particularly the 2006

project, helped CWT gain a more complete understanding of what elements should be present in HIV prevention and related programming.

The full text of the 2004-2005 Needs Assessment Report is available at:
http://www.cdphe.state.co.us/dc/cwt/2004Add.pdf
The full text of the 2002-2003 Needs Assessment Report is available at:
http://www.cdphe.state.co.us/dc/cwt/NeedsAssessmentReport.pdf

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General Methodology Descriptions

Secondary Sources
Provide a supplemental context for the information collected in the needs assessment in order to provide additional insights into the risk-behaviors, community perceived barriers, as well as the suitability and effectiveness of certain interventions for target population. In most cases, the secondary sources provided in Colorado's needs assessments were reports from community-based organization contract through CDPHE to investigate the needs/assets of community whom they advocate for or serve.

Focus Groups
A focus group is a carefully planned discussion among a small group of people with certain similar characteristics, who interact in a group setting facilitated by a trained moderator. The analysis of focus groups provides valuable qualitative insights into the prevention needs of different populations but cannot be assumed to represent the views of the broader population. A few of the focus groups were later convened to "pilot" the "consumer survey" before the surveys were sent to the larger community.

One-On-One Interviews
One-on-one interviews also provide qualitative information. Those interviewed were specifically chosen because those individuals have extensive first-hand knowledge about such matters as perceived HIV prevention needs, gaps, and barriers for particular populations or geographic areas. Again, the information provided by one-on-one interviews should not be generalized to a larger population.

Surveys
Surveys are data collection tools where structured questions are used to obtain quantitative information from a sample of Colorado communities. This report contains an analysis of those surveys in order to provide statistical information about particular target populations. Again, the results of the surveys should be construed as personal preferences, and caution should be taken when generalizing the data. Colorado's needs assessment methodology administered two different types of surveys; a consumer and a provider survey.

COLORADANS WORKING TOGETHER: PREVENTING HIV/AIDS

2006 HIV PREVENTION NEEDS ASSESSMENT REPORT

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ACKNOWLEDGMENTS

2006 HIV PREVENTION NEEDS ASSESSMENT

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

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

METHODS

Four principle methods were used in gathering data for this needs assessment including: 1) reviewing aggregate epidemiological data drawn from the HIV/AIDS Reporting

System (HARS), the Supplement to HIV/AIDS Surveillance Project (SHAS), the 2003-2004 Needs Assessment Survey (NAS), and the National Behavioral Surveillance Project (NBSP); 2) conducting ten focus groups with a total of 72 participants representing diverse groups of gay and bisexual men; 3) conducting fourteen one-on-one interviews with gay and bisexual men, all but one of whom were living with HIV and had been diagnosed within the previous two years (with the exception of one who had been diagnosed five years prior to the interview); and 4) implementing a survey that was distributed at an Internet site and received 57 responses from gay and bisexual men.

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

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

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

SUMMARY OF EXISTING AGGREGATE DATA

As mentioned above, aggregate data were drawn from four different sources and analyzed to provide critical information about the types of risk behaviors in which gay and bisexual men were engaging. Trends that were evident in these data were used to inform the population focus and the topics that were further pursued in one-on-one interviews, focus groups, and the Internet survey. One such data source was the HIV/AIDS Reporting System (HARS). HARS contains information gathered by the CDPHE Surveillance Program on all cases of HIV and AIDS diagnosed statewide and reported to CDPHE. For purposes of informing this needs assessment, male and female African American, Latino, and White cases diagnosed between January of 2001 and October of 2005 were included in the preliminary summary (n=1819). Basic demographic, risk, and diagnostic data are fairly complete for this population of persons diagnosed with HIV.

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

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

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

❖ Nearly two-thirds of all people diagnosed with HIV in Colorado between January 2001 and October 2005 were men who have sex with men (MSM). Of these, over two thirds were white.

❖ One in three MSM diagnosed with HIV were over 40 years old at diagnosis; a higher proportion of white MSM were diagnosed at the age of 40 or older (1 in 3) than African American MSM (1 in 4) or Latino MSM (1 in 5). Conversely, a greater proportion of MSM of color diagnosed with HIV/AIDS were less than 40 years of age.

- ❖ Nearly half of all MSM answering the SHAS survey reported over 100 lifetime partners, one in four reported more than 200, and one in seven reported more than 500 sexual partners in their lifetime.
- ❖ Approximately two thirds of HIV+ MSM answering the SHAS survey reported more than one sexual partner in the past twelve months, while one in ten reported 20 or more partners.
- ❖ One in 3 HIV+ MSM answering the SHAS survey reported having had sex in a bathhouse in the previous 12 months.
- ❖ Four in ten HIV+ MSM answering the SHAS survey reported having insertive anal sex with a non-steady partner without a condom the last time they had sex. The same proportion (4 in 10) reported receptive anal sex without a condom with a non-steady partner at last sex.
- ❖ White HIV-negative or status unknown MSM answering the NAS were more likely to report having unprotected sex with an HIV+ partner, or a partner of unknown serostatus than were African American or Latino MSM.
- ❖ Four in ten HIV-negative or status unknown Latino MSM answering the NAS and nearly as many white MSM reported having sex while drunk or high, while 2 in10 African American MSM reported this risk behavior.
- ❖ Nearly half of the HIV-negative or status unknown MSM answering the NAS reported having unprotected insertive anal sex and one in three reported unprotected receptive anal sex in the past 12 months.
- ❖ One in ten HIV-negative or status unknown MSM answering the NAS reported that they knowingly had unprotected sex with an HIV+ person in the past 12 months.
- ❖ One in five African American HIV-negative or status unknown MSM answering the NAS and one in six Hispanic MSM reported never being tested for HIV, compared to one in twenty white MSM.
- ❖ Nearly half of the Hispanic HIV-negative or status unknown MSM answering the NAS and four in ten white MSM reported having five or more drinks at one sitting in the past month, compared to one in four African American MSM.
- ❖ One in three HIV-negative or status unknown MSM answering the NAS reported meeting sexual partners on the Internet, over half reported meeting partners in bars, nearly four in ten had met partners in bathhouses, one in five met on the street, and one in six reported meeting partners in parks.
- ❖ Nearly half of the HIV-negative or status unknown African American MSM answering the NAS reported experiencing feelings of hopelessness.
- ❖ Almost half of the HIV-negative or status unknown MSM answering the NAS had felt shame around their sexual orientation.
- ❖ Four in ten HIV-negative or status unknown African American MSM answering the NAS had experienced homelessness.

The fourth data source used was the National Behavioral Surveillance Project (NBSP). Beginning in December 2004 and continuing through February 2005, staff from Denver Public Health (DPH) surveyed 981 MSM who lived in the Denver Metropolitan Area, one of 16 metropolitan areas where the surveys were administered, in order to assess HIV

behavioral risk among MSM. Survey participants were accessed through locations such as bars and nightclubs, social groups, bathhouses, and coffee shops at which they completed a self-administered questionnaire using handheld palm pilots. Based on survey data, DPH reported the following findings of behavioral trends that may influence the transmission and acquisition of STD and HIV among MSM living in metropolitan Denver:

❖ The majority of survey respondents (94%) reported a previous test for HIV. Approximately 7% of those surveyed reported that they had not been tested or had not received results of their last HIV test.

❖ Of the 523 men that reported the location of their last HIV test, greater than 80% were tested at a private doctor's office or at a public health clinic. A much smaller number reported being tested at an HIV CTS, hospital, STD clinic, or in an outreach setting.

❖ Eighty-one percent of the survey sample had seen a medical provider in the past 12 months. Among the 153 MSM that reported a positive test, 96% were seen by a provider for HIV care, and 78% reported receiving HAART. Overall, 79% of the respondents reported having health insurance.

❖ Of the 981 MSM respondents, 10% reported ever injecting drugs, including 17 men who reported injecting drugs in the past 12 months. Forty-four percent of all respondents reported using non-injection drugs (not including alcohol) within the past 12 months. Thirty-eight percent of respondents reported being high on alcohol or drugs while having sex in the past 12 months.

❖ Among the 17 MSM that reported injection drug use, methamphetamines and cocaine were reported most frequently as drugs used in the past 12 months. Among MSM reporting the use of non-injection drugs, marijuana and cocaine were the most frequently reported drugs used in the past 12 months.

❖ Although 11% of all the MSM surveyed reported using methamphetamines, a greater proportion of men living with HIV (20.9%) reported methamphetamine use compared to HIV negative men (9.0%).

❖ Methamphetamine users in the study were significantly more likely to have been arrested in the past 12 months (20.4% v. 4.0%), used erectile dysfunction drugs (22.9% v. 13.4%), and been homeless compared with men who did not report methamphetamine use.

❖ Unprotected anal or vaginal sex in the past 12 months was reported more frequently among methamphetamine users (70.4%) than among non-methamphetamine users (43.5%). A greater proportion of methamphetamine users (31.7%) reported testing positive for HIV compared with non-methamphetamine users (14.9%).

❖ Sixty-six percent of the MSM surveyed reported having a main partner in the last 12 months. Of those reporting a main partner, 58% also reported having a casual partner in the last 12 months.

❖ Fifty-nine percent of all MSM surveyed reported a casual partner in the last 12 months.   Of the 600 men that responded to a question about where they met their last casual sex partner, almost half reported meeting this partner in a bar or club. The

proportions of men that reported meeting their last casual sex partner through the Internet or at a bathhouse were much lower (i.e., at or approaching 10% of respondents, respectively).

❖ MSM survey respondents reported unprotected anal and vaginal sex more frequently with a main partner compared with casual partners.

❖ Among the 981 MSM that participated in the study, 64% reported discussing their HIV status with a partner. Among the 650 men that reported a main partner, 79% reported having a discussion with this partner about his and the partner's HIV status. Among the 580 men with casual partners, 68% reported having such a discussion with a casual partner.

SUMMARY OF THE FOCUS GROUPS, INTERVIEWS AND INTERNET SURVEY

Overarching Issues

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

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

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

Demographic Profile of the Participants

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

participated in focus groups or interviews. Table One shows a breakdown by participant age.

Table Two shows a breakdown by participant race/ethnicity.

Table One: Age of Respondents

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

Table Two: Ethnicity of Participants

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

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

Table Three: Geographic Residence of Participants

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

Findings

Major issues affecting gay and bisexual men and HIV. When asked about the major concerns of gay and bisexual men apart from HIV, responses most frequently offered by participants in the interviews, focus groups, and the Internet survey encompassed issues related to discrimination against gay and bisexual men by the wider society. This included concerns about societal homophobia and stigma, a puritanical society that condemns their sexual orientation and behaviors, struggles over legal rights and government policies, and violence and safety. Other issues discussed that were related, in part, to discrimination included mental health issues such as feelings of isolation, loneliness, shame, and depression, as well as the tendency for some gay and bisexual men to stay "closeted", especially men of color and men living in rural areas. The second most commonly raised issue by interview, focus group, and survey participants dealt with the prevalence of substance use and abuse among gay and bisexual men, with special concern expressed for the preponderance of methamphetamine use. The third most discussed set of concerns was related to health, including access to health insurance and to health care. A large number of the Internet survey respondents cited STDs as a major concern. Another commonly discussed set of issues in the interviews and focus groups included those related to basic needs such as jobs, housing, and financial resources. In contrast, issues related to basic needs were not commonly raised by survey respondents. Other issues cited as major concerns in the interviews and focus groups included problems within the gay community as well as issues related to sexual relationships, including those concerning multiple sex partners, anonymous relationships, the lack of HIV status disclosure, and men knowingly exposing others to HIV. More detailed summaries of several of these major issues (i.e., substance abuse, emotional well-being, relationships, disclosure, and the gay community) are included below.

After discussing the major issues that gay and bisexual men currently face, interview, focus group, and survey participants were asked their opinions about HIV as a priority and how it ranked relative to other concerns of gay and bisexual men. Internet survey respondents were specifically asked to rank HIV's importance relative to these other issues. Just over half the respondents said HIV was equally important, while 4 in 10 indicated that it was more important. Only 4 respondents indicated that HIV was less important than other concerns. In the interviews and focus groups the subject of HIV was

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

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

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

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

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

Respondents to the Internet survey were asked more closed-ended questions about the needs of those who abuse substances and who are at risk for getting or spreading HIV. When asked about the most appropriate and effective types of interventions or approaches to meeting those needs, targeted information campaigns was the most frequent response, followed by interventions that involve the larger gay and bisexual community, having multiple services available at one agency, and counselors who can deal with multiple issues such as substance abuse, HIV risk, and mental health. When asked for the single-most effective approach, survey participants most often indicated having multiple services available at one agency followed by targeted public information

campaigns**.** Suggestions for getting men into services included offering incentives; advertisements about available programs; encouragement from friends, family, and peers; and education concerning HIV and substance use. For more details on these responses see Appendix One.

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

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

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

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

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

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

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

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

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

Reasons for unsafe sex. During the course of the interviews and focus groups, participants provided a number of opinions about why many gay and bisexual men are

having unsafe sex in spite of knowing about the risks for HIV. By far the most common reason given was the use of drugs and alcohol. Such use was said to impair judgment and cause people to forget about protection or simply not care about protecting themselves or others. Not caring about themselves and/or others was the second most common reason presented. In several instances participants discussed the phenomenon of "bug chasing" in which men purposely try to become infected with HIV, either because they wanted to "get it over with" thinking infection was inevitable, to access services, or because of self-destructive tendencies. Men not liking condoms and how they feel was also a common reason presented, as were the lack of ready availability of condoms, low self-esteem and the need for acceptance, men's desire to show trust and emotional connection to their partners, and feelings of invincibility among youth. Some participants mentioned how people often thought they were being safe or were in denial of their risk. Such men were said to make judgments about the HIV status of their partners based on appearance, socioeconomic status, age, where they reside, or if they tend to be "tops" (insertive partners) or "bottoms" (receptive partners). Other reasons for unsafe sex included condom or safe sex fatigue, especially among older gay men, and prostitution.

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

Respondents to the Internet survey were first asked to choose among a list of factors that affect whether or not partners have discussions about HIV status. Assumptions about partners' HIV status, feelings for partners, and drug use were the most commonly indicated responses. Other frequent responses included fear of rejection among HIV-positive persons, potential for the relationship to move forward, behavioral expectations in the setting where men meet, concerns about confidentiality, and peer expectations. When asked why men who are living with HIV might not disclose their status, almost all respondents checked fear of rejection as a reason, and over two thirds checked fear that confidentiality would be breached. Over half responded that it was the other person's

responsibility to protect himself from infection. A third of the respondents indicated that it was no one else's business, while one quarter reported fear of violence as a reason for not disclosing.

Although many in the interviews thought that men who were living with HIV should disclose their status to sex partners, many thought that it was up to negative partners to ask about status and/or presume all partners are positive and act accordingly. Some thought that if condoms were used, disclosure was not necessary. Conversely, some men were said to disclose, but then to proceed to have unsafe sex if the partner does not object no matter what the partner's status. A number of men in the interviews and focus groups who were living with HIV talked about very positive experiences with disclosure or felt that it was necessary whether they got positive reactions from others or not. Some had chosen to remain abstinent until they felt more comfortable with disclosure. Most of these men had not had partners disclose their positive status to them before they were infected.

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

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

The gay community and culture. Although no questions were asked directly about the "gay community" and "gay culture", attitudes and opinions about these were discussed in almost every interview and focus group and were very useful for assessing influences on risk behavior and in looking for HIV prevention ideas. Many of the participants had very negative things to say about the gay community and culture, some stating that there really

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

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

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

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

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

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

Ideas for various types of group level interventions were the second most commonly discussed prevention topics. Support groups, social groups, and substance abuse recovery groups were among the suggested interventions. Groups needed to be targeted to specific populations of gay men and should address the most relevant issues of those populations. Suggested topics included substance abuse and recovery, disclosure of HIV status, emotional well-being, HIV and STD information, the meeting of basic needs, and

dealing with and challenging societal stigma and discrimination. Participants clearly asserted that the gay community needed to play a much bigger role in HIV prevention and related services and in defining solutions to a number of key issues that the community is facing. Many agreed that community forums should be held so that gay men could discuss their most relevant issues, including those related to HIV, substance abuse, mental health, and societal homophobia and discrimination. The most commonly suggested community level effort concerned the development of safe places that were alcohol and drug free where men could meet other men and be able to socialize, access services, and participate in a number of social activities. Increased outreach efforts were also commonly proposed as means of getting information to people, making condoms and lubricant readily available, making HIV and STD testing more available, and for encouraging people to take part in other types of prevention programming and related services.

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

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

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

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

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

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

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

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

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

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

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

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

❖ Social dimensions need to be built into prevention efforts.

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

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

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

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

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

Limitations of the Data

Given the reliance on qualitative information for a major part of this needs assessment, convenience samples were used and cannot be considered as statistically representative of gay and bisexual men in Colorado. Efforts were made to draw information from a diverse population of gay and bisexual men, covering various age groups, ethnic groups, rural and urban residents, and both men who were living with HIV and those who were not. Emphasis was placed on finding participants who were at high risk for getting or spreading HIV. Peer recruiters and service providers were used to gain participation in the ten focus groups that were held, and a widely diverse set of men participated.

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

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

SUMMARY AND CONCLUSION

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

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

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

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

RESOURCE LIST

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

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

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

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

APPENDIX ONE: INTERNET SURVEY RESULTS

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

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

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

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

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

Age of Respondents

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

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

1. Other than HIV, what are the biggest concerns that gay and bisexual men in Colorado currently face?
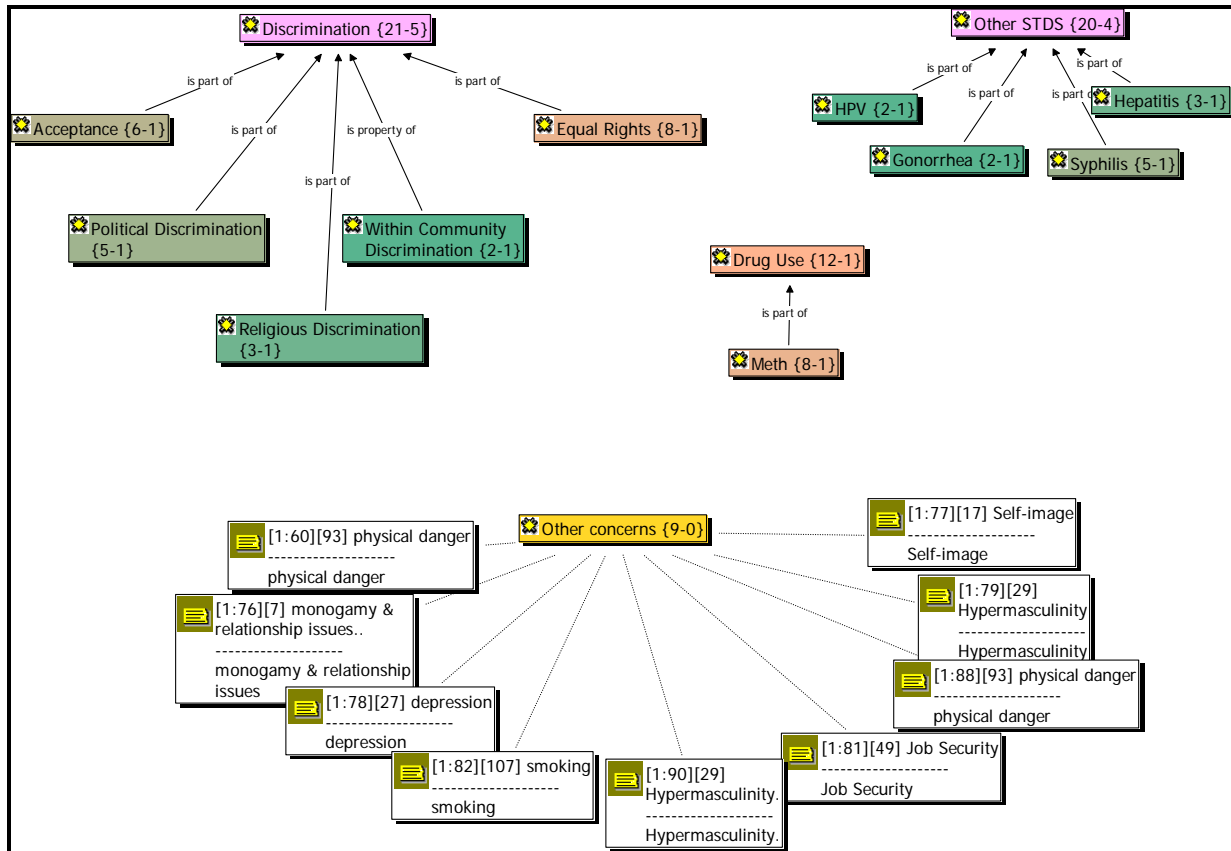
When asked how important HIV is compared with these other concerns, 93% felt HIV was equally important or much more important.

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

When asked what types of relationships gay and bisexual men engage in that would be considered healthy, over eighty percent selected relationships that involve: mutual trust

(82%), honest communication (88%), and long-term monogamy (82%). Over seventy percent checked relationships that involve total commitment, responsibility (75%), and fun(71%). Slightly fewer than half indicated relationships that involve some but not total commitment, long-term steady non-monogamous relationships, or casual short-term relationships. A minority indicated anonymous sexual relationships (21%) and relationships that involve no responsibility and commitment (13%).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When asked what gay and bisexual men need to help them more easily develop the kinds of relationships that they most want, societal acceptance and support was the top response (24 respondents). A quotation that reflects this need is: "They need to exist in a community that is open and affirming of who they are. It is very difficult living as a

gay/bi man in Colorado for a lot of people. The atmosphere here is very harsh, and this contributes to the difficulty of finding, establishing, and maintaining a healthy relationship." Related responses involved the need for self-acceptance and support from within the gay/bisexual community (4 respondents).

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

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

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

7. What do gay and bisexual men need to help them more easily develop the kinds of relationships that they most want?
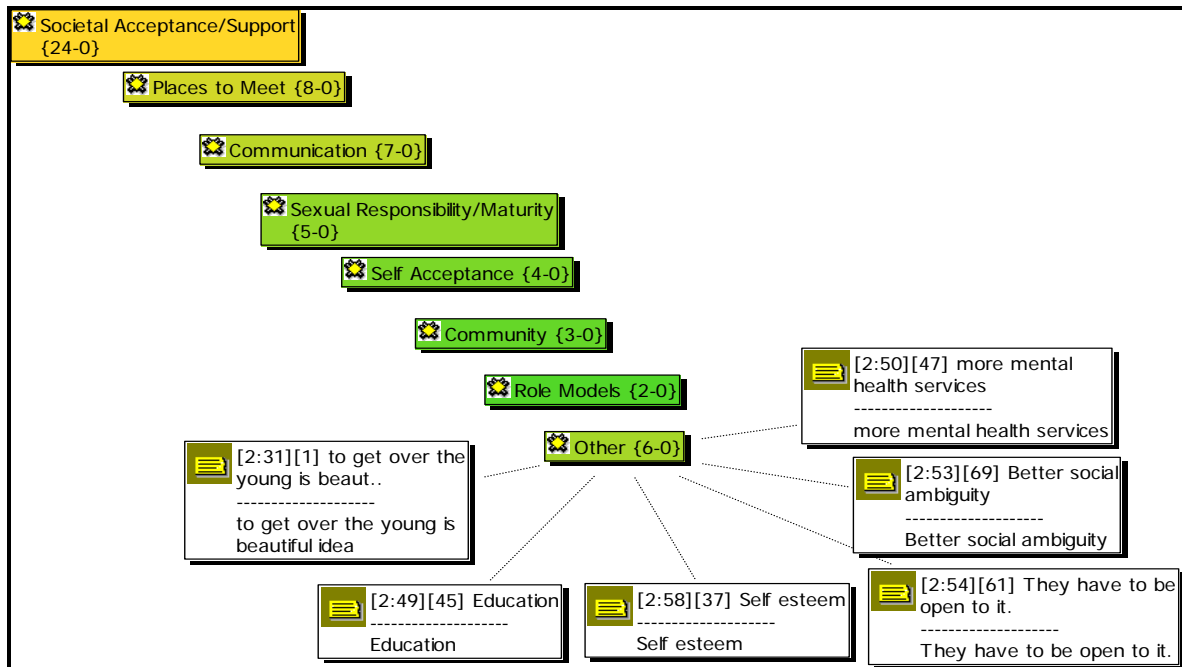
When asked "What are some of the reasons that some gay and bisexual men have unprotected sex with anonymous partners?", a wide array of responses was given. Over half indicated eroticism (54%), fantasies (57%), sexual additions (54%), and the lack of conditions or restrictions associated with anonymous partners (61%).

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

Other reasons for unprotected anonymous sex included drugs, low self

esteem/worth/respect, personal level of maturity and responsibility, easiness of

anonymous sex, attractiveness of the taboo, desire for sex without a relationship, self

destructiveness, sense of invulnerability to disease, and willingness to take informed

risks. Responses also indicated that reasons for anonymous sex and reasons for

unprotected sex need to be addressed separately.

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

When asked the most important reason gay and bisexual men engage in unprotected

anonymous sex, a variety of responses were given, however, the most popular was that

sex is more erotic without condoms (25%). Other responses checked by 4% to 11% of

respondents included speed and ease of finding sex partners (11%), fear of rejection for

wanting to use condoms (9%), lack of concern about contracting HIV (9%), greater

eroticism of sex with anonymous partners (7%), ability to keep sexual orientation private

(7%), fulfillment of fantasies (5%), and freedom from conditions and restrictions (5%).

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

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

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

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

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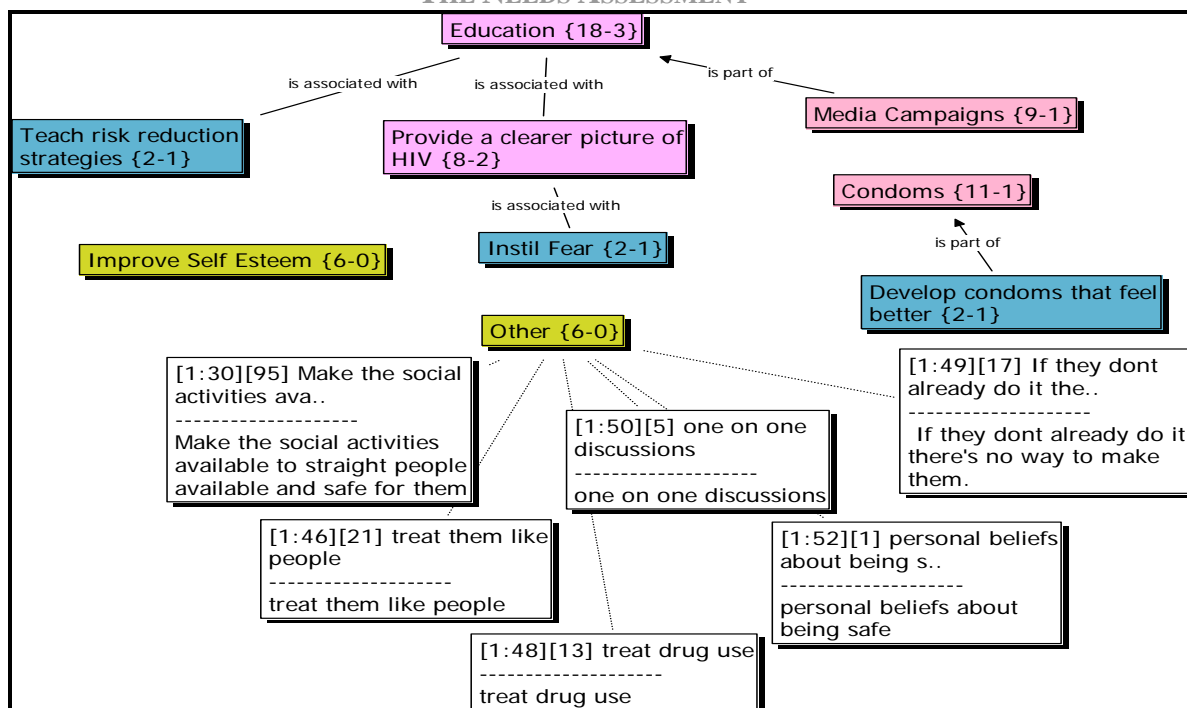
Respondents were asked what would be the most appropriate and effective types of interventions or approaches to help meet the HIV prevention needs of gay and bisexual men who seek anonymous partners. The most popular responses were social settings/events where men can meet other men (73%) and targeted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

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

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

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

When asked which of the above interventions would be most effective in helping to meet the HIV prevention needs of men who seek anonymous partners, the most popular reply was social settings where men can meet other men (39%), followed by targeted public information campaigns (20%).

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

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

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

What would it take to get men who are at high risk for HIV to participate in programs that focus on safer behaviors with anonymous partners? Seven respondents indicated that it would take various types of incentives such as money, food, and condoms while six referred to education. An example of an education related response is: "Better ways of educating them without making them feel like they're being subordinated".   Five respondents thought media campaigns including internet advertisements would be effective, although one respondent indicated disagreement by writing, "most 'safer sex' advertising increases HIV-related stigma, so something that doesn't do that". Also related to the media and education was the concept that media and advertising should portray HIV as dangerous and harmful, for example, "Just stop showing all the sexy HIV+ guys on sailboats, and running along beaches, and start reminding people about the true face of AIDS." and "Increase awareness of the real facts and what is happening today with the long term HIV treatment and side effects."

Four respondents indicated that nothing could done, "You aren't going to get that to happen. The only way they would participate was if there were hot men or they were under court order." Three men felt it would take pressure as well as understanding from the homosexual and/or heterosexual community, "maybe pressure from within the community will help them realize that their actions not only put them at risk but also reflects on the community as a whole....how can we expect compassion, understanding and acceptance when we act in irresponsible, dangerous ways???"   Other respondents indicated that it would take fun sessions in fun settings and eroticizing condom use. Other respondents felt it would take peer pressure, gay organizations, gay facilitators,

safe non-judgmental settings, a gay focus, and a focus on respect. While one suggested that by simply offering the programs and men would participate.

13. What would it take to get men who are at high risk for HIV to participate in programs that focus on safer behaviors with anonymous partners?
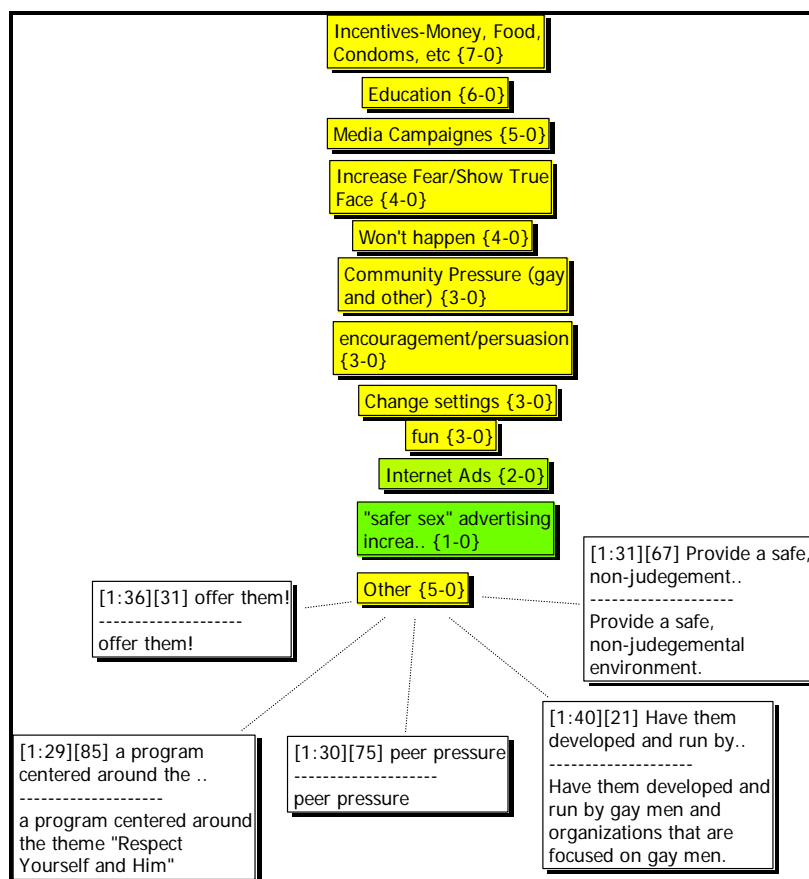
When asked how common it is for gay and bisexual men to discuss their HIV status with their sexual partners, the majority of respondents said it happens sometimes (43%) or it is pretty common (31%).

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

When asked "What affects whether or not those discussions occur?" results indicated that a number of factors affect whether the discussions occur. Sixty-one to sixty-five percent of respondents marked assumptions about HIV status (66%), feelings for partners (64%), drug use, and the settings where the partners are met (64%). Fifty-one to fifty-five percent selected fear of rejection among HIV positive persons (55%), potential for relationship to move forward (59%), behavioral expectations in the settings where men meet (53%). Nearly one-third indicated that concerns about confidentiality (38%) and peer expectations (30%) affect whether these discussions occur.

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

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

15.	What affects whether or not those discussions occur? (Please check all that apply)
#	**Response**
1	Acceptance of personal responsibility
2	consceince, common sense
3	I've never encountered a guy who lied about HIV

When asked which of the above most often affects whether the discussions occur the most popular answer to this question was fear of rejection for those who are living with HIV (23%). Other popular responses were whether or not people are drunk or high (15%) and the settings where men meet each other (15%).

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

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

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

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

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

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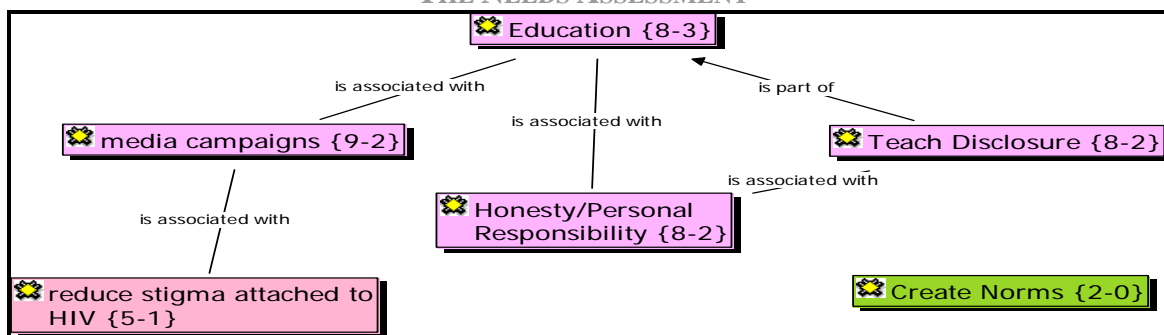
When asked reasons why gay and bisexual men who are living with HIV might not disclose their status, 95% checked fear of rejection, and 69% checked fear that their confidentiality would be breached. Fifty-five percent felt it was the other person's responsibility to protect himself from infection. Thirty-eight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

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

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

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

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

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

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

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

When asked what gay and bisexual men who are living with HIV need to help them disclose their status to their sex partners, a large theme that arose was the need for greater acceptance and less rejection from negative men. Two quotes that exemplify this theme are: "need the neg people to stop rejecting them solely based on their status… need to be

comfortable suggesting safe ways to still hook up...” and “Not sure. Maybe to let them know that not ALL gay men who are neg would rule them out. I think that would be huge.”

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

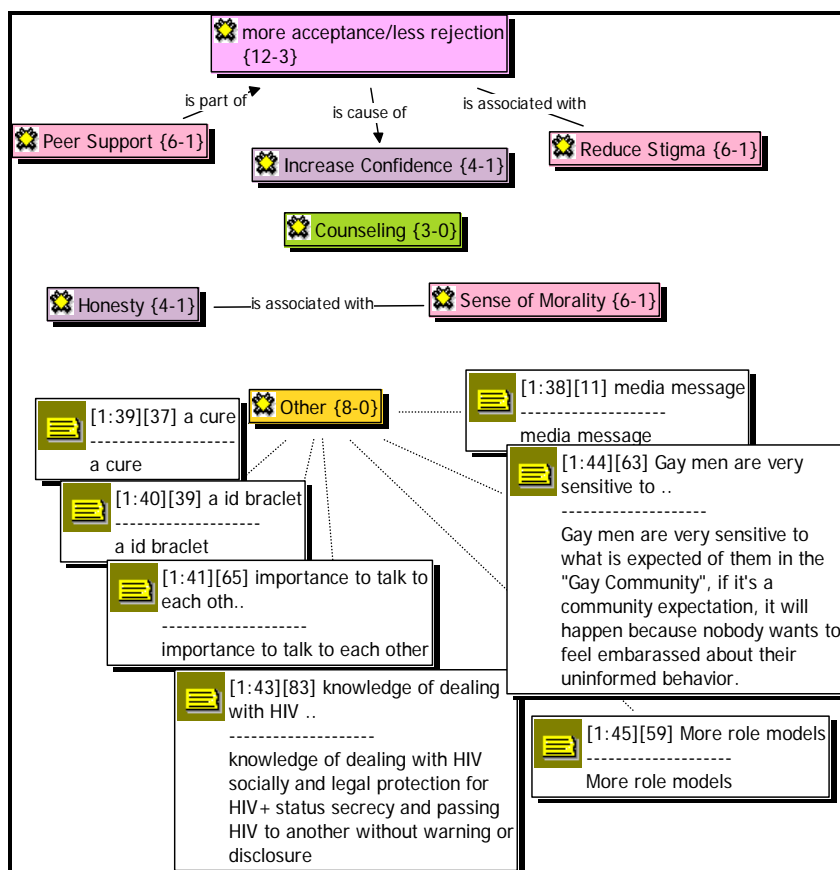20. What do gay and bisexual men who are living with HIV need to help them disclose their status to their sex partners?

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

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

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

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

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

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

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

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

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

"Less stigma attached to going to a support group for HIV infected men"

"HIV not being looked down upon",

"a nonjudgmental stance with regard to one's sexuality and/or sexual history" ,

"The elimination of the inherent embarrassment that would result from being implicated with such programs." and

"I think the fear of disclosure is too high to draw people in directly to a program specifically targeted on disclosure."

Other respondents indicated a desire not to be personally associated with such programs by requesting "full anonymity. "

Second to the cry for a safe private environment were requests for a variety of incentives including money, food, beer, condoms, antiretroviral drugs, and services for people living with HIV. The third level of responses indicated that it would require educational public awareness campaigns to get men to participate in such programs. Four respondents felt it would require a fun social setting to get men to participate. For example "Social events where men know they will have opportunities to meet other men of similar interest" and "a social event that provided a fun and safe environment".   Other responses included encouragement, a shift in societal perceptions, peer pressure, community interventions, grief counseling for new positives, programs based on respect for partners, and acceptance of the importance of the issue.

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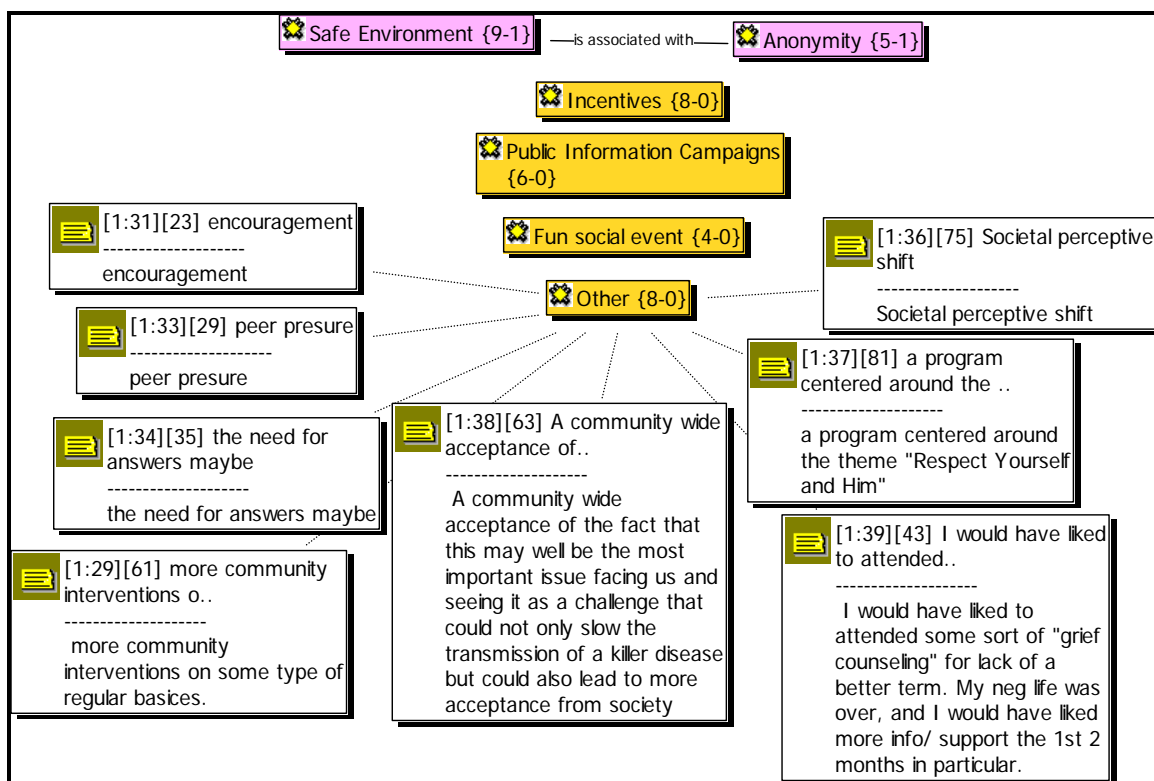
Respondent suggestions for appropriate and effective ways to address substance abuse and HIV risk among gay and bisexual men included media and advertising campaigns in bars, on the Internet, and in the gay media. Respondents suggested that the messages delivered through this media should improve self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

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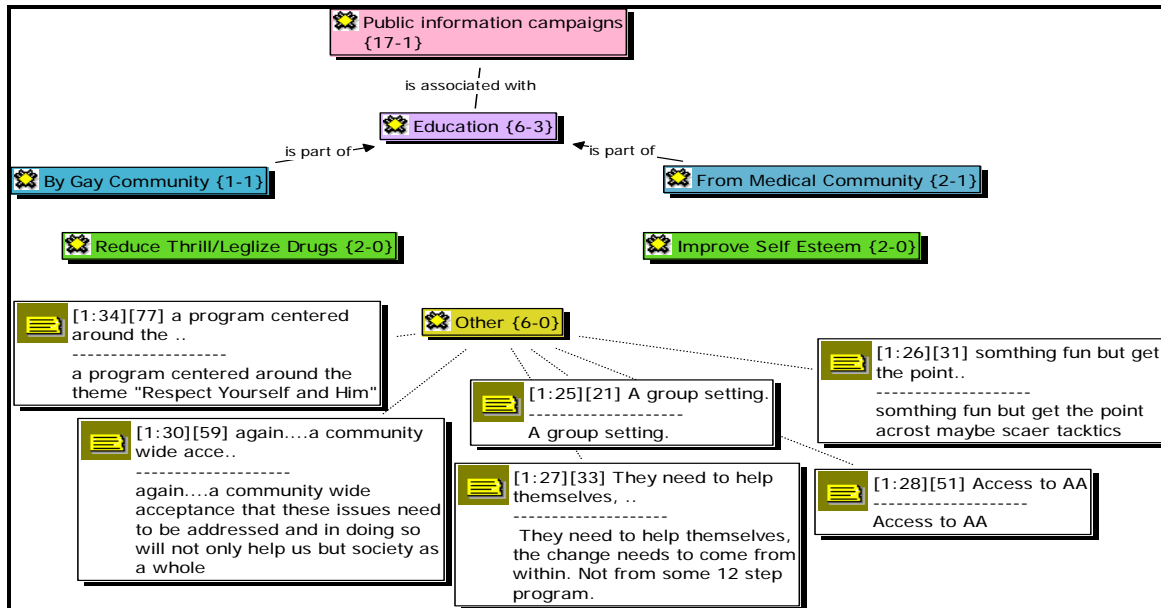
When asked, "What would be appropriate and effective types of interventions or approaches to help meet the needs of men who abuse drugs and/or alcohol and engage in high-risk sex?" The most popular responses were targeted public information campaigns (73%), multiple services at one agency (65%), one-on-one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

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

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

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

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

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

Other responses included legalization of drugs.

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

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

27. What would it take to get men who are most at risk to participate in programs that address substance abuse and HIV risk?
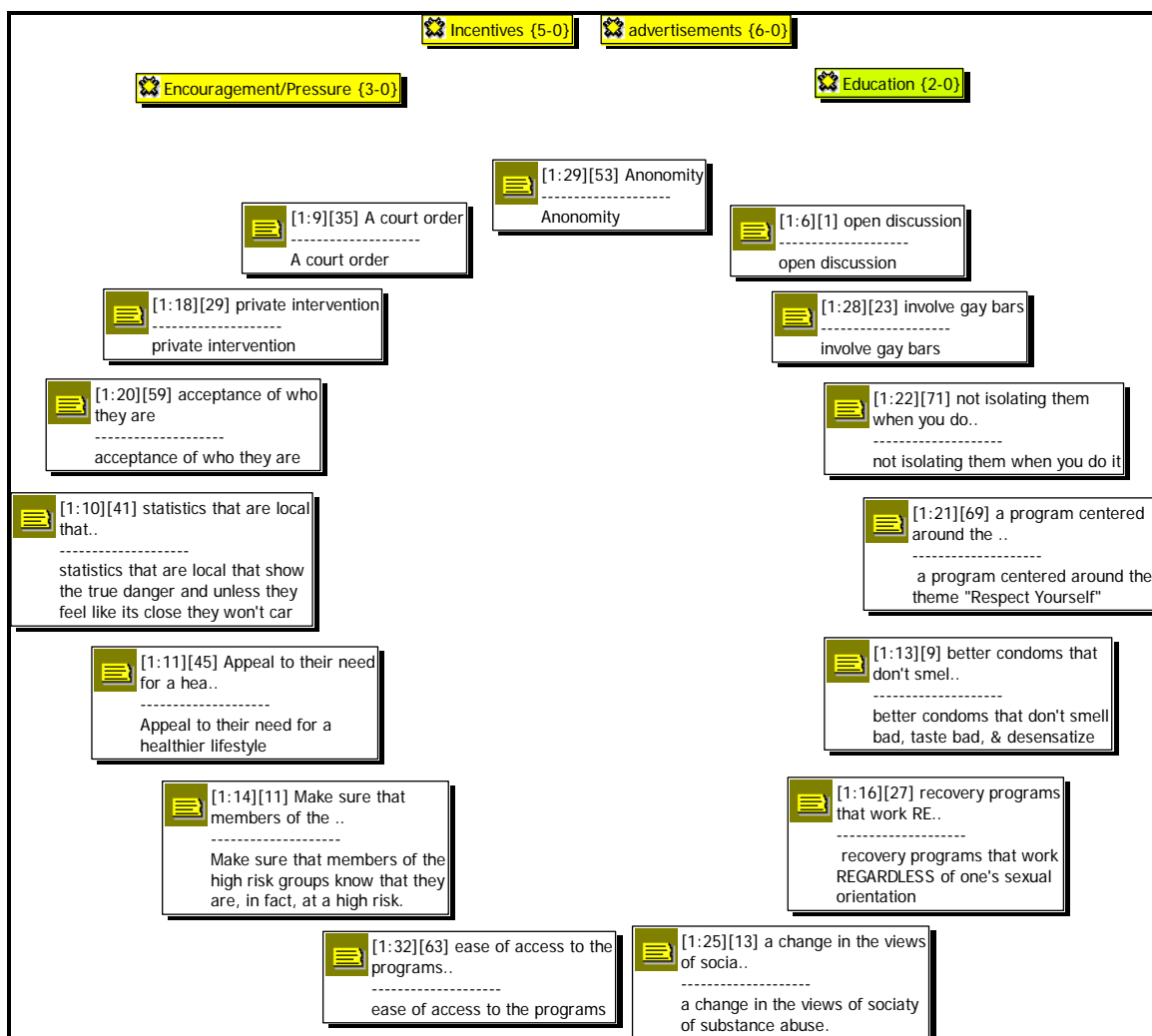
Societal acceptance was the most common answer to the question of what gay and bisexual men need to deal with issues such as feeling down, low, or depressed; low self-esteem; shame; loneliness; and feelings of isolation. This societal acceptance encompassed self acceptance and acceptance by politicians, religions, the media, family, and other MSM. Fourteen men indicated that mental health services were needed, specifically low cost affordable medications, counseling/therapy, peer counseling, support groups, and open and affirming counselors who understand the issues of MSM. Four respondents specified better social venues outside of bars and bathhouses. Two respondents suggested resorting to sexual promiscuity, drug, and alcohol use to deal with

these issues. Other needs specified were long-term partners, legal repercussions, knowledge that it's ok and not unmanly to seek mental health services, education, freedom from stereotypes of physical beauty associated with gay males, and attendance to feelings resulting from interactions with married or "DL" MSM.

28. A number of studies have shown that issues such as feeling down, low, or depressed; low self-esteem; shame; loneliness; and feelings of isolation commonly affect gay and bisexual men to varying degrees. What do gay and bisexual men need to help them deal with these issues?
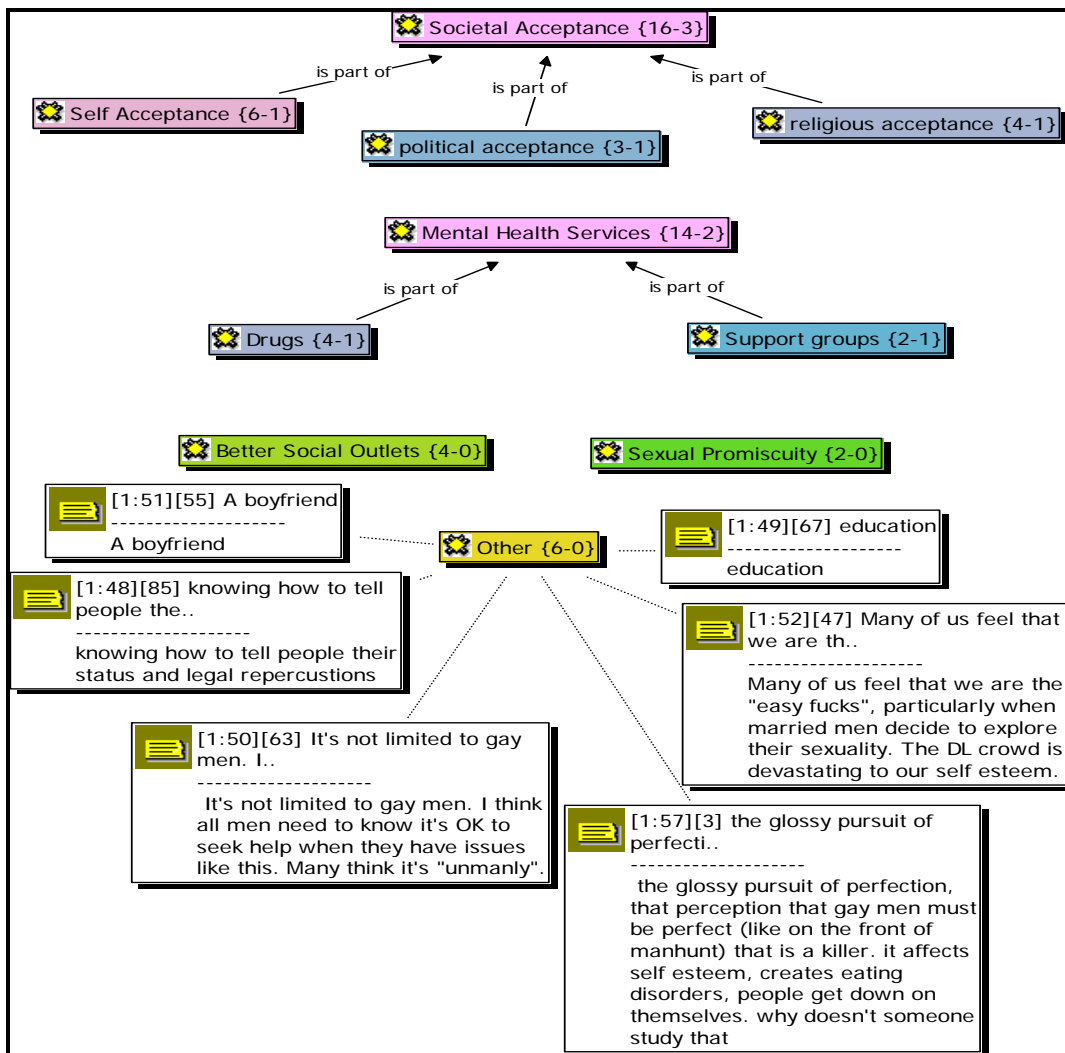
When asked what interventions or approaches would be appropriate and effective to help gay and bi-sexual men deal with issues such as feeling down, low, or depressed; having low self-esteem, shame, or loneliness; and feelings of isolation approximately half of the respondents checked interventions that address stigma and homophobia within the community at large (gay and straight)(55%), targeted public information campaigns (53%), and multiple services at one agency (49%). Slightly less than half of respondents selected interventions that involve the larger community of gay and bisexual men (45%) and support or discussion groups with peers (41%). Thirty-three percent checked one-on-one sessions with a professional counselor who can deal with both HIV risk and emotional issues, and 31% checked one-on-one sessions with a trained peer or mentor.

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

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

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

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

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

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

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

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

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

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

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

31. What would it take to get men who are most at risk to participate in programs that address these issues and HIV risk?
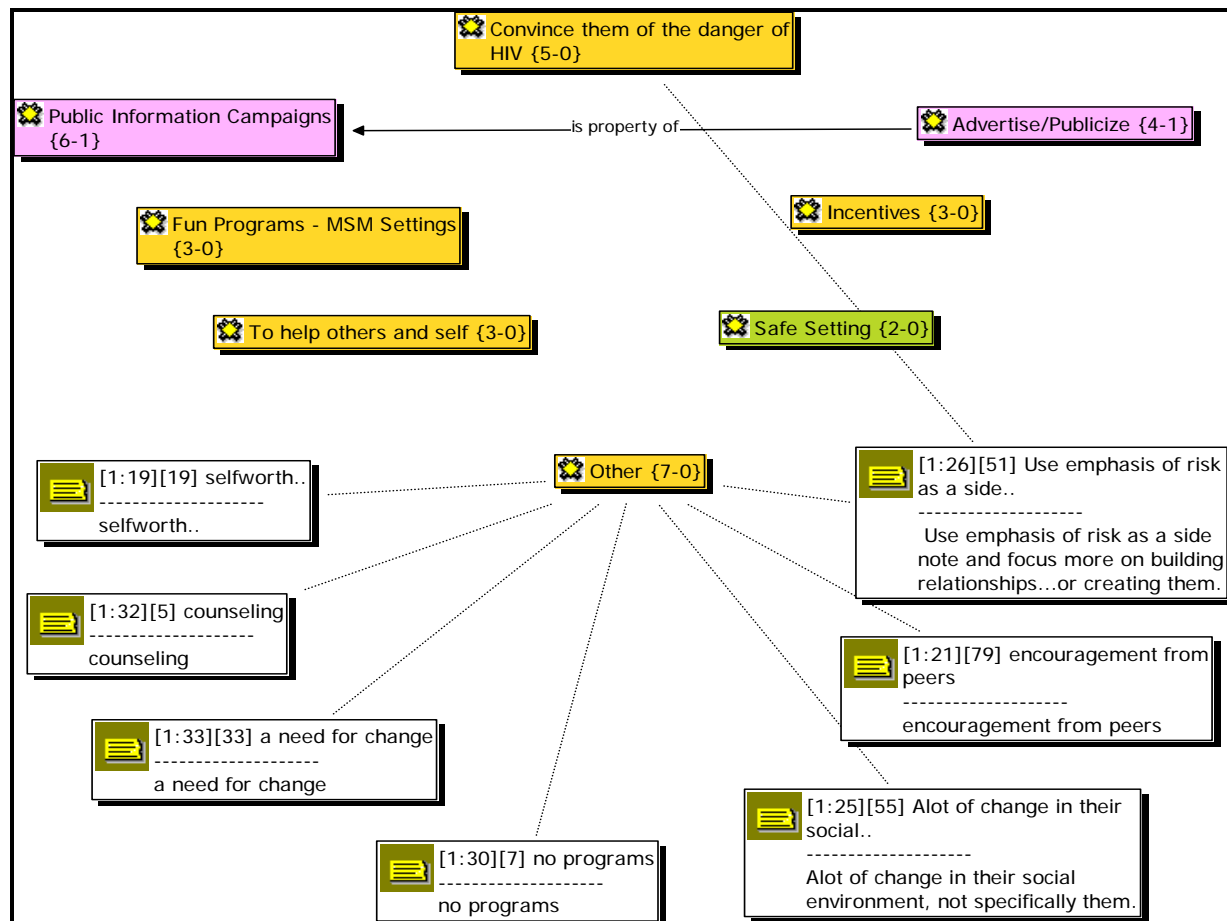
When asked what topics would be most relevant for gay and bisexual men to discuss if community forums were to be organized, the topics centered around community acceptance and HIV with associated risk behaviors. The following quote exemplifies some of the comments about acceptance. "How badly it feels to hear every day in the media about what a horrible person you are because you're gay. I don't think the straight community realizes how those words and actions affect gay people." Topics related to acceptance included self-acceptance/respect/esteem and related emotional needs, politics, religion, prejudice, coming out, and relationships and family. Topics related to HIV included drug use-methamphetamines in particular, sex, safe sex, STDs, and health. The suggested topics and the relationships between them suggest a hypothetical model linking

societal acceptance to HIV risk and ultimately HIV. This model is depicted in the
diagrams below. Further studies are needed which quantitatively explore this possible
relationship.

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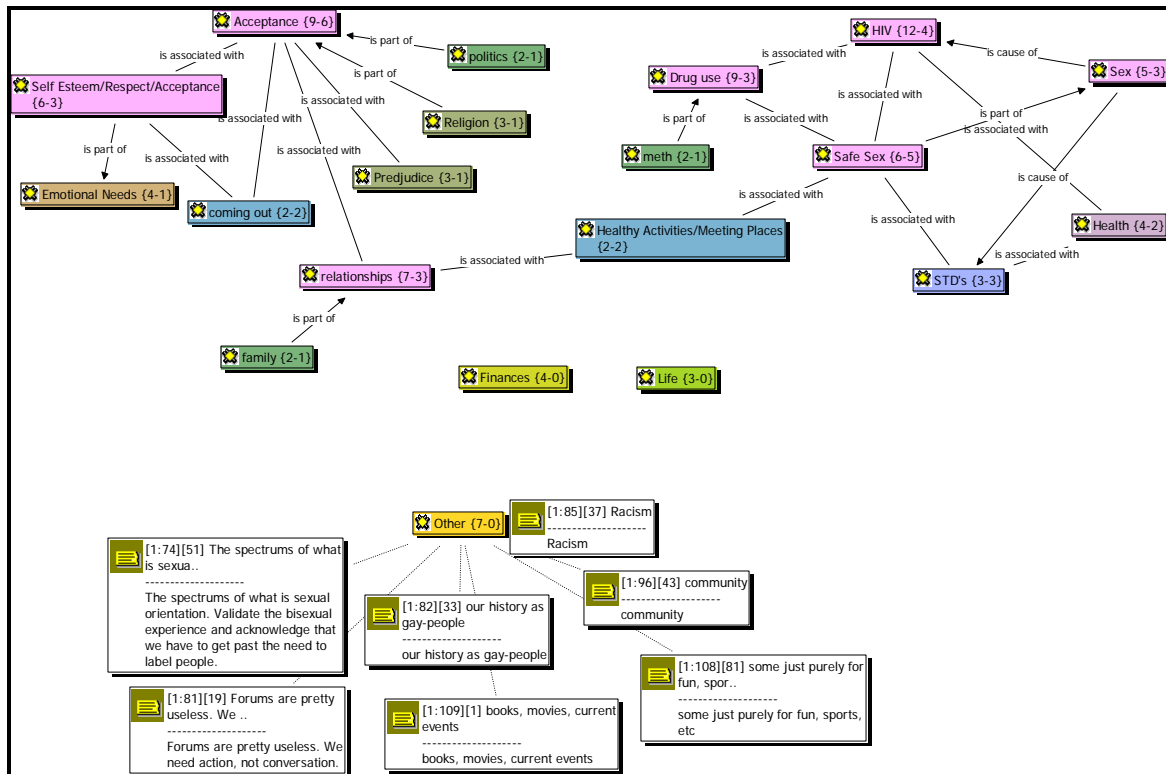
APPENDIX TWO: NEEDS ASSESSMENT DATA SUMMARY

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

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

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

HARS

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

MSM (n = 1178)

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

IDU (n = 134)

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

Other Identified Risks (n = 227)

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

NIR (n = 280)

- 15.4% of all people diagnosed with HIV from 2001-2005 (October) had no identified risk; 49.3% were White, 30.4% were Latino, and 20.4% were African American.
- 69.9% of those with no identified risk were men and 30.1% were women.
- Of all male NIRs, 50.0% were White, 34.0% were Latino, and 16.0% were African American.
- Of all female NIRs, 47.7% were White, 30.2% were African American, and 22.1% were Latina.

Women (n = 262)

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

Heterosexual Men (n = 379)

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

SHAS

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

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

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

NEEDS ASSESSMENT SURVEY (2003-2004)

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

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

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

- 27% of respondents living with HIV, 24% of MSM, 11% of IDU, and 17% of heterosexuals had an STD in the previous 5 years
- Of the respondents living with HIV, 18% met partners on the internet, 37% in bars, 31% in bathhouses, 19% in parks, and 22% on the street; 35% of MSM respondents met partners on the internet, 55% in bars, 38% in bathhouses, 17% in parks, and 23% on the street
- 34% of respondents living with HIV, 42% of MSM, 41% of IDU, and 40% of heterosexuals had 5 or more drinks in one sitting in the past month; 14% of all respondents had done this more than twice a week; among MSM, White (41%) and Latino (49%) men had higher rates of drinking than the African American MSM in the sample (26%)
- 11% of respondents living with HIV, 9% of MSM, 44% of IDU, and 14% of heterosexuals had used methamphetamines in the previous 12 months; among MSM Latinos had the highest rates of reported methamphetamine use (16%), though the rate of regular use (once a week or more) was small (3%) for all MSM
- 16% of people living with HIV, 11% of MSM, 45% of IDU, and 19% of heterosexuals had used powder cocaine; among MSM, Latinos had the highest use rate (22%) in the past 12 months (versus 5% for Whites and 9% for African Americans)
- 39% of IDU and 19% of heterosexuals had used crack in the previous 12 months
- 31% of people living with HIV, 19% of MSM, and 31% of IDU thought that it was somewhat likely or very likely that they would get HIV or give it to someone else; among MSM, Latinos had the highest rate (29%) versus 16% of Whites and 13% of African Americans.
- The most common reasons given for risks among the entire sample were: getting caught up in the heat of the moment (41%), getting drunk or high (31%), don't like condoms (28%), wanting to feel close to someone (24%), and wanting to demonstrate love and trust (22%); 14% of the sample felt pressure or forced to have sex without condoms
- Among MSM, 22% of African Americans and 16% of Latinos had never tested for HIV compared to 4% of White MSM.

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

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

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

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

Education

- Need better safer sex education, testing; be informed about HIV and STDs
- Kids need to learn at a younger age; need comprehensive sex education in schools
- Need live presentations from people they can relate to
- There isn't HIV education like before;
- Education starts at home
- Need to make people realize that HIV is serious; need more education; make HIV more serious
- High school is a good place to start with HIV education
- Should start with parents and in schools to address substance use
- Need more education to make anonymous sex safer
- Expectations that kids will remain abstinent is unrealistic and pushing it is ineffective; a lot of critical information lost; need to get information so they are prepared and take fewer risks
- Kids in high school and college need to get the message about HIV
- Some people need more information about condoms to make them easier to use or more comfortable
- Schools need to provide more sex education and normalize homosexuality; need to encourage kids to have safe sex
- Should provide education in schools; Teenagers don't go to baths or bars; get no information
- There's no education; AIDS Walk is only time it's talked about; need more education
- Need to do safe sex program in schools and recreation centers, etc.
- Little education for African American gay men; need more, especially for young men
- People need to understand the whole truth about HIV; people need to realize consequences
- Need to educate parents; have trouble talking to kids
- Knowledge can empower people; help to negotiate safe sex; encourage friends not to get drunk and have unsafe sex
- Need to educate people early and educate about the realities of the disease
- Public needs to know more about HIV; consistent
- Need more education and statistics showing people it's in the area; would encourage   people to be more protective
- Scare tactics, especially for teenagers
- Inform people about STDs
- Many people don't understand how HIV works; more embarrassing for gay men to admit not understanding about HIV; need to be more aware about HIV; need more knowledge
- Need to educate negatives and positives; need to know what you have and what to do

- Need to educate people about HIV and make them more sensitive to those who are positive
- Have positive people do public speaking
- People should take responsibility to educate others
- Need to tell people about problems associated with being positive
- Make sure people know the consequences of HIV; how it changes your life
- Health insurance is a huge issue; financial issues also huge; not just medical complications
- When positive, life revolves around refrigeration, medications, bathrooms, etc.
- People don't have current information about HIV
- Need to keep education in front of people
- Men think they know about HIV but they don't
- Need to empower people through education
- Help people know what's out there (services) and how to access it
- Give people knowledge to make healthy decisions

Outreach

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

- Rubber Raiders used to go to bars and pass out condoms and information every night; should do something similar in baths
- Bring back condom crusaders; do outreach with condoms and syringes
- Do outreach with hustlers
- Hand out dental dams
- Need more condoms everywhere; in high risk areas
- Organize a group and get those who show up to do outreach to bring more in
- People get involved in programs through word of mouth; need more outreach

Individual Level Interventions

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

Group Level Interventions

- Need support groups and social groups; need support groups for gay and homeless
- In groups, people can breach confidentiality
- There are a couple of social groups to deal with life-defining issues; need more
- Need group therapy to talk out problems and get feelings out
- Support groups can help
- Meth group helpful, but hard to be new in group
- Men and women in same group doesn't work well; all gay group better
- Should address healthy relationships in support groups
- Support groups work for some; often too negative (venting) and not about getting better
- Workshops only about prevention; not about bigger picture; not about relationships/dating
- Groups can help with disclosure; use role plays
- Recovery groups help; meetings help; need more recovery groups; need groups for gay men; need common bond/community
- Groups can help; people must be willing to go
- A lot of talk about drugs in groups can lead to relapse
- Those with poorer English skills often not comfortable in groups
- People need support systems; need to find the right one; have support groups for those who don't have family support; there needs to be more groups and more support
- Should be support groups for men who are negative
- Helps to talk to others about ideas and issues
- Groups for mostly gays don't work well for bisexuals
- Groups should focus more on life management, stress, financial issues, emotional issues about HIV, disclosure issues, medications.
- Open discussion groups can offer men support if safe environment; need to not have men hitting on each other
- A sexually neutral environment would seem safer for bisexuals and more supportive
- Need more groups where men can just talk; support
- Need more time for discussion in groups; could discuss nutrition, reinfection, relapse, disclosure, fundamentals of HIV, etc.
- Can learn from others in groups
- Need support groups for African Americans
- Should have group for African American men who are positive
- Should deal with substance abuse in support groups
- HIV and STD education should be part of rehab and recovery groups
- Get groups together so men can meet other men that feel good about themselves
- There are some social groups out there based around activities/interests
- Groups that are just about complaining get old; need to be more positive

- Support groups can help people be safer
- Need men's group that addresses relationships, etc.; drug free

Social Network Solutions

- Need more peer advocacy; peer support and help
- Need someone to say worth more, deserve better; boost confidence
- Need someone to listen to them and give advice
- People should help each other within social networks; need social network solutions
- Group members can also look out for each other
- Most effective way to help is through social support/interventions from friends
- People need to know someone cares
- Families should intervene and get people in treatment
- People need support when positive; need support around disclosure and other things
- Need to be ready to stop using and need support from friends and encouragement
- Friends/partners can encourage others to be tested
- Some will listen to the people who care about them
- People find support among friends
- People need support to feel comfortable about being gay when they're younger
- Need education for parents to support gay youth; support from parents is key
- Need alternative support system, especially when don't get support from family
- Friends should help each other to stay safe

Community Level Interventions

- Gay community should promote safer sex
- Gay men need a safe space; need alternative to bars; need alternative activities
- Up to older men to share history; young men could learn from older men; older men want to share knowledge; young want to learn; young coming out need guidance
- Substance abuse should be dealt with as a reality and not pushed aside
- Need social events and social dimensions to interventions; need prevention that's fun; social gatherings
- HIV still a problem as are other STDs; should be addressed in open, accepting way
- No good places to meet men for healthy relationships; hard to meet others; men mostly meet in bars; not good place to meet; can't judge others accurately; many meet at park
- Need places to go outside of high risk areas
- Before there was more community and mutual support, education, etc.

- Need drop-in centers; having a place to go with people to help and give referrals is motivating
- Adults should educate young
- Need to get word out; hold groups to address substance use
- Gay community should plan and conduct HIV prevention; gay men aren't involved and not calling the shots
- There needs to be more honest discussions of sex; society in denial
- Need to address stigma and talk more about HIV and homosexuality
- Rights and responsibilities of HIV-infected men should be written by positives and talk about community responsibilities
- Make being safe trendy
- Should identify gate keepers or groups to get message out; outreach workers
- Need "buddy program" within the community; social network solutions; mutual support
- Need to normalize getting tested; make testing routine; need to encourage people to get tested and know their status
- Need to change expectations to being safe
- Need positive role models/mentors; some men want to be role models
- Should have gay/straight alliance in every school
- Interventions by us, for us are the best; need to empower communities to get own solutions
- Need to educate the gay community more; increase public information; people need to be more aware about HIV
- Gay community needs to do outreach to gays and discourage risk behavior; discourage anonymous sex; discourage behaviors that make gay men look bad to society
- Need community leaders to participate in prevention and planning
- Encourage men to talk to partners about HIV and substance use
- Should promote civil unions to improve legal rights
- Should put efforts into the prevention of meth use
- Need community center; social outlets
- Need education that fights stigma
- Need the community to be more accepting of prevention activities
- Need to stigmatize bareback culture; contributes to demise of the community
- Need to reduce stigma in society
- Need more social outlets for rural gay men and ones that are safe; need activities to do together
- Need to advertise non-bar activities
- Older men need to remind younger men of the realities of HIV
- Need for positives to get the word out more
- Hold community forums
- Gay men need to share information with each other, younger and older
- Get people to vote against anti-gay initiatives

- There aren't good role models or definitions for good relationships
- Need ways to connect older men and younger men as mentors
- Meth needs to be stigmatized
- Still having the same conversations about HIV as in 80's; right information still not getting to people and people still getting infected.
- Should hold meetings to help men be safer
- Need to help men to connect to others; retreats, etc.
- Men need social support; safe place to talk about issues
- Need drop-in center for men in Pueblo
- Older men used to teach the younger ones; doesn't happen any more and younger men don't know what's going on; need mentoring
- Need to empower community; encourage people to talk to each other
- Need to promote a life giving lifestyle
- Must empower people to get involved
- Encourage individual responsibility
- Get information out to the community

Other Intervention Ideas

- People want to use their experiences to help others; people want to listen to those who have had similar experiences; people need help from those who have had similar experiences
- Need more paying jobs through which people can make a difference and a living
- Need an apartment complex that has services available on site
- Need providers who can deal with multiple problems
- Need services that help people get on their feet (e.g., job services)
- Helps people to talk to others who have been there and helps those people too; People who have been through stuff need to be talking to people
- Some in recovery could relapse if trying to help others
- Volunteers/staff often have very different lives than those they try to help; hard to relate; need effective people doing programs; people who have been there
- People who are positive want to give back and help others; need opportunities
- Mental health counselors can help with substances and HIV
- Need to build on people's assets to help
- Some doctors don't talk to positives about prevention; need to
- Doctors need to talk to patients more and listen to their issues; be more supportive
- Takes a long time to get services; need system that is tied together across agencies; information shared; consolidation takes a huge burden off the person; don't have to go here and there for help; some don't go because accessing services is too difficult; expensive
- Need more of a one-stop shopping place to get services rather than multiple places

- Need to have positive people out talking to young people about prevention; people who are positive should be doing prevention; need positive speakers bureau at colleges, high schools;
- Helping others is an education in itself
- Physicians need more education on HIV and how to deal with people testing positive
- No prevention efforts outside of Denver, except Boulder
- Need gay specific substance abuse treatment and treatment for African American gay men
- Need to approach prevention in multiple ways
- Need more motivational speakers that are peers
- Focus on empowerment
- Having people willing to tell stories about drug use can have an impact
- The best help to an addict is another addict; can talk to common language; offer solutions
- In accessing services feel bounced around from place to place

Chapter Five

The Gap Analysis

> **What is a Gap Analysis?**
> It is a description of the unmet HIV prevention needs, or service gaps, for the high-risk populations defined in the epidemiologic profile (Chapter One). The unmet needs are identified by a comparison of the needs assessment (Chapter Four) and resource inventory (Chapter Three). In other words, the gap analysis shows the difference between what you have and what you need. The gap analysis does not quantify service gaps in terms of the number of people from a specific target population who are in need of HIV prevention services. Rather, it identifies unmet service needs for specific populations and indicates the relative size of the service gap for different populations.
>
> **What is its Significance to Community Planning?**
> This information is then reviewed and analyzed in order to determine met and unmet service needs among specific target populations as well as for the overall project area. The resulting information and analysis may then be used to establish priorities regarding service needs and to develop strategies for addressing them. The gap analysis can also help community planning groups identify which populations are being failed by the current HIV prevention system and which should be receiving services or what those services should look like in order to improve HIV prevention for specific target populations.

Note: A gap analysis was not done in the spring of 2006. However, a gap analysis, using new methodology, is planned for late 2006/early 2007. Upon completion of the analysis, this chapter will be updated. Therefore, the information below is from the *2004-2006 Comprehensive Plan for HIV Prevention.*

Definitions

Met/Unmet need: "A need within a specific target population for HIV prevention services that is currently being addressed through existing HIV prevention resources. These resources are available to, appropriate for, and accessible to that population (as determined through the community services assessment of prevention needs). For example, a project area with an organization for African American gay, bisexual, lesbian, and transgender individuals may meet the HIV/AIDS education needs of African American men who have sex with men through its outreach, public information, and group counseling efforts.

An unmet need is a requirement for HIV prevention services within a specific target population that is not currently being addressed through existing HIV prevention services and activities, either because no services are available or because available services are either inappropriate for or inaccessible to the target population. For example, a project area lacking Spanish-language

HIV counseling and testing services will not meet the needs of Latinos with limited-English proficiency."[1]

Introduction

In June of 2003 the Needs Assessment/ Prioritization Committee (NA/P) determined that in order to conduct a gap analysis that would be of most use to Coloradans Working Together: Preventing HIV/AIDS (CWT), that it would need to wait until 2004 to take on this task because so much time and effort had been expended in 2003 to develop the 2003 needs assessment and prioritizing the CWT target populations and interventions. Therefore the information contained in this chapter contains information on the unmet needs of target populations as identify by CWT in the previous *2001 – 2003 Comprehensive Plan for HIV Prevention*. It was determined by the Core Planning Group (CPG) that this information still holds true until a more comprehensive gap analysis can be conducted in 2004. Postponing this effort will also allow the CPG to develop effective long terms goals to address the gaps in services for Colorado, via the Urban and Rural Planning Committees, and additional assistance from the NA/P and Steering Committees.

The following steps will be conducted in 2004 to develop the next CWT gap analysis:
1. List and review each target population identified through the epidemiologic profile.
2. Estimate total need for that target population.
3. Indicate major differences between need and demand for services for the target population.
4. Identify barriers to HIV prevention services for the target population.
5. Assess the suitability of available services for the target population.
6. Estimate met need for that target population.
7. Identify the portion of met need that CDC HIV prevention dollars are responsible for meeting.
8. Estimate unmet need for the target population.

Unmet HIV Prevention Needs of Men Who Have Sex With Men

1. Unmet Needs for Rural Men Who Have Sex With Men

Based on our analysis of need, demand, priority, barriers, suitability, and availability of HIV interventions in rural areas, the following unmet needs appear to be most pressing for men who have sex with men:

a. Geographic availability of HIV prevention interventions is a major issue. Currently, availability is concentrated in a few areas – sometimes related to epidemiology, sometimes not – leaving very large areas of the state with little or no onsite interventions.

b. Counseling, testing, and referral is very poorly marketed in rural Colorado. The sites are marginally accessible, at best. The capacity for alternative forms of testing – outreach testing, integrated with other interventions – is also very low, but these alternative forms are more promising to reach rural MSM who are infected but are unaware of their serostatus.

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[1] *2003 – 2008 HIV Prevention Community Planning Guidance*, Appendix D, Glossary of HIV Prevention Terms. Centers for Disease Control and Prevention.

c. For rural MSM of all races and ethnicities, there is a need for financially stable organizations that are competent to serve, and willing to openly advocate for MSM.

d. Structural and community interventions are urgently needed to confront hopelessness and promote healthy expectations of the future among rural MSM. These interventions should take a holistic, integrated approach to MSM health, including other STDs, community building, substance use, and mental health issues (with special emphasis on depression and the dynamics of relationships).

e. Much of the research concerning social networks among MSM has been conducted among urban men who identify as gay. Rural MSM social networks are very different, especially among those who do not gay-identify; for instance, they tend to be more linear (i.e., person A knows B, B knows C, but A does not know C directly). For providers to use these social networks to deliver interventions, more research and capacity building will be essential.

f. Substance abuse treatment is not widely available in rural Colorado, particularly inpatient treatment. Gay-friendly treatment that takes a harm reduction approach is rarer, and competent services for MSM/intravenous drug users (IDU) are almost certainly unavailable. Given its rural popularity, treatment for methamphetamine is urgently needed.

g. Providers of HIV-related care in rural areas need state-of-the-art prevention skills and materials tailored to the needs of MSM.

h. Rural organizations who have earned their credibility among rural Latinos and Native Americans need capacity building and advocacy to fulfill their essential role in addressing sensitive sexual and drug issues among rural MSM of color.

i. To meet the needs of young rural MSM, providers will require extensive new expertise to enable them to effectively use youth networks and overcome deep-rooted shame.

j. More HIV prevention interventions are needed for rural MSM with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by rural agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by rural HIV prevention providers who are competent to serve MSM with disabilities. Rural MSM with disabilities are also extremely difficult to locate in some cases.

k. Perceived and actual breeches of confidentiality discourage rural residents from seeking out HIV prevention interventions. Providers of HIV care and prevention must be assisted in addressing this serious barrier.

l. Providers of HIV prevention for MSM should never assume that their male clients are not also having sex with women. Both these men and their female partners need effective HIV prevention interventions.

2. Unmet Needs for Urban Men Who Have Sex With Men

Based on our analysis of need, demand, priority, barriers, suitability, and availability of HIV interventions in urban areas, the following unmet needs appear to be most pressing for men who have sex with men:

a. Overall, the urban HIV prevention system for MSM appears to be weakest in providing counseling testing and referral (CTR), individual level intervention (ILI), and public information (PLI). Funding from alternative sources and strategic capacity building will be needed to fully correct these weaknesses.

b. Structural and community interventions are urgently needed to confront

hopelessness and promote healthy expectations of the future among urban MSM. These interventions should take a holistic, integrated approach to MSM health, including other STDs, community building, substance use, and mental health issues (with special emphasis on depression and the dynamics of relationships).

c. A harm reduction approach should be more completely integrated into all interventions for urban MSM.

d. There is an urgent need for gay-specific substance abuse prevention and treatment tailored for MSM and taking a harm reduction approach.

e. For MSM who are in the early stages of the coming-out process, HIV prevention providers should better utilize the gay community to reach out to those who are not yet gay-identifying.

f. Providers of HIV-related care need state-of-the-art prevention skills and materials tailored to the needs of MSM.

g. There is a need for financially stable organizations run by and for African Americans and Latinos who will openly and effectively advocate for the needs of their community members who are MSM.

h. Agencies who serve injectors must build their competency in dealing with the unique issues of MSM/IDU.

i. HIV prevention programs for young MSM must build their competency to deal with the unique needs of this generation (especially the fluidity of their definition of sexual orientation and their need for open discussions that dissipate shame).

j. Transgender persons are systematically excluded from many gay venues and face many barriers when seeking assistance from programs that are segregated by sex. Such programs must be re-thought for these clients, and must directly confront the serious mental health and isolation issues that transgender persons face on a daily basis.

k. More HIV prevention interventions are needed for urban MSM with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by urban agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by urban HIV prevention providers who are competent to serve MSM with disabilities.

l. Providers of HIV prevention for MSM should never assume that their male clients are not also having sex with women. Both these men and their female partners need effective HIV prevention interventions.

m. Perceived and actual breeches of confidentiality discourage urban residents (especially non-gay identifying MSM) from seeking out HIV prevention interventions. Providers of HIV care and prevention must be assisted in addressing this serious barrier.

Unmet HIV Prevention Needs of People at Risk through Sex with Partners of the Opposite Sex

1. Unmet Needs for Rural People at risk through Sex with Partners of the Opposite Sex

Based on our analysis of need, demand, priority, barriers, suitability, and availability of HIV interventions in rural areas, the following unmet needs appear to be most pressing for people at risk through sex with partners of the opposite sex (POS):

a. Geographic availability of HIV prevention interventions is a major issue. Currently, availability is concentrated in a few areas – sometimes related to epidemiology, sometimes not

– leaving very large areas of the state with little or no onsite interventions. Overall, the rural HIV prevention system for POS appears to be weakest in providing ILI and PLI, with additional weaknesses in terms of group level intervention (GLI) and CTR. Funding from alternative sources and strategic capacity building will be needed to fully correct these weaknesses.

b. Counseling, testing, and referral is very poorly marketed in rural Colorado. The sites are marginally accessible, at best. The capacity for alternative forms of testing – outreach testing, integrated with other interventions – is also very low, but these alternative forms are more promising to reach rural POS who are infected but are unaware of their serostatus.

c. Female partners of MSM and IDU need to be served both directly and indirectly. As a direct service, more providers should design and implement services uniquely tailored to the needs of these women. Second, as an indirect service, all HIV prevention providers with MSM and/or male IDU clients should address the manner in which these male clients are placing their female partners at risk.

d. Women at risk of, or living with, HIV often have multiple needs, and their HIV prevention providers should be prepared to provide or link clients to a comprehensive range of services (such as housing, health care, child care, and women-friendly substance abuse treatment).

e. In light of the vulnerability of survivors of domestic and sexual abuse, programs that have systematic intake procedures should assess current and past abuse, and better linkages should be made to domestic violence programs and programs that address sexual abuse.

f. Providers of HIV-related care in rural areas need state-of-the-art prevention skills and materials tailored to the needs of POS.

g. More HIV prevention programs should be designed to effectively deal with the risky behavior of men who have sex with women. More research and better service models are needed, especially in regard to rural men.

h. Programs should be sensitive to men who identify as heterosexual, or who prefer to describe themselves as heterosexual due to the stigma generated by homophobia. Some MSM will only access programs that are either "orientation neutral" or that are at least ostensibly for heterosexual men.

i. Transgender persons are systematically excluded from many venues and face many barriers when seeking assistance from programs that are segregated by sex. Such programs must be re-thought for these clients, and must directly confront the serious mental health and isolation issues that transgender persons face on a daily basis.

j. More HIV prevention interventions are needed for rural people with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by rural agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by rural HIV prevention providers who are competent to serve POS with disabilities.

k. Perceived and actual breeches of confidentiality discourage rural residents from seeking out HIV prevention interventions. Providers of HIV care and prevention must be assisted in addressing this serious barrier.

l. To address the issues of rural women at high risk and their male sexual partners, agencies that deliver services related to domestic violence and substance use are underutilized as potential settings and providers of HIV prevention.

m. Structural and community interventions are needed to address the erroneous belief that HIV is exclusively a gay

disease and the barriers imposed by the often harsh rural political environment.

2. Unmet Needs for Urban People at risk through Sex with Partners of the Opposite Sex

Based on our analysis of need, demand, priority, barriers, suitability, and availability of HIV interventions in urban areas, the following unmet needs appear to be most pressing for people at risk through sex with partners of the opposite sex (POS):

a. Overall, the urban HIV prevention system for POS appears to be weakest in providing ILI and PLI, with additional weaknesses regarding CTR. Funding from alternative sources and strategic capacity building will be needed to fully correct these weaknesses.

b. Female partners of MSM and IDU need to be served both directly and indirectly. As a direct service, more providers should design and implement services uniquely tailored to the needs of these women. Second, as an indirect service, all HIV prevention providers with MSM and/or male IDU clients should address the manner in which these male clients are placing their female partners at risk.

c. Women at risk or, of living with, HIV often have multiple needs, and their HIV prevention providers should be prepared to provide or seamlessly refer to a comprehensive range of services (such as housing, health care, child care, and women-friendly substance abuse treatment).

d. More HIV prevention programs should be designed to effectively deal with the risky behavior of men who have sex with women. More research and better service models are needed.

e. Programs should be sensitive to men who identify as heterosexual, or who prefer to describe themselves as heterosexual due to the stigma generated by homophobia. Some MSM will only access programs that are either "orientation neutral" or that are at least ostensibly for heterosexual men.

f. In light of the vulnerability of survivors of domestic and sexual abuse, programs that have systematic intake procedures should assess current and past abuse, and better linkages should be made to domestic violence programs and programs that address sexual abuse.

g. Structural and community interventions are urgently needed to address the stigma faced by commercial sex workers, who are too often seen only as vectors of disease, although they are more often the victim than the victimizer.

h. Transgender persons are systematically excluded from many venues and face many barriers when seeking assistance from programs that are segregated by sex. Such programs must be re-thought for these clients, and must directly confront the serious mental health and isolation issues that transgender persons face daily.

i. More HIV prevention interventions are needed for urban people with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by urban agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by urban HIV prevention providers who are competent to serve POS with disabilities.

Unmet HIV Prevention Needs for Injectors

1. Unmet Needs for Rural Injectors

Based on our analysis of case need, demand, priority, barriers, suitability, and availability of HIV interventions in rural areas, the following unmet needs appear to be most pressing for injectors:

a. Geographic availability of HIV prevention interventions is a major issue. Currently, availability is

concentrated in some areas – sometimes related to epidemiology, sometimes not – leaving very large areas of the state with little or no onsite interventions. Overall, the rural HIV prevention system for injectors appears to be weakest in providing PLI, with additional weaknesses in terms of GLI. Funding from alternative sources and strategic capacity building will be needed to fully correct these weaknesses.

b. Counseling, testing, and referral is very poorly marketed in rural Colorado. The sites are marginally accessible, at best. The capacity for alternative forms of testing – outreach testing, integrated with other interventions – is also very low, but these alternative forms are more promising to reach rural injectors who are infected but are unaware of their serostatus.

c. Enacting and enforcing restrictive laws are not a sound, proven public health approach to preventing HIV among injectors. As voiced by the National Institutes of Health (NIH) consensus statement, underline needle exchange programs should be implemented at once.

d. Female partners of MSM and IDU need to be served both directly and indirectly. As a direct service, more providers should design and implement services uniquely tailored to the needs of these women. Second, as an indirect service, all HIV prevention providers with MSM and/or male IDU clients should address the manner in which these male clients are placing their female partners at risk.

e. Providers of HIV prevention interventions for injectors must effectively address sexual risks as well as injection-related risks. Programs should recognize that sexual activity varies over the duration of drug use and the drug of choice – for instance, some drugs increase the desire for sex for the first few months of use, but inhibit sex in the long run.

f. All programs that serve injectors – especially providers of HIV prevention and drug treatment – should take a harm reduction approach, honoring basic civil rights and human dignity. The harm reduction approach is particularly rare among rural providers. (See Chapter Two, part 6, Harm Reduction.)

g. Effective, confidential, humane substance abuse treatment on demand is urgently needed in rural Colorado. Given its rural popularity, treatment for methamphetamine is urgently needed.

h. Structural and community interventions are urgently needed to address the repressive stigma faced by rural drug users.

i. More HIV prevention interventions are needed for rural people with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by rural agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by rural HIV prevention providers who are competent to serve injectors with disabilities.

j. Female partners of MSM and IDU need to be served both directly and indirectly. As a direct service, more providers should design and implement services uniquely tailored to the needs of these women. Second, as an indirect service, all HIV prevention providers with MSM and/or male IDU clients should address the manner in which these male clients are placing their female partners at risk.

k. Transgender persons are systematically excluded from many venues and face many barriers when seeking assistance from programs that are segregated by sex. Such programs must be re-thought for these clients, and must directly confront the serious mental health and isolation issues that transgender persons face on a daily basis.

l. Much of the research concerning social networks among injectors has been

conducted among urban residents. Rural injector social networks are very different; for instance, they tend to be more linear (i.e., person A knows B, B knows C, but A does not know C directly). For providers to use these social networks to deliver interventions, more research and capacity building will be essential.

m. Providers of HIV-related care in rural areas need state-of-the-art prevention skills and materials tailored to the needs of injectors.

n. To address the issues of rural women at high risk and their male partners, agencies that deliver services related to domestic violence and substance use are underutilized as potential settings and providers of HIV prevention.

o. Rural organizations who have earned their credibility among rural Latinos and Native Americans need capacity building and advocacy to fulfill their essential role in addressing sensitive sexual and drug issues among rural injectors of color.

p. Providers of HIV, mental health, and substance abuse services need increased capacity to deal effectively with all three issues concurrently, in terms of both prevention and treatment/care.

2. Unmet Needs for Urban Injectors

Based on our analysis of need, demand, priority, barriers, suitability, and availability of HIV interventions in urban areas, the following unmet needs appear to be most pressing for injectors:

a. Enacting and enforcing restrictive laws are not a sound, proven public health approach to preventing HIV among injectors. As voiced by the NIH consensus statement, needle exchange programs should be implemented at once.

b. Providers of HIV prevention interventions for injectors must effectively address sexual risks as well as injection-related risks. Programs should recognize that sexual activity

varies over the duration of drug use and the drug of choice – some drugs increase the desire for sex for the first few months of use, but inhibit sex in the long run, for instance.

c. All programs that serve injectors – especially providers of HIV prevention and drug treatment – should take a harm reduction approach, honoring basic civil rights and human dignity.

d. Effective, confidential, humane substance abuse treatment on demand is urgently needed in urban Colorado.

e. Structural and community interventions are urgently needed to address the repressive stigma faced by urban drug users.

f. Female partners of MSM and IDU need to be served both directly and indirectly. As a direct service, more providers should design and implement services uniquely tailored to the needs of these women. Second, as an indirect service, all HIV prevention providers with MSM and/or male IDU clients should address the manner in which these male clients are placing their female partners at risk.

g. More HIV prevention interventions are needed for urban people with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by urban agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by urban HIV prevention providers who are competent to serve injectors with disabilities.

h. Transgender persons are systematically excluded from many venues and face many barriers when seeking assistance from programs that are segregated by sex. Such programs must be re-thought for these clients, and must directly confront the serious mental health and isolation issues that transgender persons face on a daily basis.

i. Providers of HIV, mental health, and substance abuse services need increased

capacity to deal effectively with all three issues concurrently, in terms of both prevention and treatment/care.

Chapter Six

Prioritizing Target Populations

What are Prioritized Target Populations?
Simply speaking, priorities are a list of the most impacted target populations and the interventions recommended for those populations. With information provided by the health department and other information sources, the planning group learns all it can about those populations and their prevention needs – while recognizing that complete and perfect information can never be truly obtained. Using this information, the group attempts to objectively decide and rank which populations are most at risk. The community planning group (CPG) develops and implements a process to rank the target populations using factors to distinguish the relative risk and the epidemiological impact of HIV for those populations.

What is their Significance to Community Planning?
Besides developing a Comprehensive HIV Prevention Plan, priority setting is the main task for CPGs. The prioritized list of target populations and interventions forms the basis for the Comprehensive Plan that the health department uses when developing its annual application to the Centers for Disease Control and Prevention (CDC) for HIV prevention funding. The priority setting process ultimately helps the CPG identify those populations most at risk of HIV infection in Colorado. By identifying and providing services to those target populations, Colorado can reduce the greatest number of new HIV infections. Priority setting can be complex and controversial for the planning group, but ultimately an important outcome of priority setting is that it helps the Colorado Department of Public Health and Environment (CDPHE) direct its limited funds to those populations most at risk for HIV. Priority setting is particularly challenging for planning group members because it asks the members to separate themselves from their roles as advocates for specific communities, set those allegiances aside, and make decision about the information as objectively as possible. While all populations deserve services, when funding is limited, hard decisions must be made in order to make sure those most at risk get the necessary attention to reduce the greatest number of new infections.

Definitions

Target Population: Groups or populations that are the focus of HIV prevention efforts because they have high rates of HIV infection and high levels of risky behavior. These groups are identified using a combination of behavioral risk factors and demographic characteristics.

Prioritized Population: Population for which prevention programs can make the biggest impact on the epidemic, (i.e., if HIV rates can be reduced in such a population, then it would have a major impact on the epidemic in the jurisdiction).

Introduction

Coloradans Working Together: Preventing HIV/AIDS (CWT) works on a three-year planning cycle to update its list of prioritized target populations, thereby having developed its last list in 2003. The prioritization process used in 2003 was developed with technical assistance from the Academy for Educational Development (AED) and proved to be very well received by the CPG and successful in helping the group through the prioritization process.

The majority of the work to prioritize target populations was performed in 2006, although planning began in 2005. A two-day Community Planning Development Retreat was held in October of 2005 with most CWT members in attendance to discuss the concepts, terms, processes, and activities related to prioritization. CWT members that had participated in the 2003 process also had the opportunity to share their knowledge and experience, as well as any recommendations for how to improve the process in 2006. The first part of the Development Retreat focused on prioritizing target populations, with the latter portion dedicated to prioritizing interventions.

The CPG identified what worked and what didn't work in the 2003 process, as well as discussed ideas on how to further improve the process for prioritizing target populations in 2006. This information helped set the groundwork for moving forward and was integral to a smooth process for prioritizing target populations. See the "Community Planning Development Retreat Final Report" Attachment.

During the retreat, the CPG agreed that using the CWT committees to complete steps of the process and then bringing the work back to the full CPG to complete the decision- making process worked well and wished to retain this process for 2006. Therefore, the Needs Assessment/Prioritization (NA/P), Urban, and Rural Committees were instrumental in developing the target populations that were brought to the CPG.

The NA/P Committee, first established in 2002 to help develop the guidelines of the prioritization process on behalf of the entire CPG, helped guide the overall prioritization process again in 2006. Using overall guidance from the NA/P Committee, the Urban and Rural Committees developed the target populations.

Following the recommendations from the Development Retreat, the CPG worked to identify "Guiding Principles" necessary for a successful process in 2006. These Guiding Principles are essentially ground rules used during prioritization as a way to help keep the group focused as they work through the prioritization tasks. Using the principles identified and used in 2003 as a starting point, the CPG revised them for the 2006 process. It was anticipated that the principles would require only small revisions, although this did not occur. After rich discussion at the February CPG meeting regarding this agenda item, several CWT committees reviewed and revised the principles, and several revisions occurred over a three-month period. The 2006 Guiding Principles were set by CWT at the June CPG meeting. The June 3, 2006, Core Planning Group (CPG) Meeting was dedicated to prioritizing target populations.

The 2006 Guiding Principles are:
- Remember the mission statement for CWT.

    (Our Mission: To improve the availability, accessibility, cultural appropriateness, and effectiveness of HIV prevention interventions through an open, candid, and participatory process where differences in background, perspective, and experience are valued and essential.)

- Keep the big picture in mind – the goal is to reduce HIV. Remember that populations impact one another, don't think of populations in isolation from one another (i.e., MSM – but also MSM who have sex with women).
- The work should be based on a combination of outcome measures and experience when possible.
- Conflict can be healthy, and should be constructive when it arises.
- Respect each other – Everyone is equal – No "name calling" – Be careful when using humor.

- Acknowledge when you were heard; allow opportunities for others to be heard.
- Acknowledge when you feel you have been ignored and/or disrespected.

Methodology/Implementation

STEP 1: IDENTIFY AND DEFINE TARGET (HIGH-RISK) POPULATIONS TO BE CONSIDERED BY THE CPG

The committees responsible for identifying the target populations felt that while the overall target populations will not be drastically different than those set in 2003, they wanted to broaden the population groups (using behavior as the descriptor) and add sub-groups defining demographic characteristics for the 2006 populations.

During the 2003 process, test criterion was developed to help more accurately describe target populations. This was useful due to the significant number of target populations and subsequent overlap of the populations CWT identified in the past. However, the committees did not feel this criterion was necessary this year and instead chose to use the 2003 target populations and move forward from those descriptions.

Through committee work, the Urban Committee chose to remove the descriptions of risk behavior (i.e. unprotected anal sex) and characteristics (i.e. history of substance abuse or early childhood sexual trauma), but discussed the possibility of including the importance of that information in the discussion of interventions for those target populations. In contrast, the Rural Committee chose to keep the descriptions of risk behavior and characteristics in the population descriptions.

A total of nine target populations were brought to the CPG in June of 2006, four urban populations, four rural populations, and one population brought forth by both groups. The populations proposed by both committees to the CPG were:

- HIV Positive Persons
- Men Who Have Sex with Men
- Injecting Drug Users
- Female High-Risk Heterosexuals
- Male High-Risk Heterosexuals

The CPG agreed, through consensus, to move forward with the proposed populations.

STEP 2: DETERMINE A LIST OF FACTORS TO BE USED TO SET PRIORITIES FOR TARGET POPULATIONS

In previous CPG discussions, members had agreed that factors are a useful way to help maintain an unbiased priority setting process. Factors are simply pieces of information that allow for the comparison of one at-risk population to another so that relative HIV impact can be determined.

Therefore, the Urban and Rural Committees each reviewed a list of possible factors to consider when prioritizing target populations. Initially, the Urban Committee proposed eight factors, while the Rural Committee proposed six. In addition to choosing factors, the committees also discussed the data sources for each factor. Based on the tentative list of factors chosen, the CPG coordinator gathered data for each of the committees based on the data sources identified.

The committees then reconvened and reviewed the data. After reviewing the data and discussing the potential impact of each factor relative to the other proposed factors, the Urban and Rural Committees each narrowed down the proposed list of factors to five. Both Committees proposed the same factors.

The final list of proposed factors, as well as the data sources, was presented to the CPG at the June 2006 meeting. The CPG agreed, through consensus, to move forward with the proposed factors. The factors are presented on the following page.

Final List of Factors for Prioritizing Target Populations

Factor	Definition	Discussion/Data Sources
HIV/AIDS Surveillance	*This group of factors shows the extent of the HIV/AIDS epidemic among the target population.*	
Factor #1: HIV Incidence (Diagnosed)	The number of HIV cases diagnosed in a defined population in a specified period, usually a year	Colorado Surveillance Data: HIV cases reported in 2002 and 2005.
Factor #2: HIV Prevalence (Diagnosed)	The number of people living with HIV in a defined population on a specified date	Colorado Surveillance Data: HIV cases reported through 2002 and through 2005.
Factor #3: AIDS Incidence (Diagnosed)	The number of AIDS cases diagnosed in a defined population in a specified period, usually a year	Colorado Surveillance Data: AIDS cases reported in 2002 and 2005.
Factor #4: AIDS Prevalence (diagnosed)	The number of people living with diagnosed AIDS in a defined population on a specified date	Colorado Surveillance Data: AIDS cases reported through 2002 and through 2005.
Socio-demographic Characteristics	*This factor examines complex issues that may affect the provision of HIV prevention interventions.*	
Factor #5: Barriers to reaching the population	The extent to which barriers to providing HIV prevention programs to the population have been identified	Information gleaned from the 2002-2003 Needs Assessment (for IDU and Heterosexual populations) and the 2006 Needs Assessment (for MSM population)

STEP 3: ASSIGN <u>WEIGHTS</u> TO FACTORS (RELATIVE LEVEL OF IMPORTANCE OF EACH FACTOR)

The committees responsible for identifying the target populations agreed that numeric weights were useful as a way to show the relative importance of each factor and wished to keep the weighting simple. Therefore, a scale of "1" (low importance) to "3" (high importance) was used (which was also the scale used in 2003). The committees proposed weights of "3" for HIV Incidence, HIV Prevalence, AIDS Incidence, AIDS Prevalence due to the high validity of the data and relevance for determining which populations are most at risk for HIV/AIDS in Colorado. The

committees proposed a weight of "1" for Barriers to Reaching the Population, due to the limitations and subjectivity of the needs assessment data.

The weights were proposed to the CPG at the June 2006 meeting. After some discussion, the CPG agreed to change the weight of the Barriers to Reaching the Population factor from a "1" to a "2" (medium importance), as several participants felt it deserved greater relative importance. The CPG agreed, through consensus, to move forward with the proposed weights.

Final List of Factors

Factor	Definition	Weight
HIV/AIDS Surveillance	**This group of factors shows the extent of the HIV/AIDS epidemic among the target population.**	
HIV Incidence (diagnosed)	The number of HIV cases diagnosed in a defined population in a specified period (2001-2002 and 2004-2005).	3 (High)
HIV Prevalence (diagnosed)	The number of people living with diagnosed HIV in a defined population, through December 31, 2005.	3 (High)
AIDS Incidence (diagnosed)	The number of AIDS cases diagnosed in a defined population in a specified period (2001-2002 and 2004-2005).	3 (High)
AIDS Prevalence (diagnosed)	The number of people living with AIDS in a defined population, through December 31, 2005.	3 (High)
Socio-demographic characteristics	**This group of factors examines complex issues that may affect the provision of HIV prevention interventions.**	
Barriers to reaching the population	The extent to which barriers to providing HIV prevention programs to the population have been identified – as supplied by the Needs Assessment Projects.	2 (Medium)

STEP 4: R̲A̲T̲E̲ TARGET POPULATIONS USING FACTORS

In advance of the June 2006 CPG meeting, the committees agreed that a similar ranking system would be used to rate the target populations (thereby comparing the target populations to one another in terms of risk for HIV/AIDS). A scale of 1-3 was used, "1" indicating low impact, "2" medium impact and "3" high impact.

Using each factor as a measure, including the data sources available for each factor, participants rated each of the nine target populations.

STEP 5: S̲C̲O̲R̲E̲ TARGET POPULATIONS USING FACTORS

Participants either worked individually or in groups to use the factors and supporting data, as well as the weighting system approved by the group, to complete a "Scoring Target Populations Worksheet" for each of the nine target populations. A simple equation was used to determine the scores for each factor (Rating x Weight= Score of Factor). Next, the sum of the scores for each factor determined the total score of the target population. This process was done for each of the nine populations.

The following is a copy of the scoring matrix that was used by the participants:

Target Population: _____

Factor	Weight	Rating	Score (Rating X Weight = Score)
Factor #1: HIV Incidence (Diagnosed)	3		
Factor #2: HIV Prevalence (Diagnosed)	3		
Factor #3: AIDS Incidence (Diagnosed)	3		
Factor #4: AIDS Prevalence (Diagnosed)	3		
Factor #5: Barriers to Reaching the population	2		
Total Score for population			

All of the completed worksheets were then submitted to the CWT coordinator in order to calculate the overall score for each of the target populations.

STEP 6: R̲A̲N̲K̲ TARGET POPULATIONS

The total score for each population was then presented to the CPG. The populations were rank-ordered (listed in order of priority), thereby placing the target populations in order of their overall scores, highest to lowest. Therefore, the target population with

the highest overall score would be ranked #1.

Note: Per *CDC's 2003-2008 HIV Prevention Community Planning Guidance,* HIV positive persons must be priority number one, due to this populations' potential to substantially reduce HIV incidence.

After reviewing the final results of the scoring system and subsequent ranking, the CPG felt comfortable that this would be the list of ranked target populations.

STEP 7: REVIEW RANKINGS TO SEE IF THERE IS AGREEMENT AMONGST THE CPG AND APPROVE A FINAL LIST OF TARGET POPULATIONS

The final list of ranked target populations was officially presented to the CPG at the June 3, 2006 meeting as a Decision Item. The Decision Item was submitted to a formal consensus check and approved by the full CPG. One participant had concerns about that the urban female high risk heterosexual population was ranked higher than the urban injecting drug users population, based on the epidemiology, however allowed the process to move forward.

Please see the following page for a final list of CWT prioritized target populations.

HIV Incidence Data Used in Prioritizing Populations

Category	HIV Incidence (1/02-12/02)		HIV Incidence (1/05-12/05)	
	Number	Percent	Number	Percent
Sex				
Male	228	82.9%	263	85.9%
Female	47	17.1%	43	14.1%
Race				
White	153	55.6%	183	59.8%
Black	41	14.9%	43	14.1%
Hispanic	71	25.8%	67	21.9%
Asian	2	0.7%	6	2.0%
Native American	6	2.2%	6	2.0%
Multiple Races	*	*	1	0.3%
Unknown	2	0.7%	0	0.0%
Age at Diagnosis				
0-4	1	0.4%	2	0.7%
5-12	0	0.0%	0	0.0%
13-19	10	3.6%	13	4.2%
20-24	33	12.0%	39	12.7%
25-29	56	20.4%	41	13.4%
30-39	100	36.4%	112	36.6%
40-49	55	20.0%	77	25.2%
Over 49	20	7.3%	22	7.2%
Exposure Category				
Male/Male Sex (MSM)	143	52.0%	166	54.2%
Injecting Drug Use (IDU)	19	6.9%	24	7.8%
MSM and IDU	18	6.5%	16	5.2%
Transfusion Recipient	0	0.0%	1	0.3%
Hemophilia	0	0.0%	0	0.0%
Heterosexual Contact	31	11.3%	27	8.8%
Risk Not Identified	63	22.9%	70	22.9%
Mother with Risk for HIV Infection	1	0.4%	2	0.7%
Region				
Urban	*	*	*	*
Rural	*	*	*	*

AIDS Incidence Data Used in Prioritizing Populations

Category	AIDS Incidence (1/02-12/02)		AIDS Incidence (1/05-12/05)	
	Number	Percent	Number	Percent
Sex				
Male	207	89.2%	264	86.0%
Female	25	10.8%	43	14.0%
Race				
White	123	53.0%	158	51.5%
Black	50	21.6%	54	17.6%
Hispanic	54	23.3%	79	25.7%
Asian	2	0.9%	6	2.0%
Native American	3	1.3%	4	1.3%
Multiple Races	*	*	6	2.0%
Unknown	0	0.0%	0	0.0%
Age at Diagnosis				
0-4	0	0.0%	0	0.0%
5-12	0	0.0%	0	0.0%
13-19	1	0.4%	2	0.7%
20-24	6	2.6%	9	2.9%
25-29	21	9.1%	36	11.7%
30-39	95	40.9%	111	36.2%
40-49	78	33.6%	107	34.9%
Over 49	31	13.4%	42	13.7%
Exposure Category				
Male/Male Sex (MSM)	131	56.5%	176	57.3%
Injecting Drug Use (IDU)	23	9.9%	30	9.8%
MSM and IDU	19	8.2%	28	9.1%
Transfusion Recipient	0	0.0%	0	0.0%
Hemophilia	0	0.0%	1	0.3%
Heterosexual Contact	20	8.6%	39	12.7%
Risk Not Identified	39	16.8%	33	10.7%
Mother with Risk for HIV Infection	0	0.0%	0	0.0%
Region				
Urban	*	*	*	*
Rural	*	*	*	*

HIV Prevalence Data Used in Prioritizing Populations

Category	HIV Prevalence (1/02-12/02)		HIV Prevalence (1/05-12/05)	
	Number	Percent	Number	Percent
Sex				
Male	*	*	5424	89.8%
Female	*	*	615	10.2%
Race				
White	*	*	4245	70.3%
Black	*	*	813	13.5%
Hispanic	*	*	884	14.6%
Asian	*	*	39	0.6%
Native American	*	*	49	0.8%
Multiple Races	*	*	9	0.1%
Unknown	*	*	0	0.0%
Age at Diagnosis				
0-4	*	*	22	0.4%
5-12	*	*	8	0.1%
13-19	*	*	141	2.3%
20-24	*	*	856	14.2%
25-29	*	*	1398	23.1%
30-39	*	*	2444	40.5%
40-49	*	*	899	14.9%
Over 49	*	*	270	4.5%
			1	0.0%
Exposure Category				
Male/Male Sex (MSM)	*	*	3834	63.5%
Injecting Drug Use (IDU)	*	*	522	8.6%
MSM and IDU	*	*	545	9.0%
Transfusion Recipient	*	*	25	0.4%
Hemophilia	*	*	10	0.2%
Heterosexual Contact	*	*	416	6.9%
Risk Not Identified	*	*	660	10.9%
Mother with Risk for HIV Infection	*	*	27	0.4%
Region				
Urban	5497	89.3%	5388	89.2%
Rural	629	10.2%	643	10.6%
Uknown	31	0.5%	8	0.1%

AIDS Prevalence Data Used in Prioritizing Populations

Category	AIDS Prevalence (1/02-12/02)		AIDS Prevalence (1/05-12/05)	
	Number	Percent	Number	Percent
Sex				
Male	7068	92.5%	7709	91.9%
Female	575	7.5%	684	8.1%
Race				
White	5531	72.4%	5883	70.1%
Black	870	11.4%	996	11.9%
Hispanic	1158	15.2%	1384	16.5%
Asian	32	0.4%	42	0.5%
Native American	52	0.7%	63	0.8%
Multiple Races	*	*	25	0.3%
Unknown	*	*	*	*
Age at Diagnosis				
0-4	21	0.3%	21	0.3%
5-12	9	0.1%	9	0.1%
13-19	30	0.4%	36	0.4%
20-24	201	2.6%	232	2.8%
25-29	1051	13.8%	1111	13.2%
30-39	3705	48.5%	3936	46.9%
40-49	1916	25.1%	2206	26.3%
Over 49	710	9.3%	842	10.0%
Exposure Category				
Male/Male Sex (MSM)	5188	67.9%	5617	66.9%
Injecting Drug Use (IDU)	695	9.1%	776	9.2%
MSM and IDU	854	11.2%	906	10.8%
Transfusion Recipient	77	1.0%	73	0.9%
Hemophilia	80	1.0%	80	1.0%
Heterosexual Contact	435	5.7%	531	6.3%
Risk Not Identified	287	3.8%	383	4.6%
Mother with Risk for HIV Infection	25	0.3%	26	0.3%
Healthcare Worker Exposure	2	0.0%	2	0.0%
Region				
Urban	6758	88.4%	7387	88.0%
Rural	885	11.6%	1006	12.0%

CWT Prioritized Target Populations for *2007-2009 Comprehensive Plan*

TOTAL SCORE	RANK	POPULATION GROUP	POPULATION SUB-GROUPS
693	1	**HIV Positive Persons***	n/a
694	2	**Urban Men Who Have Sex with Men (MSM)**	White ages 25-49 years African American ages 25-49 years Latino ages 25-49 years Youth (ages 13-24 years)
649	3	**Rural Men Who Have Sex with Men (MSM)** All men, who have anal sex, with men who are HIV positive or unknown status partners (including MSM/IDU and who may have experienced early childhood sexual trauma)	White African American Latino Native American/American Indian
633	4	**Urban Female High Risk Heterosexuals**	African American ages 12-49 years Latina ages 12-49 years White ages 12-49 years
596	5	**Urban Injecting Drug Users (IDU)**	White African American Latino
559	6	**Rural Injecting Drug Users (IDU)** All males and females who inject drugs (IDU) and practice unsafe needle/drug sharing behaviors, including new initiates.	White African American Latino/Latina Native American/American Indian
518	7	**Rural Female High Risk Heterosexuals** All women who have unprotected sex, with MSM, non-gay identifying (NGI) men, IDUs, HIV positive men or multiple partners, including female sex workers, or women who have experienced early childhood sexual trauma or substance abuse.	White African American Latina Native American/American Indian
517	8	**Urban Male High Risk Heterosexuals**	African American Latino White
465	9	**Rural Male High Risk Heterosexuals** All men, who have unprotected sex, with HIV positive women or men, IDU women or men, or women or men with multiple sex partners.	White African American Latino Native American/American Indian

* Per CDC, this population has priority (#1 rank)

Acknowledgement
While the entire CPG contributed to the prioritization process in a very import way giving many hours of the their time and talents to this intensive process, we would like to acknowledge the work done by the Rural, Urban, and NA/P Committees that helped guide the prioritization process. Often they were asked to complete difficult homework assignments and read a tremendous amount of information for numerous committee meetings. Members of the three committees continually rose to the challenge presented to them and produced commendable results.

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Acknowledgement should also be given to information provided in the Academy for Educational Development (AED) manual: *Setting HIV Prevention Priorities: A Guide for Community Planning Groups*.

Chapter Seven

Prioritizing Interventions

What are Prioritized Interventions?
Simply speaking, prioritizing interventions identifies a comprehensive list of HIV prevention activities for each target population that are recommended by the community planning group because of their proven or potential effectiveness, cultural appropriateness, and ability to respond to high-priority, community-validated needs of the target populations. The recommended list of interventions are identified based on a set of criteria: behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.

What is their Significance to Community Planning?
Besides developing a Comprehensive HIV Prevention Plan, priority setting is the main task for community planning groups. The prioritized list of target populations and interventions forms the basis for the Comprehensive Plan that the health department uses when developing its annual application to the Centers for Disease Control and Prevention (CDC) for HIV prevention funding. Coloradans Working Together: Preventing HIV/AIDS (CWT) has intentionally not ranked the interventions for the target populations. Identifying a set of potential strategies and activities for the target populations (identified in chapter six), and implementing those strategies via intervention providers, can prevent the greatest number of new HIV infections.

Definition

Intervention: An activity (or set of related activities) intended to bring about HIV risk reduction in a particular target population using a common strategy of delivering the prevention message. An intervention has distinct objectives and a protocol outlining the steps for implementation.

Intervention Definitions

Intervention	Definition	Excludes
Community-level Intervention (CLI)	(See "Other")	
Comprehensive Risk Counseling and Services (CRCS) *Formerly known as Prevention Case Management (PCM)*	Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. CRCS provides intensive, on-going, individualized prevention counseling, support, and service brokerage.	One-to-one counseling that lacks ongoing and individualized prevention counseling, support, and service brokerage.
Counseling, Testing, and Referral (CTR)	An individualized intervention of usually two sessions (pre-test and post-test) aimed at learning current serostatus; increasing understanding of HIV infection; assessing risk of HIV acquisition and transmission; negotiating behavior change to reduce risk of acquiring or transmitting HIV; and providing referrals for additional medical, preventive, and psychosocial needs.	HIV counseling and testing is more than an information session; however, it is not therapy. This intervention is closely linked with Partner Counseling and Referral Services (PCRS)
Group-Level Intervention (GLI)	Health education and risk-reduction counseling (see above) that shifts the delivery of service from the individual to groups of varying sizes. GLI uses peer and non-peer models involving a wide range of skills, information, education, and support.	Any group education that lacks a skills component (e.g., information only education such as "one-shot" presentations). These types of interventions should be included in the HC/PI category.
Health Communication/Public Information (HC/PI)	The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-, or statewide) audience.	Group interventions with a skills-building component, which constitutes a separate intervention category.

Health Communication/Public Information (HC/PI) *(continued)*	Print Media: These formats also reach a large-scale or nationwide audience and include any printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage. Hotline: Telephone service (local or toll-free) offering up-to-date information and referral to local services (e.g., counseling/testing and support groups). Internet Sites/Chat Rooms: This is a vehicle for delivering HIV prevention messages and promoting behavior change and is increasing in popularity. The internet has the potential to reach large numbers of people and can be targeted to high-risk groups, such as those seeking sex via websites and chat rooms. Clearinghouse: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations Presentations/Lectures: These are information-only activities conducted in-group settings, often called "one-shot" education interventions.	
Individual-Level Intervention (ILI)	Health education and risk-reduction counseling provided to one individual at a time. ILI assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior and includes skills building activities. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services.	Outreach and prevention case management. Each intervention constitutes its own category. Also excludes HIV counseling and testing which is reported in a separate category using CDC's Program Evaluation and Monitoring System (PEMS) forms and 270 lab slips.

Outreach	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the neighborhoods or other areas where they typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Includes peer opinion leader models. In the HIV Prevention Community Planning Guidance of 2003, CDC emphasizes that a major purpose of outreach activities is to encourage those at high risk to learn their HIV status.	Condom drop offs, materials distribution, and other outreach activities that lack face-to-face contact with a client.
Partner Counseling and Referral Services (PCRS)	A systematic approach to notify sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.	HIV counseling and testing, which is reported in its own category.
Other	Category to be used for those interventions funded with CDC Program Announcement 99004 funds that cannot be described by the definitions provided for the other six types of interventions. This category includes **Community-Level Intervention (CLI).** CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups; this is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilizations; social marketing campaigns; community-wide events; policy interventions; and structural interventions.	Any intervention that can be described by one of the existing categories.

Sources

- *Guidelines for Health Education and Risk Reduction Activities,* April 1995. Available on the Centers for Disease Control and Prevention (CDC) website: *http://www.cdc.gov/hiv/HERRG/activities.htm*

- *Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs*, March 2002. Available on the Centers for Disease Control and Prevention (CDC) website: *http://www.cdc.gov/hiv/aboutdhap/perb/guidance.htm*

- *Compendium of HIV Prevention Interventions With Evidence of Effectiveness* revised August 2001. Available on the Centers for Disease Control and Prevention (CDC) website: *http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm*

Common Abbreviations

CLI	Community Level Intervention
CRCS	Comprehensive Risk Counseling and Services (formerly known as PCM)
CTR	Counseling, Testing, and Referral
CTS	HIV Counseling and Testing Site
DEBI	Diffusion of Effective Behavioral Interventions
GLI	Group Level Intervention
ILI	Individual Level Intervention
HC/PI	Health Communication/Public Information
HE/RR	Health Education/Risk Reduction
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
TATP	Technical Assistance & Training Program (DCEED – CDPHE Unit)

Introduction

Coloradans Working Together: Preventing HIV/AIDS (CWT) has been working on a three-year planning cycle to update its list of prioritized target populations and interventions, having developed its last list in 2003. As mentioned in Chapter Six, planning for the prioritization process began in the fall of 2005 during the CWT Retreat. At the retreat, CWT decided to use a similar prioritization process to the one used in 2003.

Similar to the process for prioritizing target populations, CWT felt the process for identifying effective interventions needed to rely more on preparatory work performed by the Urban and Rural Committees, rather than completing all the work as a group at a CPG meeting, due to time constraints at the CPG meetings. Therefore, it was decided at the retreat that the Urban and Rural

Committees would be charged with developing a recommended list of interventions for urban and rural target populations, and that these recommended lists would be presented to the full CPG at its July meeting to make the final decisions on the list of effective interventions for each of the target populations. See the "Community Planning Development Retreat Final Report" Attachment for more details.

The Needs Assessment/Prioritization (NA/P) Committee helped guide the overall process for identifying effective interventions in 2006. Using the overall guidance from the NA/P Committee, the Urban and Rural Committees developed the recommended interventions. All committees, as well as the CPG, kept the Guiding Principles in mind when identifying effective interventions.

Methodology/Implementation

Objective – To create a comprehensive list of proven and potentially effective HIV prevention interventions and describe an effective mix of interventions for each priority target population.

STEP 1: IDENTIFY A LIST OF INTERVENTIONS:
Tasks:
- Identify and determine what interventions should be considered for each population.
- List all possible HIV prevention interventions for the each target population.
- Use consistent terminology when comparing interventions.

The NA/P, Urban, and Rural Committees began their work for identifying effective interventions in June of 2006. All committees agreed to use CDC's established definitions for

HIV prevention interventions from the *Evaluation Guidance Handbook.* This list was used as the "master list" of all possible interventions.

The committees did struggle with this step in light of the prominence of the Diffusion of Effective Behavioral Interventions (DEBI's) recommended by CDC. Moreover, the NA/P Committee also discussed the importance of evaluating interventions and would like the Health Department to consider providing resources for evaluation of community interventions/programs that agencies feel are working but do not have the scientific documentation to prove it due to lack of funding for evaluation components (so that they can become documented, proven effective programs).

In addition, the Urban Committee requested a complete list of the DEBI's (including target population, target behavior, and core elements) for reference when identifying interventions.

STEP 2: DETERMINE WHAT ARE THE COMPONENTS OF AN EFFECTIVE INTERVENTION

Tasks:

- Determine if a list of components/criteria should be used to evaluate interventions by target population.
- If using a set of components/criteria, develop and submit the list of potential criteria to Urban and Rural Committees.
- Review the CDC minimum list of intervention factors.
- (If using a set of components/criteria) finalize the list of potential components/criteria.

The NA/P Committee developed the list of decision-making criteria (factors) to recommend to the Urban and Rural Committees when assessing effective interventions. Similar to the process used in 2003, the committee determined that factors should be used during the process because if the CPG didn't base its decisions on a consistent and pre-defined set of criteria that decisions could be based on personal, and perhaps biased, impressions rather than in an objective manner. Moreover, since the CPG had decided not to rank the list of interventions, the committee decided that it would not be necessary to weight the factors.

The committee started the process to develop an initial list of potential factors by using a worksheet containing CDC recommended criteria as well as reviewing criteria chosen by other states. Based on the recommendations submitted by the committee members, via the worksheet assignments, the committee reviewed the following original list of 10 factors.

Initial list of potential factors

(Factors to consider when assessing how well an intervention will reduce HIV infections in a target population.)
1. Targets a specific population

2. Targets (a) specific behavior(s) (that will change as a result of the intervention)
3. Indicators of Intervention Effectiveness *(either demonstrated or probable)*
4. Sound theoretical basis
5. Cost effectiveness*
6. Intervention Feasibility: Legality*
7. Intervention Feasibility: Capacity
8. Intervention Feasibility: Resources
9. Intervention Feasibility: Sustainability*
10. Intervention Feasibility: Norms, values, consumer preferences

* These factors were later deleted from the final list because either not enough supporting information was available or they appeared to limit the community planning groups ability to make appropriate decisions for the diverse communities throughout Colorado.

The list of 10 potential factors was reviewed and revised by the NA/P Committee to its most critical components at its June 2006 meeting. The committee chose to change the "Sound theoretical basis" factor to read ""Theoretical Consideration" and revised the description of the factor to allow for a mix of multiple theories to also be included in this factor. Secondly, the committee chose to combine both the "Resources" and "Capacity" factors under "Intervention Feasibility" to be one factor. Lastly, under "Other Considerations" the committee wished to add "Other CDC Recommendations" to include other recommendations such as routine testing. The final list of factors, to be considered by the Urban and Rural Committees (and later by the CPG) when assessing how well an intervention will reduce HIV infections in a target population, was then submitted to the Rural and Urban Committees. Both committees felt comfortable using the list of factors. The final list of factors was also supported and used by the CPG at the July meeting. The final list of factors can be found on the following pages.

The Research and Evaluation (R&E) Unit completed the needs assessment and presented them to the NA/P, Urban, and Rural Committees in July of 2006. The reports were then submitted to the full CPG prior to the July CPG meeting. It is important to note that the majority of the CPG members participated on the NA/P, Urban, or Rural Committee, and were therefore familiar with the needs assessment findings in advance of the July CPG meeting.

STEP 3: FINALIZE A LIST OF POSSIBLE EFFECTIVE INTERVENTIONS PER TARGET POPULATION
Tasks:
- Review identified interventions listed in the needs assessment reports
- Review data collected regarding intervention effectiveness, cultural appropriateness, and community relevance of HIV prevention interventions.
- Review the recommended list of interventions (from the Urban and Rural Committees) for urban and rural target populations.
- Support or amend the proposed list of interventions (from the Urban and Rural Committees) for urban and rural target populations.

After the final list of factors were completed by the NA/P committee and submitted to the Urban and Rural Committees in June 2006, the two latter committees began the work of developing and finalizing the potential list of interventions for the urban and rural target populations. After reviewing and applying the final list of factors and reviewing the supporting documents the Urban Committee met in July 2006 and developed its final list of recommended interventions for the urban target populations. It is important to note that the Urban Committee also chose to identify specific types of interventions (DEBI's). They wanted these specific types

of interventions/programs to be emphasized but not inclusive.

The Rural Committee also completed its list for rural target populations in July of 2006. However, they chose not to identify specific types of programs as they feel that decision should be made by a specific agency when deciding what its resources, capacity, and local needs are. The final list of recommended lists of urban and rural interventions were presented at the July 21, 2006, CPG meeting.

On July 21, 2006, the full CPG met at its regular CPG meeting to develop the final list of interventions for the CWT target populations. The R&E Unit gave a final PowerPoint presentation on the needs assessment reports (focus was on the 2006 report, but summaries were also presented on the findings from the 2003-2004 and 2002-2003 reports) at the July CPG meeting so that the members could ask questions about the data collection techniques, report finings, methodology and use the data during the decision-making process. The full CPG considered the final list of factors submitted by the NA/P, Rural, and Urban Committees, reviewed the supporting documents referenced by the factors, and the recommended urban and rural list of interventions. After reviewing the supporting information and factors the CPG proposed some additional changes to the recommended list of urban and rural interventions. The committees accepted the recommended changes. A copy of the final list of CWT interventions can be found on the following pages.

STEP 4: REVIEW FINAL LIST OF INTERVENTIONS AND THE DESCRIPTION OF THE EFFECTIVE MIX OF INTERVENTIONS PER TARGET POPULATION

At the conclusion of the July CPG meeting the CWT meeting facilitator, Ramon Del Castillo, asked the CPG members if they felt satisfied with the final results of the process identifying interventions for CWT's target populations. There was strong support of the process, committee and member contributions, and the final list of interventions. A formal Decision Item containing the CPG's recommended interventions was presented and unanimously approve by the CPG on July 21, 2006.

Important Issues to Note

During CWT's work to identify effective interventions, a few important issues were discussed. The Urban Committee felt that while specific types of interventions/programs were being identified, a more holistic approach is critical to the success of that particular intervention/program. They discussed the importance of "wrap around services" with a specific intervention/program just being one of several important things that need to be done. In addition, they feel using the "wrap around services" concept assures that the issues identified in the needs assessment report are addressed.

Moreover, the committee identified three main issues that must be addressed when looking at effective interventions.

- Cultural Competence

Several items related to this issue were discussed, including culturally competent providers, referrals, and interventions/programs. They discussed that effective interventions are dependent on all stakeholders being culturally competent (clients, providers, contract agencies, and health department employees). In addition, the committee feels that each agency delivering services/programs needs to define and assure cultural competence (in way that is specifically tailored for their clients and community). Moreover, the committee believes that interventions/programs need to be adapted in a way specific to their audience in order to be effective and that there needs to be openness and flexibility to allow agencies to do this.

- Training

The committee also discussed the lack of training opportunities (particularly local trainings) and would like to have the opportunity to address this issue in more detail and assure that trainings are available.

- Evaluation

The committee feels there is a lack of research and evaluation around funded (and non funded) interventions. They feel the state health department should be more fully committed evaluation of interventions/programs and should be on-going (and not just a part of the grant process).

Similarly, the Rural Committee felt it was important to adapt/modify interventions to fit local needs in order for it to be effective.

Final List of Factors for Determining Effective Interventions

Factor	Questions to Consider When Assessing this Factor
✓ **Targets a specific population**	Is the intervention specifically designed to reach the target population? How well is it designed to reach its target population?
✓ **Targets a specific behavior (that will change as a result of the intervention).**	Does the intervention target specific behaviors, attitudes, beliefs, norms, or barriers that place people at risk for HIV infection? Is the intervention specifically designed to change the target behavior?
✓ **Indicators of Intervention Effectiveness (either demonstrated or probable)**	Are there indicators that the intervention is effective, **or might be effective**, in averting or reducing high-risk behaviors within the target population? The evidence might include • An outcome evaluation of the intervention – how much the intervention reduced risky behaviors • A process evaluation of the intervention – whether the intervention was conducted as planned • Evaluation of an HIV program that targets the same population in a similar environment • Evaluation of a similar program targeting a related health behavior
✓ **Theoretical Consideration**	Was behavioral and/or social science research and theory considered for designing the intervention? Is the theory supported by a formal or informal theory, or a mix of multiple theories?
✓ **Intervention Feasibility**	*The factors listed below should be used to evaluate whether an intervention is feasible.*
	✓ **Resources/Capacity** Are resources/capacity available to assist delivery of the intervention? Do supporting activities exist to supplement and assist delivery of the intervention?
	✓ **Norms, values, consumer preferences** Is the intervention acceptable to the target population? Did members of the intended audience either develop the intervention themselves or provide input into its development?

✓ **Other CDC Recommendations**	Does CDC recommend other interventions/programs/activities? (i.e. routine testing without counseling)	

CWT's List of Recommended Interventions for Target Population in *Urban* Areas

(As consensed upon by the CPG at the July 21, 2006 CPG meeting.)

Note: Specific programs listed should be emphasized but not inclusive to a recommended type of intervention.

HIV POSITIVE PERSONS

Recommended Interventions:

Type of Intervention	Name of Intervention	Comments
GLI	Healthy Relationships	Providers are aware of community resources and able to refer
CLI	Social Marketing Campaign	Specifically about disclosing/discussing status
HC/PI	Internet, electronic chat rooms, websites	
HC/PI	Print ads, newspapers	General HIV awareness
CRCS		Both health department and community settings, providers need appropriate training and able to appropriately refer clients
Outreach		
PCRS		
ILI		
GLI	Together Learning Choices	For youth living with HIV

Not Recommended Interventions:

Type of Intervention	Name of Intervention	Comments
CTR		

MEN WHO HAVE SEX WITH MEN (MSM)

Recommended Interventions:

Type of Intervention	Name of Intervention	Comments
CTR		
PCRS		Need to assure culturally competent providers, service delivery to be effective
CLI	Popular Opinion Leader	
Outreach		
GLI	Many Men, Many Voices	
GLI	Mpowerment	
GLI	Brotherhood University	Washington, DC, African American men
GLI	Aguilas El Ambiente Empowerment Model	San Francisco, CA, Latino men
CLI	Social marketing campaign	
HC/PI		
ILI		
GLI	Healthy Relationships	Not just for those living with HIV, focus on issue of disclosure (major core element of program)

Not Recommended Interventions:

Type of Intervention	Name of Intervention	Comments
N/A		

FEMALE HIGH RISK HETEROSEXUALS

Recommended Interventions:

Type of Intervention	Name of Intervention	Comments
GLI	SISTA	Also possibly SiHLe, Willow
CLI	Popular Opinion Leader	
HC/PI		
ILI		
Outreach		Use technology (i.e. website such as MySpace.com), particularly for younger populations
CTR		

Not Recommended Interventions:

Type of Intervention	Name of Intervention	Comments
N/A		

INJECTING DRUG USERS

Recommended Interventions:

Type of Intervention	Name of Intervention	Comments
Outreach		One on one, bleach kits and syringe exchange with "wrap-around services" (i.e. mental health, drug abuse treatment, safe injecting practices)
ILI		
GLI		Support group
CTR		
ILI/GLI/CTR	Safety Counts	
CLI	Community PROMISE	

Not Recommended Interventions:

Type of Intervention	Name of Intervention	Comments
N/A		

MALE HIGH RISK HETEROSEXUALS

Recommended Interventions:

Type of Intervention	Name of Intervention	Comments
CTR		
GLI	Voices/Voces	
Outreach		
HC/PI		Use technology (i.e. website such as MySpace.com), particularly for younger populations
ILI		
CLI	Popular Opinion Leader	
CLI	Real AIDS Prevention Project	Would like more information on if this program has been effective (in other states) for reaching male high risk heterosexuals

Not Recommended Interventions:

Type of Intervention	Name of Intervention	Comments
N/A		

NOTES: Although not explicitly listed, the committee proposes that other "not recommended" interventions would be those program models that have gender specific populations (i.e. Many Men, Many Voices is not recommended as a GLI for female high risk heterosexuals, SISTA is not recommended for male high risk heterosexuals). Also, the committee believes that in many cases ILI will lead to counseling.

CWT's List of Recommended Interventions for Target Population in *Rural* Areas

(As consensed upon by the CPG at the July 21, 2006 CPG meeting.)

Note: CWT feels it is important to keep in mind that these interventions need to be adapted to fit local needs.

HIV POSITIVE PERSONS

Recommended Interventions:

Type of Intervention	Comments
GLI	
ILI	
HC/PI	
PCRS	
CRCS	Both health department and community settings, providers need appropriate training and able to appropriately refer clients
Outreach	
CLI	

Not Recommended Interventions:

Type of Intervention	Comments
CTR	

MEN WHO HAVE SEX WITH MEN (MSM)
Recommended Interventions:

Type of Intervention	Comments
CTR	
ILI	
GLI	
HC/PI	
PCRS	
CLI	
CRCS	Both health department and community settings, providers need appropriate training and able to appropriately refer clients
Outreach	

Not Recommended Interventions:

Type of Intervention	Comments
N/A	

INJECTING DRUG USERS

Recommended Interventions:

Type of Intervention	Comments
CTR	
ILI	
GLI	
HC/PI	
PCRS	
CLI	
CRCS	Both health department and community settings, providers need appropriate training and able to appropriately refer clients
Outreach	One on one, bleach kits and syringe exchange with "wrap-around services" (i.e. mental health, drug abuse treatment, safe injecting practices)

Not Recommended Interventions:

Type of Intervention	Comments
N/A	

FEMALE HIGH RISK HETEROSEXUALS

Recommended Interventions:

Type of Intervention	Comments
CTR	
ILI	
GLI	
HC/PI	
PCRS	
CLI	
CRCS	Both health department and community settings, providers need appropriate training and able to appropriately refer clients
Outreach	

Not Recommended Interventions:

Type of Intervention	Comments
N/A	

MALE HIGH RISK HETEROSEXUALS

Recommended Interventions:

Type of Intervention	Comments
CTR	
ILI	
GLI	
HC/PI	
PCRS	
CLI	
CRCS	Both health department and community settings, providers need appropriate training and able to appropriately refer clients
Outreach	

Not Recommended Interventions:

Type of Intervention	Comments
N/A	

Chapter Eight

Annual and Long Term HIV Prevention Goals

What are the Annual and Long Term HIV Prevention Goals?

Community planning groups (CPG) develop goals for community planning in order to provide direction over a five-years period. The CPG annually reviews those goals in order to determine the CPG's progress towards their goals and if efforts need to be directed or new strategies need to be developed in order to reach those goals.

What are their Significance to Community Planning?

These goals are intended to help improve the community planning process in Colorado, in terms of participation and access, as well as to improve HIV prevention in Colorado by evaluating the needs and assets of Colorado's prioritized target populations and methods to improve the prevention activities.

Introduction

During CWT's last planning year (2003), the Coloradans Working Together (CWT) Steering Committee reviewed the draft of the new *2003 – 2008 HIV Prevention Community Planning Guidance* developed by the Centers for Disease Control and Prevention (CDC) and in accordance with the guidance, developed performance goals for the next five years.

The CDC has set three major goals for HIV Prevention Community Planning. The goals provide an overall direction for HIV prevention community planning. The three major goals for HIV Prevention Community Planning are:

Goal One — Community planning supports broad-based community participation in HIV prevention planning.

The objectives that will be monitored and measured to determine progress in achieving Goal One:

- Objective A: Implement an open recruitment process (outreach,

nominations, and selection) for CPG membership.

- Objective B: Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.

- Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.

Goal Two — Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

The objectives that will be monitored and measured to determine progress in achieving Goal Two:

- Objective D: Carry out a logical, evidence-based process to determine

the highest priority, population-specific prevention needs in the jurisdiction.

- Objective E: Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.
- Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.

Goal Three — Community planning ensures that HIV prevention resources

target priority populations and interventions set forth in the comprehensive HIV prevention plan.

The objectives that will be monitored and measured to determine progress in achieving Goal Three:

- Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.
- Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

CWT's Performance Plan to Achieve, Sustain, and Improve Its Community Planning Goals

Goal One – Community planning supports broad-based community participation in HIV prevention planning.

As stated in the CWT Charter, "Toward the goal of full inclusiveness," CWT promotes involvement by the following populations in HIV community planning efforts: men who have sex with men (MSM); high-risk youth; injecting drug users (IDU); seasonal workers; African Americans; Asian Americans; Latinos/as; Native Americans; people with disabilities; deaf and hard-of-hearing people; women at risk; people who are incarcerated, on parole, or probation; people living with HIV infection; children/pregnant women; substance users; and people living with hepatitis C virus." These populations are represented from both the rural and urban areas of Colorado. CWT measures the ratio of representation demographic, as compared to Colorado HIV epidemiology, after every meeting of the full CPG. The CWT Steering Committee assesses gaps in representation demographic categories and provides guidance when possible for filling those representation gaps.

Individual members of the CPG as well as the Colorado Department of Public Health and Environment (CDPHE) Planning Unit staff attempt to recruit new members in accordance with the identified representation gaps on an ongoing basis throughout the year. (See the HIV Prevention Community Planning Membership Survey Report, Part I, for further details on CWT's demographic makeup and population representation figures.) Once potential new members are identified, they are encouraged to attend one of the quarterly "CWT 101" training sessions that include an orientation to community planning. Participants are also provided with a new member orientation manual during the session that includes by-laws (a.k.a., the CWT Charter), essential paperwork, the CDC Community Planning Guidance, CWT history and milestones, member biographies, descriptions of committees, an outline of CWT's decision-making process, and descriptions of member roles and responsibilities. The CWT Membership/Participation Committee developed the orientation session. Participants in the CWT 101 complete an

evaluation at the end of the session to help qualitatively measure their understanding of community planning based on the training session. The Membership/ Participation committee assesses the outcomes of the CWT 101 sessions in order to update the information and format as necessary. Throughout the year, the CWT Membership/Participation Committee also assesses general parity, inclusion, and representation (PIR) issues and other potential barriers to full participation identified by CPG members via CPG meeting evaluations and the annual community planning membership survey. Based on the evaluation of the issues, the committee provides assistance to the CWT Steering Committee to determine if further technical assistance should be provided to members during the annual fall CWT retreat.

CWT prides itself on its "open membership" process, which does not use a nomination process or require term limits. (Note: While formal nominations are not used by CWT, the CPG still measures participation demographics and attempts to balance those demographics with the results of the annual HIV epidemiological profile by identifying and recruiting new members who might fill gaps.) CPG members feel this open membership structure fits their participation requirements well by allowing for greater participation and a more informal representation structure. At the beginning of each year, or as new members join the CPG, all members who request full (Consensus Building) membership are required to complete an assurance form indicating which communities they intended to represent and how. Contributing members are also requested to identify with communities they represent. Consensus Building members are required to attend two CWT committee meetings during the year and attend 75 percent of the meetings for those committees. Consensus Building members are also required to submit "assurance" documentation to the Steering

Committee describing how they received regular direct community input from the populations that they represent in order to maintain their full membership rights.

In order to better inform the CPG members on community planning issues and committee work, the CWT coordinator maintains a web site for the CPG. That web site can be accessed at *www.cdphe.state.co.us/dc/cwt.* Those interested in learning more about CWT and its current activities, but who are not current members, are also regularly directed to the web site for information. The CWT coordinator and the planning unit liaison provide ongoing assistance to anyone wishing to learn more about CWT and community planning.

All of the committees that help improve community planning participation issues are permanent standing committees of CWT, as documented in the CWT Charter. It is expected that these committees (and ad hoc committees that may be developed) will continue the work described above to improve community planning participation throughout the next five years.

Goal Two – Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

CWT attempts to ensure a logical, evidence-based prioritization process by producing a community assessment (a.k.a., needs assessment). The most recent community assessment report was produced in 2006 and focused on men who have sex with men. Two additional community assessment reports will be conducted in 2007, to identify the needs of injecting drug users and high-risk heterosexuals. Please see Chapter Four of the *2007 – 2009 Colorado Comprehensive Plan for HIV Preventio*n for a copy of the report and details regarding the

process. CWT also attempts to prioritize target populations based on sound scientific data such that the target populations indicate those communities in Colorado most impacted by HIV/AIDS and to recommend a list of activities that will help reduce the greatest number of infections in those communities. Please see Chapter Six of the Comprehensive Plan for a description of the process CWT used to develop the prioritized list of target populations, and Chapter Seven for a description of the process used to prioritize a set of effective activities/interventions for the target populations.

The CPG will continue to review its list of prioritized target populations and recommended list of intervention activities for the target populations on an annual bases and update or change them as necessary.

Goal Three — Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

CWT ensures that HIV prevention resources target priority populations and interventions via the *Letter of Concurrence*[2] process, by annually reviewing the link between activities included in CDPHE's HIV Prevention Program application and those described in its current Comprehensive Plan.

It is important to note that there was a relatively short timeline for the CPG to review the Colorado Department of Public Health and Environment (CDPHE) 2007 Interim Progress Report (IPR). A CPG meeting was held on August 31, 2006 for the concurrence process and to review the Comprehensive Plan and the 2007 IPR. In addition, CDPHE management staff were in attendance and able to answer questions about the IPR and highlight the main points/revisions of the document. The CPG acknowledged that the group identified numerous effective interventions for the target populations and understood the reality that CDPHE could not possibly fund all of the recommended interventions. Acknowledging this fact, the CPG unanimously approved the Letter of Concurrence on August 31, 2006.

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[2] **Concurrence:** The community planning group's (CPG's) agreement that the health department's application for HIV prevention funds reflects the CPG's target populations and intervention priorities (see "non-concurrence"). As part of its application to the CDC for federal HIV prevention funds, every health department must include a letter of concurrence, non-concurrence, or concurrence with reservations from each CPG officially convened and recognized in the jurisdiction.

Evaluation of CWT's HIV Prevention Community Planning Goals

The CDC's *2003 – 2008 HIV Prevention Community Planning Guidance* provides performance indicators that help community planning groups "measure" progress towards achieving its community planning goals. CWT set baseline performance goals in 2003. Based on the review of these baseline measurements, the CWT Steering Committee developed one-year and five-year targets in 2003. CWT annually evaluates its progress towards these targets, and updates the Comprehensive Plan accordingly.

Further details of how CWT evaluates it planning process can be found in Chapter Thirteen of this Comprehensive Plan.

The Core Planning Group completed the "Community Planning Membership Survey" in June of 2006. A total of 31 CPG members completed the survey, for a total response rate of 84%.

Indicator E.1: Proportion of populations most at risk (up to 10), as documented in the epidemiologic profile and/or the priority populations in the Comprehensive Plan, that have at least one CPG member that reflects the perspective of each population.

	2003 (Baseline)		2006		2007 (Target)	2008 (5-Year Goal)	
	Original	Revised	Target	Actual	NEW	Original	Revised
Numerator: The number of populations most at risk (up to ten), as documented in the epidemiologic profile and/or the priority populations in the Comprehensive Plan, that have at least one CPG member that reflects the perspective of each population.	8	N/A	9	10	10	9	
Denominator: The number of populations most at risk (up to ten), as documented in the epidemiologic profile and/or the priority populations in the Comprehensive Plan.	10	N/A	10	10	10	10	
Proportion= (numerator/denominator)	80%	N/A	90%	100%	100%	90%	

Indicator E.2: Proportion of key attributes of an HIV prevention planning process that CPG membership agreed have occurred.

	2003 (Baseline)		2006		2007 (Target)	2008 (5-Year Goal)	
	Original	Revised	Target	Actual	NEW	Original	Revised
Numerator: The number of key attributes of which CPG members agreed occurred.	869	N/A	N/A*	1148	N/A*	N/A*	
Denominator: The total number of valid responses ("agree" and "disagree").	1015	N/A	N/A*	1185	N/A*	N/A*	
Proportion= (numerator/denominator)	86%	N/A	91%	97%	94%	88%	
* Please note that CWT is not able to project in advance the exact total number for the numerator and denominator in the table above, as the results from question-to-question vary too much from participant-to-participant. However, the CWT has been able to reasonably project the overall annual percentages.							

Indicator E.3: Percent of prevention interventions/other supporting activities in the health department's CDC funding application specified as a priority in the Comprehensive HIV Prevention Plan.

	2003 (Baseline)		2006		2007 (Target)	2008 (5-Year Goal)	
	Original	Revised	Target	Actual	NEW	Original	Revised
Numerator: The number of prevention interventions/other supporting activities in the health department's CDC funding application specified as a priority in the comprehensive HIV prevention plan.	77	N/A	74	N/A	51	N/A*	
Denominator: The number of all prevention interventions/other supporting activities identified in the health department's CDC funding application.	83	N/A	83	N/A	71	N/A*	
Proportion= (numerator/denominator) x 100	93%	N/A	89%	N/A	72%	93%	

Indicator E.4: Percent of health department-funded prevention interventions/other supporting activities that correspond to priorities specified in the Comprehensive HIV Prevention Plan.

	2003 (Baseline)		2006		2007 (Target)	2008 (5-Year Goal)	
	Original	Revised	Target	Actual	NEW	Original	Revised
Numerator: The number of funded prevention interventions/other supporting activities that correspond to priorities specified in the most current comprehensive HIV prevention plan.	77	N/A	74	N/A	N/A*	N/A*	
Denominator: The number of all health department-funded prevention interventions/other supporting activities.	83	N/A	83	N/A	N/A*	N/A*	
Proportion= (numerator/denominator) x 100	93%	N/A	89%	N/A	80%	93%	

Note: In the past, no funds have been provided by the state of Colorado or any other non-federal source of funds for HIV prevention. Therefore, CDPHE has not administered any HIV prevention services others than those designated under the CDC HIV Prevention Projects 04012. However, the state of Colorado will begin providing funds for HIV Prevention and Education on July 1, 2006 (although actual grant contracts are not expected to go out until spring of 2007). Thus, it is expected that this indicator will be drastically revised later in 2007.

Chapter Nine

Linkages to Other Related Systems

A. The Importance of Linkages

To most effectively prevent HIV, service providers must recognize that people at high risk of being infected with or infecting others with HIV often have multiple issues and complicated lives. Clients often seek out the services of multiple agencies that offer different types of services, *and each of these agencies has a critical role to play in helping prevent HIV*. This will work best when the multiple providers work in partnership. CWT has identified nine types of linkages in this regard:

- Early intervention and medical support for people living with HIV/AIDS
- Ryan White CARE Act programming
- Substance abuse prevention and treatment,
- Mental health services
- STD prevention and treatment
- Reproductive health care services and services to prevent perinatal transmission
- Services regarding Hepatitis C
- Short- and long-term correctional systems
- Faith-based services.

For the remainder of this chapter, these nine additional services will be called "linked comprehensive services."

In addition, there are services that people living with, or affected by, HIV often require in order to meet basic needs, often on an emergency basis. While providers of these services may not directly provide HIV prevention themselves, their services are vital if HIV risk is to be effectively addressed. CWT has recognized four of these closely related services: support for the homeless, transportation, employment, and basic social services (as described at the end of this chapter).

These four will be collectively called "safety net services" in the remainder of this chapter.

B. The Challenges of Creating and Sustaining Linkages

Generally, health care systems have not been structured to address multiple issues and multiple needs simultaneously. Parallel systems of health care emerge as a result of enacted federal and state health policies and categorical funding streams, often evolving in divergent directions. Public health policies and the structure of related programs must adapt to be more responsive to the complicated needs of persons living with HIV/AIDS and those at risk of infection.[3]

There are many challenges in linking HIV prevention services to any other services:

- The lack of awareness about the co-factors for HIV infection or risk,
- The lack of available and appropriately trained providers,
- Social stigma for the client and/or the provider who may be reluctant to extend appropriate services,
- The tendency of each system to place its specific issue in the position of highest priority, and to relegate other issues to secondary importance (regardless of the priorities set by the clients themselves), and
- The need to coordinate our very limited public financing more effectively.
- Federal and state budget cuts have dramatically impacted all services in areas of the state.

To deal with these challenges, CWT recommends the following:

1. Providers of linked comprehensive services should have staff trained in HIV prevention, onsite HIV prevention resources, and HIV prevention programming incorporated into the services they provide for their clients where feasible. This prevention programming should reflect, as much as possible, the standards of practice included in Chapter Two of this Comprehensive Plan.

2. Clients of the HIV prevention system should have seamless access to linked comprehensive services and safety net services, as needed. In addition, clients of linked comprehensive services and safety net services should have seamless access to the services offered by the HIV prevention system, as needed. For this to occur effectively, a methodology for assessing client HIV risk must be developed and implemented in all systems. Reciprocally, the HIV prevention system should systematically assess the needs of clients in regard to linked comprehensive services and safety net services and refer clients accordingly.

3. Competence in regard to culture, disability, and other diversity must be a critical concern for providers of linked comprehensive services and safety net services. Providers often find it particularly challenging to competently serve those at highest HIV risk – men who have sex with men (MSM), persons with a history of substance use, and the most marginalized segments of our communities of color. Providers should be encouraged and assisted to make ever-improving progress toward competence and proficiency in regard to culture, disability, and other diversity. HIV prevention service providers should systematically gather and report the stories of their clients concerning their experiences with the providers of linked comprehensive services and safety net services, without violating client confidentiality. When necessary, HIV service providers (including Colorado Department of Public Health and Environment [CDPHE]) should assume a systems advocacy role to promote necessary change in all relevant

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[3] NASTAD report, *Linking HIV/AIDS Services with Substance Abuse and Mental Health Programs,* available at *www.nastad.org*.

systems. See Chapter Twelve of this Plan for information about system advocacy.

4. To make progress toward goals one through three above, capacity building will be essential. HIV prevention resources received through the cooperative agreement with Centers for Disease Control and Prevention (CDC)

should not be expected to bear all of the costs of such capacity building and the resulting interventions. Providers of linked comprehensive services and safety net services should make good faith contributions in this regard.

5. Seek funding to replace local, state, and federal budget cuts.

C. Early Intervention and Medical Support for People Living With HIV/AIDS

In addition to the four general goals regarding comprehensive linked services and safety net services, the following are specific recommendations regarding early intervention and medical support for people living with HIV/AIDS:

1. **For more people to benefit from advances in HIV treatment, providers of HIV counseling and testing must redouble their efforts to serve people who are HIV positive but unaware of their serostatus.**

   It is important to encourage people to get tested as early as possible. CDPHE examined the time between the first positive HIV test and AIDS diagnosis for cases of AIDS diagnosed between 1993 and 2002. A significant number of AIDS cases are tested relatively late in the course of their HIV infection. Thirty-six percent were tested for HIV within two months and 43 percent within 12 months of AIDS diagnosis.[4] The delay in testing late in the course of HIV infection appeared to be increasing, until 2002 when 45 percent of persons tested within 12 months of their AIDS diagnosis.[5]

To be most useful as a prevention intervention and a link to early intervention and medical support for people living with HIV/AIDS, HIV testing should be: targeted to serve those most likely to be infected, and minimize barriers by being conveniently available through as many outlets as possible, including anonymous and confidential test sites, home collection kits, rapid testing, and integration into other services. See details described in Advancing HIV Prevention below.

2. **People living with HIV often turn to their provider of early intervention and medical support when they have questions about HIV prevention, including disclosing their serostatus to their partners. Capacity building and seamless referrals should improve to better meet this need.**

Managed care and other demands on providers of primary care leave less and less time to counsel clients on HIV prevention. New relationships with managed care organizations and closer relationships with care providers are needed in order to promote the economic and social benefits of prevention.

3. **Pharmaceutical companies, governments, and medical laboratories need to work**

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[4] *HIV and AIDS in Colorado: Integrated Epidemiologic Profile of HIV and AIDS Prevention and Care Planning* reported through June 2003, page 49 – 50.
[5] Ibid, 49 – 50.

together to ensure that all HIV infected people have equal access to the new treatments, both in the US and internationally.

The high cost of the new drugs and viral load testing has already put a strain on public funds for HIV healthcare, including Medicaid, the Ryan White CARE Act's Colorado Indigent Care Program and the AIDS Drug Assistance Program (ADAP).

4. **Providers of HIV prevention must be prepared to deal with an increasing public perception that HAART is a "cure" for AIDS and will halt the spread of HIV.**

Clients are increasingly under the impression that undetectable or lowered viral load eliminates the needs to practice safer sex and safer sharing of needles and other injection paraphernalia. HIV prevention providers must carefully weigh the implications of their messages for such clients. For some clients, their own or their partner's willingness to remain on HAART is the only harm reduction strategy they will accept to lessen the risk of transmitting or acquiring HIV. Insisting on less risky behaviors may alienate such clients and have no HIV prevention benefit. Other clients, when fully informed of the real HIV risk, will find a post-HAART level of unprotected risk unacceptable and will want support to practice only protected intercourse and non-sharing.
Any and all information in this regard must be delivered in an understandable and culturally competent manner.

Address Colorado's extensive waiting list to access ADAP, due to state budget cuts in funding to be used to purchase antiretroviral medications for low-income residents suffering from HIV/AIDS.

This funding cut impacts a critical safety net program for people accessing HIV care, as Ryan White CARE Act is considered a "payer of last resort."

6. **Address increasing barriers that providers are facing when attempting to refer clients to medical and care services in their area, especially in El Paso County.**

7. **Address co-payments fees and/or caps on patient case load for clients without insurance that are being required at HIV and STD clinics due to local budget cuts.**

8. **Address the client caseload capacity of rural providers to serve uninsured clients.**

ADVANCING HIV PREVENTION

In 2003 the CDC initiated new strategies for reducing the number of new HIV infections. This new initiative is called Advancing HIV Preventions (AHP). Advancing HIV Prevention is aimed at reducing barriers to early diagnosis of HIV infection and increasing access to and utilization of quality medical care, treatment, and ongoing prevention services for those living with HIV.[6] The four priority strategies of AHP are:

- Make voluntary HIV testing a routine part of medical care
- Implement new models for diagnosing HIV infections outside medical settings
- Prevent new infections by working with persons diagnosed with HIV and their partners
- Further decrease perinatal HIV transmission

[6] CDC announcement, Advancing HIV Prevention, New Strategies for a Changing Epidemic, available at www.cdc.gov/hiv/partners/ahp.htm#announcement.

Strategy 1: Make Voluntary Testing a Routine Part of Medical Care

- Work with partners to include HIV testing, when indicated, as a part of routine medical care;
- Expand routine offering of testing
- Promote adoption of simplified voluntary testing procedures that do not require prevention counseling prior to testing;
- Fund demonstration projects of routine offering HIV testing to all patients in high HIV prevalence health care settings;

Strategy 2: Implement New Models for Diagnosing HIV Infections

- Fund demonstration projects using the rapid HIV test to increase testing in high-HIV prevalence settings including correctional facilities;
- Fund community-based organizations (CBOs) to pilot new models of counseling, testing, and referral (CTR) in nonmedical settings;
- Increase emphasis on partner counseling and referral services (PCRS);
- In 2004, implement the new models through the new health department and the new CBO announcements

Strategy 3: Prevent New Infections by Working with Persons Diagnosed with HIV

- Publish *Recommendations for Incorporating HIV Prevention into the Medical Care of Persons with HIV Infection (CDC, HRSA, NIH, and IDSA)*
- Fund demonstration projects to provide prevention case management (PCM) for people with HIV who have ongoing high-risk behavior
- Fund demonstration projects of new models of PCRS
- In 2004, implement these services

Strategy 4: Further Decrease Perinatal HIV Transmission

- Work with partners to promote routine, voluntary prenatal testing, with right of refusal;
- Develop guidance for using rapid tests during labor and delivery or post partum;
- Provide training in conducting prenatal testing;
- Monitor integration of routine prenatal testing into medical practice.

D. Integrating Ryan White Case Management and HIV Prevention

The staff from organizations involved in primary prevention advises and work with Ryan White Title I and II funded programs help to facilitate referrals across the full spectrum of prevention and care services. Many organizations have staff working on both primary prevention efforts and secondary prevention efforts funded by Ryan White Titles I, II, and III.

In addition to the four general goals regarding comprehensive linked services and safety net services, the following are specific recommendations regarding Ryan White Care Act programming:

1. **Most clients of programs funded under the Ryan White CARE Act also have need for HIV prevention services, particularly in this "post-HAART" era.**

Up until the advent of HAART, clients accessing such programs were already very ill or became ill very soon. Issues of continuing sexual expression or substance use were often secondary to survival on a day-to-day basis. Now, quality of life has vastly improved for most people living with AIDS, and the

issues of sexual expression and substance use have become more pressing. Prevention can and should be made available to support long-term, sustainable safety in regard to HIV risk behaviors.

2. **As mentioned above, HAART may have a prevention benefit due to** **lowered infectiousness. If so, issues of drug adherence over the long term will have prevention implications, and HIV prevention service providers can and must promote drug adherence and help clients deal with the challenges posed by years of difficult treatment.**

E. STD Prevention and Treatment

As explained in the Epidemiologic Profile (see Chapter One of the Comprehensive Plan), people who have a STD may have considerably heightened risk of becoming infected, or infecting others, with HIV.

However, while the epidemics of STD and HIV have grown in parallel, prevention efforts to combat the adverse consequences of sexual behavior have not always worked in tandem. In the US HIV epidemic, heterosexual transmission is an increasing cause of infection, and people of color and younger people are increasingly infected. Alarming increases in early syphilis cases among MSM in 2002 to 2003 indicate increased sexual risk behavior, which increases the possibility of transmission of HIV. In the first six months of 2003, 32 cases of early syphilis were reported. Of those, 20 (63%) were among MSM and 11 (34%) were HIV positive. This is similar to the two previous six-month periods.[7] Bathhouse contacts continue to be an important source of new infections of both HIV and syphilis. Although increases involving small numbers of cases should be view with caution as to whether they present a new trend or not, the concern regarding syphilis is worthy of attention and requires a strong response to limit the number of new cases.

An opportunity was lost in the 1970s, when gay men were among the most common clients of STD treatment programs, but there were few or no efforts to employ behavior change strategies to intervene in their risky behaviors. We are repeating this same mistake with African Americans and Latinos, who are also frequent clients of STD treatment and increasingly bear a disproportionate share of HIV cases. Colorado continues to see an increase of gonorrhea and chlamydia cases among all populations, and in recent years has witnessed increases in syphilis cases among men who are already HIV positive. Several manifestations of syphilis are also being seen by providers, including syphilis of the eyes and brain indicating extremely rapid progression of disease in those that are co-infected with HIV. There needs to be a stronger response to this increase of co-infections.

In addition to the four general goals regarding comprehensive linked services, the following are specific recommendations regarding STD prevention and treatment:

1. **HIV prevention efforts may be more effective among certain populations if condom use and HIV are addressed together with STD or pregnancy prevention.**

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[7] *HIV & AIDS in Colorado: Integrated Epidemiologic Profile of HIV and AIDS Prevention and Care Planning* reported through June 2003, page 29.

For instance, young people are much more likely to know someone who has had an STD or an unintended pregnancy than they are to know someone with HIV. HIV prevention programs, as well as family planning and STD clinics, might create a more effective and realistic message by putting all three together – HIV, STDs, and unintended pregnancy – and saying condoms can protect against all three. [8] [9]

2. **It is time to further integrate STD, HIV and unintended pregnancy efforts, both on a programmatic and a research level.**

   Wherever and whenever feasible, HIV prevention behavior change programs, STD clinics, family planning clinics, and primary care facilities need to incorporate all three – HIV, STDs, and unintended pregnancies – in their education, testing, counseling, and treatment services.[10] Research on HIV, both clinical and behavioral, needs to include the effects of STD and pregnancy.

3. **Although funding for HIV, STDs and family planning have traditionally been separate, government agencies and foundations need to provide funds for improved coordination or integration.**

4. **Workers in STD, HIV and family planning should be cross-trained. In particular, providers of STD and family planning services should become knowledgeable and implement interventions that lower behavioral risk.**

5. **Seek funding to replace budget cuts to rural reproductive health clinics that were providing STD screening and prevention services.**

6. **The complacency of assuming STDs are intermittently endemic in certain populations needs to be addressed by the entire HIV and STD community.**

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[8] Cates W. Sexually transmitted diseases and family planning. Strange or natural bedfellows, revisited. Sexually Transmitted Diseases. 1993;20:174-178, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "How Do HIV, STD and Unintended Pregnancy Prevention Work Together?"

[9] Stein Z. Family planning, sexually transmitted diseases, and the prevention of AIDS-divided we fail? American Journal of Public Health. 1996;86:783-784, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "How Do HIV, STD and Unintended Pregnancy Prevention Work Together?"

[10] Stein Z. Family planning, sexually transmitted diseases, and the prevention of AIDS-divided we fail? American Journal of Public Health. 1996;86:783-784, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "How Do HIV, STD and Unintended Pregnancy Prevention Work Together?"

F. Substance Abuse Prevention and Treatment

It is important to emphasize that the HIV risk associated with drug use involves both injected and non-injected drugs. People who abuse alcohol, speed, crack cocaine, poppers, or other non-injected drugs are more likely than non-substance users to become seropositive or already be HIV positive. People with a history of non-injection substance abuse are also more likely to engage in high-risk sexual activities. When an IDU is HIV positive, needle sharing may be the primary risk factor, but other non-injected drug use may have a great effect on risk behaviors.

Substance abuse prevention targets many of the same underlying factors that place people at risk of HIV. Joint programming and strategic alliances hold promise in strengthening both prevention systems.

In addition to the four general goals regarding comprehensive linked services, the following are specific recommendations regarding substance abuse prevention and treatment:

1. **Prioritized access to subsidized substance abuse treatment should be made available in recognition of imminent HIV-related public health concerns.**

   Costs of substance abuse treatment can be a serious barrier for people at highest risk of HIV. Yet, Drug injectors who do not enter treatment are up to six times more likely to become infected with HIV than are injectors who enter and remain in treatment (National Institute on Drug Abuse [NIDA], 1999). If even a small number of new HIV infections are avoided, it will more than compensate for the costs of subsidized substance abuse treatment for those who need it most. Every \$1 invested in substance abuse treatment reduces the

costs of drug-related crime, criminal justice costs, and theft by \$4 to \$7. The cost of 1 year of imprisonment per person is about \$18,400. When health care savings are added in, total savings can exceed costs by a ratio of 12 to 1 (NIDA, 1999).

2. **Gender specific programs are needed that address women's substance use needs.**
   Women have a higher physical vulnerability to alcohol and higher levels of traumatic events associated with substance use than men.[11]

3. **Treatment programs should be sensitive to the issues of transgender clients.**

4. **Gay-specific treatment is needed.**

5. **Additional research is needed to identify promising new approaches in treatment for drugs strongly associated with heightened risk of HIV, such as crack cocaine. Such research findings must be better disseminated to treatment providers, and additional funding will be needed to improve access to improved treatment.**

6. **Substance treatment programs affiliated with prisons and jails need training and authority to incorporate HIV prevention education into their programs.**

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[11] el-Guebaly N. Alcohol and polysubstance abuse among women. Canadian Journal of Psychiatry. 1995;40:73-79, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Are Substance Abusers Who Don't Inject At High Risk Of Infection?"

The HIV epidemic has closely paralleled the epidemics of substance use and incarceration.

7. **Review federal guidance for substance abuse treatment to see if mandates differ from services being provided in Colorado, so as to ensure that STD/HIV prevention education is being offered.**

8. **Increase access to affordable methadone maintenance (as an HIV prevention method), and ensure that those on methadone maintenance receive adequate doses of medication.**

    Studies of methadone maintenance treatment have shown that participation in treatment is associated with lower HIV risk behaviors as well as lower rates of HIV seroprevalence and seroincidence.[12]

9. **Develop better relationship between HIV prevention and pharmacists regarding the public health concerns surrounding transmission of blood-borne infections (including HIV or hepatitis C) through the use of non-sterile or shared syringes.**

    Pharmacies are conveniently located in about every urban neighborhood or rural community, and are staffed by licensed professionals who could make referrals to HIV counseling and testing, substance abuse treatment, as well as other health care or community services.

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[12] CDC report, *Hepatitis C Virus and HIV Coinfection*, available at *www.cdc.gov/idu/hepatitis/hepc_and_hiv_co.htm* .

G. Reproduction Health Care Services and Services to Prevent Perinatal Infection

Every time a woman accesses reproductive health services, there is a critical opportunity to assess HIV risk and prevent HIV infection. For a variety of reasons, women are more likely to protect themselves from pregnancy using methods that do not depend on partner cooperation, such as oral contraceptives. Unfortunately, these methods do not protect against STDs and HIV. Anecdotal evidence also suggests that youth are relying on anal and oral intercourse to "preserve virginity" and prevent pregnancy.

As quality of life improves for more and more people living with HIV, couples wherein one or both partners are living with the virus will also be exploring the option of becoming pregnant. Ignoring or sidestepping this controversial issue will only result in greater misinformation and more potential risk of infection, reinfection, and vertical transmission.

In recent years, advances in decreasing the rate of mother-to-child HIV transmission (vertical transmission) have occurred. Opportunities like those outlined in the AHP section above that discuss strategies to reduce perinatal HIV infections should be leveraged to ensure better access for women to improved health care. A women's annual pap exam is AN under-utilized opportunity to screen for and treat STDs.

In addition to the four general goals regarding comprehensive linked services, the following are specific recommendations regarding reproductive health services and services to prevent perinatal transmission:

1. **Women who are pregnant or considering becoming pregnant should be routinely offered HIV counseling and testing. Such testing should also be offered to the male partners of these women.**

2. **Reproductive health services should routinely include the taking of sexual history in a respectful, appropriate manner.**

3. **Providers of reproductive health services should thoroughly, accurately, and nonjudgmentally advise a woman of all the potential benefits and drawbacks of each birth control method.**

   This should include a discussion of a woman's life circumstances, her vulnerability to HIV and STDs, and why she may or may not choose barrier methods (such as male or female condoms).

4. **The most important step in preventing vertical transmission remains taking good care of the pregnant woman.**

   There are still many unknowns regarding the best way to reduce the risk of vertical transmission. Even if a guideline is someday proposed, not every woman will choose to follow it, nor should she be expected to. In addition to providing pregnant women with the best possible HIV care, she should also receive good prenatal care, preferably administered by providers educated about HIV and pregnancy.

5. **A pregnant women living with HIV should be thoroughly, accurately, and nonjudgmentally advised about every aspect of her pregnancy related to HIV.**

   Critical areas include the known effects of anti-HIV treatments on her health and on the fetus; benefits and known risks

associated with planned, elective c-section; and risks associated with breast feeding

6. People who are considering pregnancy when one or both partners are living with HIV should be thoroughly, accurately, and nonjudgmentally advised about

current methods that allow for impregnation while minimizing the risk of infection, re-infection, and vertical transmission.

Both partners should feel fully informed in their decisions about the pregnancy and neither partner should feel coerced.

H. Hepatitis C Programs

The hepatitis C virus (HCV) is the most common chronic blood-borne virus in the US and a major cause of liver disease. About four million Americans are estimated to be infected with HCV. In the US, 8,000 to 10,000 deaths per year are attributed to HCV-associated liver disease and these are expected to triple in the next 10 – 20 years.[13]

Some public health officials are referring to HCV as "the new HIV," due to their similarities. Most people, once infected with HIV or HCV remain CO-infected for life. HCV and HIV are also transmitted via the blood and follow a chronic course. For both diseases, there is still no definitive cure and no preventive vaccine. If someone is at risk for HCV, they are engaging in behaviors that put them at risk for HIV. It is estimated that 40 percent of HIV positive individuals in the US are co-infected with HCV, and many are unaware of it.[14] Co-infection rates

are highest among IDUs and persons with hemophilia.

However, there are distinct differences between the two infections. Compared with HIV, 15 – 25 percent of persons who acquire HCV infection appear to completely recover. HCV is more efficiently transmitted by needle stick than HIV, but it is less efficiently transmitted perinatally or sexually. HCV is not transmitted by breastfeeding.

Injecting drug use accounts for 60 percent of all new HCV infections in the US, through sharing of syringes directly, or possibly through sharing of drug preparation equipment.[13] Among IDUs, HCV is usually acquired rapidly after initiation of drug injection. As a result, prevalence of HCV among IDUs is very high, estimated at up to 90 percent. [15] HCV infection is acquired more rapidly than other viral infections, and rates of HCV infection among young IDUs

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[13] Centers for Disease Control and Prevention. Recommendations for prevention and control of hepatitis C virus (HCV) infection and HCV-related chronic disease. Morbidity and Mortality Weekly Report. 1998;47(RR19):1-39, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

[14] Tolmachoff R. When you have HIV and hepatitis C. Women Organized to Respond to Life-Threatening Diseases (WORLD). October 1998 Newsletter; p.3-5, as quoted in University of California at San Francisco, Center for AIDS

Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

[15] Alter MJ, Moyer LA. The importance of preventing hepatitis C virus infection among injection drug users in the United States. Journal of Acquired Immune Deficiency Syndromes. 1998;18:S6-S10, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

are four to 100 times higher than rates of HIV infection.[16][17]

Persons who received blood transfusions or an organ transplant before 1992 and hemophiliacs who received clotting factor concentrates produced before 1987 are also at risk for HCV. At moderate risk are those who have received chronic hemodialysis. Others at risk are infants born to infected mothers (which is higher if the mother is co-infected with HIV), healthcare workers exposed to needle sticks contaminated with HCV positive blood and persons with high-risk sexual practices. [13]

According to the 2002 NIH Consensus Development Conference Statement on the Management of Hepatitis C, "significant overlap exists for risk factors for HCV and HIV infections. Therefore, patients with documented HIV infection should be routinely screened for HCV infection. Patients with hepatitis C who are at risk for HIV should be offered testing for evidence of HIV infection with appropriate pretest and posttest counseling." In terms of which patients with hepatitis C should be treated, the recommendation in the statement is that "all patients with hepatitis C are potential candidates for antiviral therapy." The statement further clarifies that "many patients with chronic hepatitis C have been

ineligible for trials because of injection drug use, significant alcohol use, age, and a number of comorbid medical and neuropsychiatric conditions. Efforts should be made to increase the availability of the best current treatments to these patients"… "Treatment of active injection drug users should be considered on a case-by-case basis, and active injection drug use in and of itself not be used to exclude such patients from antiviral therapy." "A history of alcohol abuse is not a contraindication to therapy; however, continued alcohol use during therapy adversely affects response to treatment, and alcohol abstinence is strongly recommended before and during antiviral therapy." Support should include concurrent substance abuse treatment, careful physician monitoring, access to sterile syringes and education on safer injection and safer sexual practices to prevent reinfection.

HIV infection appears to affect the course of HCV infection, sometimes causing accelerated progression to liver disease and cirrhosis.[18][19] In addition, HCV-related liver disease may limit tolerance to HIV medications. HCV infection has been associated with increased morbidity and mortality in persons infected with HIV.[20]

[16] Garfein RS, Doherty MC, Monterroso ER, et al. Prevalence and incidence of hepatitis C virus infection among young adult injection drug users. Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology. 1998;18:S11-19, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

[17] Crofts N, Aitken CK, Kaldor JM. The force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not. Medical Journal of Australia. 1999;170:220-221, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

[18] Soto B, Sanchez-Quijano A, Rodrigo L, et al. Human immunodeficiency virus infection modifies the natural history of chronic parenterally-acquired hepatitis C with an unusually rapid progression to cirrhosis. Journal of Hepatology. 1997;26:1-5, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

[19] Pol S, Lamorthe B, Thi NT, et al. Retrospective analysis of the impact of HIV infection and alcohol use on chronic hepatitis C in a large cohort of drug users. Journal of Hepatology. 1998;28:945-50, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

[20] Piroth L, Duong M, Quantin C, et al. Does hepatitis C virus co-infection accelerate clinical and immunological evolution of HIV-infected

Co-infected patients should be considered for HCV treatment and treated on a case-by-case basis with close monitoring for potential adverse effects.

In addition to the four general goals regarding comprehensive linked services, the following are specific recommendations regarding Hepatitis C programming:

1. **The needs of people living with or at risk of infection with HCV should be studied and considered when pursuing changes in drug paraphernalia laws.**

   Because HCV is most easily transmitted through injection drug use, providing sterile equipment through needle exchange programs (NEPs) has been a major prevention effort. Although an earlier study in Tacoma, Washington, showed NEPs to be an effective HCV prevention intervention, a more recent study found that the Seattle NEP had no effect on HCV transmission.[21] This may be due to the fact that IDUs acquire HCV infection very rapidly after beginning injecting, that is, before they can benefit from NEPs.

2. **Prevention programs that seek to prevent the spread of HIV among IDUs should adjust their messages to include the prevention and spread of HCV.**

   HIV prevention programs, especially those targeted to IDUs, should directly incorporate or make seamless referrals to HCV prevention, counseling and testing services, as well as hepatitis A and B screening and/or vaccination for HCV-infected persons.

HCV is highly prevalent in IDUs and is more easily transmitted than HIV, which makes it difficult to prevent. It is possible that transmission occurs several ways: sharing needles and syringes; sharing auxiliary paraphernalia such as cookers, straws, swabs, tourniquets and cotton; sharing drug doses from a common syringe; accidental needle sticks; and receiving an injection from another person.[22] [23] In addition, while current bleaching guidelines for HIV state that 30 seconds of bleaching will kill HIV, it appears that significantly more time is needed to kill Hepatitis C.[24] Although not a substitute for the use of sterile needles and/or works or cessation of injection, bleach disinfection of syringes may help to prevent HCV infection among injection drug users.[25]

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[21] Hagan H, McGough JP, Thiede H, et al. Syringe exchange and risk of infection with hepatitis B and C viruses. American Journal of Epidemiology. 1999;149:201-213, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

[22] Hagan H, McGough JP, Thiede H, et al. Syringe exchange and risk of infection with hepatitis B and C viruses. American Journal of Epidemiology. 1999;149:201-213, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

[23] Kral AH, Bluthenthal RN, Erringer EA, et al. Risk factors among IDUs who give injections to or receive injections from other drug users. Addiction. 1999;94:675-683, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

[24] Harm Reduction Coalition, Harm Reduction Methods to Prevent Hepatitis A, B, and C, Harm Reduction Communication, Spring 98, available at:
http://hivinsite.ucsf.edu/topics/hepatitis/2098.3eb 3.html

[25] National AIDS Treatment Advocacy Project (NATAP) fact sheet, *Does Bleach Disinfection of Syringes Protect Against Hepatitis C Infection Among Young Adult Injection Drug Users?,* available at,

patients? AIDS. 1998;12: 381-811, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

3. **There is an urgent need for HCV programming for incarcerated populations, in light of the high prevalence of HCV among inmates.**

Rhode Island has developed a promising model in this regard. Inmates receive health education about HCV, and those who request screening or treatment are then subjected to nine criteria to see if they are eligible for treatment. These include inmates whose stay is long enough to allow for lengthy treatment, and inmates who have not used injection drugs or alcohol for the past 12 months. Using these criteria, HCV treatment is cost-effective for inmates.[26]

4. **Research to better understand the HCV epidemic that will also help focus HIV prevention programming.**

Understanding transmission and prevention of HCV will require greater knowledge of what's going on within the culture of those at risk, particularly among IDUs. More research needs to be done among teenagers and young adults to identify the factors that lead to IDU as well as how to promote safe injection practices among those who start. Research on sexual transmission should also be a priority.

5. **Testing for HCV will require significant new funding.**

The majority of persons infected with HCV do not know they are infected and have not yet been tested. Public health officials worry that health care systems are not currently prepared to handle the masses of Americans at risk for HCV who want to be tested or treated. Blood banks are sending notification of past exposure to transfusion recipients, but testing other high-risk groups will require huge public health expenditures. Federal, state, and local governments must make life-saving budgetary decisions.[27] The standard of care for all infectious disease prevention efforts should include testing, counseling, and access to treatment for HIV, STDs, and hepatitis B and C.

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www.natap.org/2002/Dec/121202_1.htm.

[26] Spaulding A, Green C, Davidson K, et al. Hepatitis C in state correctional facilities. Preventive Medicine. 1998;28:92-100, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

[27] Making sense of hepatitis C (editorial). Lancet. 1998;352:1485, as quoted in University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "Is Hepatitis C (HCV) Transmission Preventable?"

For more information on HIV and HCV co-infection or treatment guidelines, please refer to the following web sites: *www.cdc.gov/ncidod/diseases/hepatitis/index. htm*, *www.natap.org,*

www.hivandhepatitis.com, *www.cdphe.state.co.us/dc/Hepatitis/hep_home .asp*.

I.   Mental Health Services

In regard to mental health services and HIV prevention, two types of clients should be considered: clients with needs for general counseling and clients with severe mental illness who may or may not be domiciled in an institution.

Clients with needs for general counseling often discuss issues directly related to HIV: sexual expression, "coming out" as gay men, dealing with current or past sexual coercion, and so on. These are perfect opportunities to build healthy relationship skills, raise self-esteem, and deal with other underlying factors that increase a person's vulnerability to HIV. A client may also have direct questions about the degree of HIV risk their behavior poses, and their mental health counselor has both the trust and credibility to be effective HIV preventionists in these circumstances.

As described in Chapter Seven of the Comprehensive Plan, people with severe mental illness, whether domiciled in institutions or living in community settings, have clear needs for HIV prevention. Studies have shown high HIV prevalence as well as high rates of sexual behavior, with disproportionate levels of sexual abuse.

Although sexual behavior plays a part in the lives of many people with serious mental illnesses, the structure and policies of the psychiatric care delivery system have often been based on the premise that sexuality is not a significant issue for this group. Pregnancy rates, STD rates, and self-reported sexual behaviors among people with diagnosed severe mental illness dispute this premise. There is a substantial and

growing body of epidemiological evidence that people with severe mental illness, specifically those in large urban centers, have a high prevalence of HIV infection. Risk behaviors include unprotected sex with multiple partners, sex in exchange for drugs or money, men having unprotected anal sex with men, and sharing of injection drug use equipment. Factors that may contribute to these risk-taking behaviors include a high rate of substance use disorders, various social circumstances, and psychopathology.

Clinical and medical interviews are ideal settings for taking a patient's sexual history; however, few physicians or clinicians do so. A 1991 study of practitioners at a teaching hospital found that only 11 percent routinely asked patients about risk behaviors. A telephone survey of 1,350 adults determined that only 19 percent of these patients had ever had a discussion about AIDS with their physician. Furthermore, the patient initiated the majority of these. [28]

In addition to the four general goals regarding comprehensive linked services, the following are specific recommendations regarding mental health services:

1. **Prioritized access to subsidized mental health care should be made available in recognition of imminent HIV-related public health concerns.**

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[28] Goldfinger, S.M., Susser, E., Roche, B.A., and Berkman, A. "HIV, Homelessness, and Serious Mental Illness: Implications for Policy and Practice." Rockville, MD: Center for Mental Health Services, 1998. Available at *http://www.prainc.com/nrc/papers/hiv/hiv_toc. htm*

2. **HIV prevention providers need to build their capacity to recognize and deal with the underlying mental health issues of their clients.**

3. **Capacity building for mental health counselors should raise their knowledge and skills in dealing with issues directly or indirectly related to HIV.**

    Counselors should also recognize questions and circumstances that require outside resources in order to protect their client and their client's partners from HIV.

4. **It is imperative that health professionals, including those in mental health, incorporate a comprehensive sexual history in their assessment interviews.**

    Understanding that discrepancies may exist between sexual identity and behavior is an important aspect of the sexual history interview. For example, Susser and his colleagues (1995) report that individuals who engage in same-sex sexual activity may not identify themselves as homosexual or even bisexual.[29]

5. **In serving the HIV prevention needs of the severely mentally ill, providers may need to adapt prevention materials and models. [28]**

    a) Information should be presented clearly, using simple language and straightforward descriptions.

    b) Repetition of material is essential, given the frequent attention deficit and cognitive processing disorders in this population.

    c. Approaches should address the social and physical skills necessary for safe sex practices through role-playing and participation in physical activities, such as putting a condom on an inanimate object.

    d) The attitude of staff must be nonjudgmental and accepting of a wide variety of sexual practices, including abstinence and same-sex exchanges.

    e) Programs must be sensitive to the cultural, linguistic, and personal needs and situations of the target audience.

    f) Participation should be encouraged; however, it can be expected that some participants may not be willing or able to stay for entire sessions.

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[29] Susser E, Valencia E, Miller M, Meyer Bahlburg H, Tsai W, Conover S. 1995. Sexual behaviors of homeless mentally ill men at risk for HIV. Am J Psychiatry, 152(4):583-7.

J. Short- and Long-Term Correctional Systems

Prisons and jails are critically important battlegrounds in the fight against HIV/HCV infection, and prevention programs must emphasize risk behaviors that occur while people are incarcerated and those that are likely to be factors once people are released. Nationally, inmates in prisons and jails have disproportionately high rates of HIV infection and other STDs, hepatitis, and other health problems. Histories of risk behavior among women and people under 25 who become incarcerated indicate that particularly vigorous HIV prevention efforts should be mounted in facilities for these groups. Whenever possible, prevention efforts should be tailored for African American and Latino inmates, for those with histories of prostitution, for those involved in injection drug use, and for those with other substance abuse histories. They should also be tailored according to the length of incarceration. Prevention efforts should be especially extensive for people who are within a few months of being released, emphasizing the behavioral skills necessary to adopt and maintain safer behaviors.

Currently there are several barriers to implementing effective corrections-based prevention programs that must be addressed. These include, but are not limited to:

- **Access.** There is an incredible amount of bureaucracy involved in the penal system, as well as many types of programs and activities competing for time and space. It is often critical to reach the person at the top of the system since their buy-in is key or look for ways to coordinate between programs.

- **Surroundings.** Often the settings are not conducive to doing good prevention work since the space can be extremely large, loud, and distracting. Lobbying for appropriate surroundings is often necessary.

- **Retention.** Due to the transient nature of the inmates, especially in jail and community corrections settings, health educators often do not have the same people for the full duration of an intervention, making it difficult to build on past lessons and insure all the material is covered for all participants.

- **Education/developmental levels.** A wide range of educational, literacy, and ability levels exist among inmates, making it difficult to have appropriate and engaging conversation for all involved.

- **Beliefs and attitudes**. A wide range of beliefs and attitudes exist among those involved in the penal system, both among management and those who are incarcerated. Depending on the setting, men may feel especially constrained to discuss behavioral issues in an open and constructive way when other inmates are present.[30]

Mandatory sentencing for drug offenses has changed the composition of correctional institutions, as a higher proportion of inmates are in on drug-related charges. Therefore HIV prevention programs in correctional facilities must deal with drug dependency issues. During incarceration an inmate may accrue risk from sharing needles and/or other materials used in the injection process, and, given the more compromised accessibility of such materials in such a setting, the incidence of sharing is likely to be elevated. Sexual risk associated with drug dependency (including exchanging sex for drugs or drug-related sexual violence) is also likely to be high in a setting where prevention materials (e.g., condoms) are virtually unavailable. Once people are released from prison, the barriers

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[30] Challenges of HIV Prevention Targeting Incarcerated Populations, NASTAD HIV Prevention Community Planning Bulletin (Jan. '98)

to prevention associated with incarceration may no longer play a role. However, the strong connections between substance abuse and HIV risk continue to be profound and may take on a new character as people react to freedom and/or face the pressures of getting by in the world outside prison walls. Therefore, linking HIV prevention efforts with substance abuse treatment programs is one way to effectively address the interrelationship between drug abuse and HIV both in and outside of the incarcerated setting. Facilitating uninterrupted treatment for people as they are released from prison via formally established structural linkages with non-prison based facilities can further HIV prevention efforts and likely lower recidivism rates as well. Also, for people on methadone maintenance who are arrested and housed for a relatively short time in city or county jails, it is critical that the continuation of their treatment be facilitated if the system is to insure that such people do not resume drug use, and possibly the sharing of injection equipment, upon their release. [31]

Similarly, other aspects of the broader context of factors influencing incarceration, such as poverty, racism, and mental illness, also have implications for HIV prevention. To assure the effectiveness of prevention programs, the roles of such factors should be addressed. Also, the roles of other factors such as prostitution, limited life options, and previous trauma must be better understood, and program content should be adapted accordingly. Such factors also underscore the need for linkages between the corrections system, comprehensive linked services, and safety net services, as described in this Chapter. Services that maybe required to support HIV prevention

interventions with released prisoners could include prevention case management, individual health education, support groups, and other group level interventions. [31]

However, within the correctional system, collaborative action is hampered by the fragmentation of Federal, State, and local jurisdictions, necessitating further cooperative planning which assures consistency and lack of interruption of services. Furthermore, cooperative planning across systems has typically been impeded by a tangle of ethical questions related to the conflicts between individual and collective rights, as well as the competing ideologies and priorities of public health and public safety officials. In order for those concerned to move toward consensus, empirical evidence of the safety and efficacy of contested prevention strategies is needed. In some cases, legislative mandates must be created or removed to allow such innovative interventions to be implemented and evaluated.[31]

In addition to HIV/AIDS, other sexually transmitted diseases, HCV, and tuberculosis menace the health of prisoners and, in turn, the public health. Effectively addressing these challenges presents further opportunities to improve the lives of prisoners and their families and partners, lower the rates of transmission of HIV, and guard the safety of the general public. Bridging barriers to coordinated actions between systems can have a significant impact in these areas as well. [31]

In addition to the four general goals regarding comprehensive linked services (see section B, above), the following are specific recommendations regarding HIV prevention within the corrections system.

1. **Inmates should have access to free condoms and other HIV risk reduction materials.**

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[31] Polonsky, Sara; Kerr, Sandra; Harris, Benita; Gaiter, Juarlyn; and others. HIV prevention in prisons and jails: obstacles and opportunities. Public Health Reports v109, n5 (Sept-Oct,1994):615, available at *http://www.caps.ucsf.edu/toolbox/SCIENCEpriso nX.html.*

2. **HIV prevention programs should begin as early as possible for those at increased risk when a they become involved with the criminal justice system, and should be sustained over an extended period of time including post-release services, whenever possible.**

3. **A variety of prevention interventions should be available to inmates and should be tailored to the person's needs, circumstances, the setting, and the length of incarceration.**

   Intervention types should include one-on-one education and counseling and small group risk reduction efforts. Large group educational sessions are not recommended due to their lack of effectiveness in lowering risk.

4. **HIV prevention programs should make use of peer educators whenever feasible, because people tend to be more receptive to those with similar histories and past experiences. Peer-led programs provide significant benefits to peer educators themselves in terms of empowerment, self-esteem and positive contributions to society.**

5. **Access to HIV care in municipal, county, and state incarceration settings are required under the Colorado state constitution and meets a critical public health need when provided. However, many local and county jails do not have the budgets to accommodate HIV care, therefore ongoing, uninterrupted care and treatment frequently are not provided in those incarceration settings. Appropriate advocacy and financial systems need to be in place to address these gaps and barriers in cooperation with incarceration facilities.**

   Gaps in treatment are directly linked to the development of multi-drug resistant strains of the virus and must be avoided as inmates are transitioning between systems and facilities, and when being released.

6. **Prevention providers should present consistent and relevant information in a sincere and non-judgmental manner, appropriately and realistically addressing risks that occur both while incarcerated and after release.**

7. **Transition planning is critical and must involve uninterrupted care, prevention services, and materials for those who are HIV infected before and after release.**

   Prevention case management may be particularly important during this transitional period. Those needing drug treatment, mental health, or other comprehensive linked services must also be immediately linked to the necessary organizations upon release, regardless of their serostatus. Safer sex information and resources should be made available at discharge to all inmates. Inmates should also be made aware of, and linked to, when necessary, other prevention resources available in the areas they intend to live after release. Inmates should also be offered HIV counseling and testing upon release.

8. **Continue to support the current methadone maintenance programs recently provided in the Denver area jails.**

   Jail-based methadone maintenance has shown positive results among participants, including lowered rates of drug use and criminality after release.[32]

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[32] Magura S, Rosenblum A, Lewis C, Joseph H. The effectiveness of in-jail methadone maintenance, *Journal of Drug Issues* 1993; 23 (1): 75 - 99.

Statistics on persons incarcerated in the Colorado Department of Corrections were downloaded from the DOC website at *http://www.doc.state.co.us/Statistics.htm*

Statistics regarding county incarceration rates were downloaded from the web sites of the respective counties.

K. Faith-based Services[33]

Some within the religious community, especially AIDS ministries, have been involved in AIDS prevention on one level or another since the beginning of the epidemic. At the core of the vast majority of religions in America is a call to compassion, a call to care for the sick, seek justice and reach out to the neighbor in need, that "golden rule" echoed in the Baha'i, Buddhist, Christian, Hindu, Muslim, Jain, Jewish, Sikh and Zoroastrian traditions, which reminds the follower to "love one each other as you would be loved."[33]

When faced with the devastation of the AIDS epidemic, faced with individuals struck by a relentless virus, many religious institutions and persons of faith contributed an abundance of compassion, service, leadership and even dollars. The ethic of compassion within our traditions, after all, seems to be a collective ethic, a way in which the body of believers pulls together under an ethic of love for the common good of all. The issue of AIDS prevention, however, has to do with some very difficult issues for the religious community in this country.

While the faith community generally supports the response of compassion where care for the person with AIDS is concerned, the faith community ethic surrounding sexuality, specifically sexual behavior, is quite another matter. For the faith community, it is much more difficult, if not impossible, to get any kind of consensus around safer sex education or the promotion of condom use or even the distribution of HIV prevention materials. From the call to compassion, to care, found deep within the religious community view of things, a dramatic philosophical and political shift occurs – for the call to prevention raises that extremely personal ethic where sex is concerned. (It is interesting to note that the term morality is now almost exclusively used only in the context of sexual behavior. When people say "but this is a moral issue" they almost always are referring to something involving sex and its expression.)

The following are specific recommendations regarding faith-based services:

1. Training for faith communities should build capacity to provide accurate, effective prevention services while sensitively addressing their unique needs and concerns.

2. Faith communities have historically fulfilled a critical leadership role in communities of color. Such leadership could potentially meet a critical need in HIV prevention.

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[33] The text for this section was excerpted from an article by Rev. Kenneth T. South, Executive Director AIDS National Interfaith Network from the AIDS National Interfaith Network Newsletter, March/April 1995.

3. Faith communities are not monolithic in regard to HIV prevention issues. There are significant differences between different faiths, among denominations, and even among individual churches within denominations.

L. Safety Net Services

1.   Homelessness

Few empirical data exist on the prevalence of HIV infection among homeless people, who are often beyond the reach of the public health system. However, it is estimated that between one-third and one-half of people with AIDS are either homeless or at imminent risk of homelessness and that, conversely, approximately 15 percent of homeless Americans are infected with HIV.[34]

We can learn a lot about HIV prevention for homeless populations by looking at prevention and treatment of tuberculosis (TB) in this population. To successfully treat TB, people need to be housed, fed, and ensured access to clinical care. More attention and funding have been given to TB among homeless people in the last decade because of the risk of infection spreading to the general population (due to airborne transmission). HIV prevention deserves equal dedication and support.

Nontraditional programs are needed that engage homeless populations at every place they access basic services, such as soup kitchens, shelters, hotels, and clinics. Staff who work in these settings should be trained in HIV prevention. Group interventions that have worked in certain settings need to be disseminated and replicated in various institutions. Prevention services must have realistic expectations for change, and must give homeless people concrete goals that they can accomplish.

A comprehensive HIV prevention strategy uses a variety of elements to protect as many people at risk for HIV as possible. As one of the most vulnerable populations in our society, the homeless need support, respect, protection and continued prevention efforts.[35]

Behavior change programs may need to be significantly altered for use with homeless people. Life in shelters and on the streets rarely affords privacy, and sexual interaction is often furtive and of short duration. In addition, much of the sex in homeless settings is predicated on the exchange of cigarettes, money, or drugs for sexual favors. Traditional approaches that focus primarily on "getting to know one's partner," taking a sexual history prior to engagement, or other such recommendations are frequently neither appropriate nor useful with this group.

2.   Transportation

Some people who face very high levels of HIV risk – the risk of both acquiring and transmitting HIV – have little or no access to affordable transportation. In many rural areas, public transportation (including taxi service) is simply unavailable; even if

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[34] Summers TA. 1993. Testimony on AIDS Housing, Subcommittee on Housing and Community Development of the Banking, Finance and Urban Affairs of the US House of Representatives, as quoted in Goldfinger, S.M., Susser, E., Roche, B.A., and Berkman, A. "HIV, Homelessness, and Serious Mental Illness: Implications for Policy and Practice." Rockville, MD: Center for Mental Health Services, 1998, available at
http://www.prainc.com/nrc/papers/hiv/hiv_toc.ht m.

[35] University of California at San Francisco, Center for AIDS Prevention Studies Fact Sheet, "What Are Homeless People's HIV Prevention Needs?"

clients have access to automobiles in such areas, their HIV-related conditions or substance use history may pose a significant barrier. This lack of access may contribute to the circumstances associated with their risk. For instance, people living in poverty have been shown to be disproportionately affected by many health problems, including HIV. People without transportation often find it difficult to locate and keep a job, and this contributes to their remaining in poverty.

Providers of HIV prevention services and linked comprehensive services may underestimate the importance of transportation issues in the lives of their clients. It is helpful to remember that current and potential clients of these services are at various stages on the "Readiness to Change" Spectrum, and transportation has different impact at different stages. Some clients (or potential clients) are at the precontemplative state, with no perception that they might be at risk for the virus. Others are at the contemplative stage, willing to at least acknowledge risk and consider change in the long range. Clients at the ready-to-change stage have short-range intentions to change, if the perceived advantages outweigh the perceived costs. Clients at the action stage will attempt to change immediately, again if the advantages outweigh costs. Finally, clients at the maintenance stage need long-term support for long-term consistency in practicing their new behaviors. Rethinking these stages in terms of transportation, clients at the precontemplative stage will not travel any distance to receive prevention services. Such services must be instantly accessible, or at least travel to them as needed, if HIV is to become more significant for them. At the contemplative stage, lack of transportation will be used as an excuse for placing behavior change in the far distant, perhaps never-to-arrive, future. Clients at the ready-to-change stage might be willing to travel a short distance, but if the transportation costs and inconvenience are too much, they will postpone the change.

Clients who have poor access to transportation will have more difficulties accessing HIV prevention services that support long term changes in their lives.

3.   Employment
As mentioned previously, people living in poverty have been shown to be disproportionately affected by many health problems, including HIV. If a person is not earning a livable wage, HIV is more likely to be less of a priority than paying the rent, buying food, and otherwise taking care of basic needs. If she or he must also earn enough to support dependents, HIV will tend to be even lower priority.

People who lack abilities and skills necessary for employment may choose to earn money in ways that pose an imminent HIV risk: commercial sex work and involvement in the drug trade. People in these straits have fewer choices when it comes to extricating themselves from risky living circumstances. If they are dependent on a wage earner, but unemployed themselves, they may feel that they have no choice but to tolerate abuse, including coerced sexual and needle sharing. Job training and placement can open a variety of new options, which will make avoidance of HIV risk possible for them.

4.   Basic social services
The current and potential clients of our HIV prevention system may also need assistance in accessing basic social services, such as social security programs, emergency payments, subsidized long-term housing, and food banks.

Child protective services have proven especially problematic when providing HIV prevention services to women. Fear of losing custody of their children - whether real or perceived - leads women to delay HIV testing and avoid other HIV prevention services. The HIV prevention system must allay this fear when possible. It must also deal sensitively with situations where loss of

custody is possible (due to imminent threat to the child's health and welfare) but avoidable.

M. Summary – What Must Be Done

The extensive needs for linkages described in this chapter will require significant time, resources, and political will to be met. CDPHE, local health departments, nongovernmental HIV prevention service providers, and community activists must join together for this to have any chance of success.

As noted in Chapter Eleven of the Comprehensive Plan, all HIV interventions have a role to play in providing seamless access to linked comprehensive services and safety net services. However, it is likely that different interventions will employ different methodologies and must have different expectations. For instance, those who provide more intensive one-on-one interventions - such as counseling, testing and referral (CTR) prevention counseling and referral (PCRS); and prevention case management (PCM) - will probably gain a deeper understanding of a particular client's circumstances than a provider of one-time outreach or a short-term group level intervention. From this understanding, active, and more highly tailored referrals can be made more readily to one or more of the essential linked services and safety net services. The same can be said of the referral from essential linked services and safety net services. Those services that are more intensive and one-on-one, such as substance abuse or mental health treatment, are more likely to be active in making highly tailored referrals to one or more HIV interventions.

Providing access to linked comprehensive services and safety net services is already incorporated into the practice of some HIV interventions. For example, providers of HIV CTR and PCRS make use of a CDPHE-developed *Health Workbook*, which takes a holistic approach, emphasizing that taking care of oneself includes the entire being - social, psychological, spiritual, sexual, and physical. The Workbook's referrals/support services list contains services by category, such as clinical trials/drug information, advocacy, insurance, medical services, mental health, nutrition, spiritual, case management, substance abuse, support groups, and community level interventions. Beyond this written source, some providers of HIV prevention (especially CTR, PCRS, and PCM) routinely make active referrals to family planning, substance abuse treatment, sexually transmitted diseases diagnosis and treatment, mental health care, behavioral support, general medical care, tuberculosis testing and treatment, CD4 screening and TB testing (as part of a complete medical evaluation), and clinical drug trials.

Building linkages will require a re-examination of laws and regulations regarding confidentiality. Narrow interpretations such laws and regulations may be borne out of well-intentioned commitment to absolute confidentiality, but this may sometimes act against the best interests and needs of people living with or at risk of HIV. A balance must be struck, producing flexibility where possible without eroding the trust so essential to providing both linked comprehensive services and HIV interventions.

Chapter Ten

Surveillance, Research, and Evaluation

A. Surveillance

1. Current HIV/AIDS Surveillance Activities at CDPHE

The Colorado Department of Public Health and Environment (CDPHE) Surveillance Program characterizes the HIV/AIDS epidemic in Colorado by collecting data about the epidemic and by analyzing and distributing aggregate results without personal identifiers to agencies and community groups, such as Coloradans Working Together: Preventing HIV/AIDS (CWT) and Ryan White programs, who advocate for and provide prevention and care services to affected communities.

The HIV Surveillance Program reviews reports of HIV positive tests, CD4+ counts of <500 mm^3 and HIV viral load reports from laboratories and, through medical record review and contact with care providers, ascertains patient clinical status and determines if they meet the CDC AIDS Surveillance Case Definition or if they are confirmed with HIV infection.

Active surveillance activities to identify cases are also conducted through comparisons with other data sources, such as death certificates, TB registry, and review of selected hospital discharge data.

Directed surveillance activities for African American and Latino communities are conducted through a contract with Denver Public Health. Through this contract CDPHE supports active AIDS and HIV surveillance activities at the Denver Department of Health and Hospitals which includes Denver Health Medical Center,

associated ambulatory care clinics, and the eight satellite Neighborhood Health Centers located in inner city neighborhoods with large African American and Latino populations. These facilities reported 337,006 patient visits in 2001. Of the total patient visits, 16 percent were African American (they comprise 11% of the Denver county population) and 59 percent were Latino(a) (they comprise 32% of the Denver county population).

Surveillance staff identifies cases of AIDS for whom there were no identified risks for acquiring HIV infection. The program also identifies cases of AIDS or HIV infection with unusual modes of transmission (i.e., unusual laboratory, clinical or transmission characteristics, including possible HIV transmission in health-care settings, among public safety workers, as well as cases of HIV-2 infection, cases with clinical evidence of HIV infection but negative HIV test results, and cases of suspected female-to-female transmission). These activities allow the prevention counseling and referral (PCRS) programs to conduct PCRS, identify previously undisclosed risks and determine other or emerging modes of transmission.

The Surveillance Program conducts look back investigations of transfusion-related AIDS cases and of seroconverted blood donors to identify people who may be HIV infected but who do not realize their risk or know if they might be infected. These individuals are offered counseling and testing, PCRS, and prevention case management as well.

All care providers of women with HIV infection are queried as to whether their patient is currently pregnant. Care providers of pregnant HIV infected women are asked the gestational age of the pregnancy and surveillance staff follow up in the appropriate time frame to determine the outcome of the pregnancy. The Surveillance Program notifies the PCRS Programs about the infected mothers, so they can assure that they receive information on how to prevent perinatal transmission and how and where to access care, prevention case management, and other community based and social services. Surveillance staff follows up with care providers to ascertain whether the infant has been diagnosed with HIV infection and to provide referrals to the National Institutes of Health (NIH) and the US Department of Health and Human Services (HRSA) funded pediatric HIV clinic at the Children's Hospital in Denver. Surveillance staff review medical records or contact the infant's care provider periodically to determine whether a diagnosis of HIV infection has been made and if necessary, the mother is contacted to determine if the infant has been tested for HIV infection.

Annually, the Surveillance Program compares the list of persons who are HIV infected and are provided with health insurance through the Ryan White CARE Act, which is administered at CDPHE; all but 2.7 percent (9/337) of the persons insured by the Ryan White CARE program had matching records in the surveillance program database (HARS). This comparison is done to evaluate completeness of reporting.

The Surveillance Program also conducts two specialized projects aimed at measuring the prevalence of HIV antiretroviral drug resistance in people who are newly diagnosed with HIV and estimating the incidence rate of HIV infection in Colorado.

These projects provide additional information to epidemiologists, prevention and care planners, and providers on the size, scope, and direction of the epidemic in persons newly diagnosed with HIV. This information can assist in designing interventions for underserved and emerging populations. Both the antiretroviral drug resistance surveillance and HIV incidence estimation project utilize the Serological Testing Algorithm for Recent HIV Sero-conversion (STARHS) methodology; also know as a detuned enzyme-linked immunosorbent assay (ELISA) test. The STARHS testing method, when conducted as a population-based measure, can indicate if the HIV infection is recent or longstanding. This will allow the Surveillance Program to estimate the HIV incidence rate in populations throughout Colorado. The Centers for Disease Control and Prevention (CDC) and the CDPHE will also be using the information gathered by the HIV incidence estimation project as an outcome evaluation tool for our HIV prevention programs. This evaluation process will allow HIV prevention planners to more effectively allocate funding to those groups that need it the most.

Through a contractual agreement with Denver Public Health, the surveillance of the HIV Testing Survey (HITS) was conducted in 1996 and in 1998 in nine jurisdictions across the US, including Denver. HITS sampled gay men in bars, heterosexual STD clinic clients, and injection drug users in street settings. The purpose was to assess testing behaviors and barriers to testing, particularly where it related to (name-based) HIV reporting in different jurisdictions. This information is useful for planning and targeting for intervention programs, and for evaluating the impact of name-based reporting and to improve surveillance system.

The Surveillance Program analyzes and disseminates HIV and AIDS surveillance data to groups conducting HIV prevention

and health service planning, promotes the use of HIV/AIDS surveillance data to groups conducting HIV prevention and health service planning and provides technical assistance to these groups. Each year, the Surveillance Program prepares and presents the HIV/AIDS Epidemiologic Profile to CWT. Data tables for CWT geographic planning regions and population groups are included for use in setting behavioral and population priorities. Epidemiological data are used to set targets for funding local providers via competitive request for proposal (RFP) and in setting statewide priorities. The program makes presentations to the Ryan-White (Titles I and II) care planning groups regarding the Epidemiologic Profile and provides technical assistance to increase understanding of the data and provide further data as requested by the group for planning purposes. Others working with HIV/AIDS (local health departments, infection control practitioners, providers, community-based organizations, media, and interested citizens) also use the Epidemiologic Profile of HIV and AIDS in Colorado. The Epi Profile includes an assessment of the most recent transmission patterns, trends by risk group, and an assessment of the future impact of HIV. See Chapter One of the Comprehensive Plan for a copy of the latest Epi Profile.

Health care planners and clinical researchers in Colorado, such as the University of Colorado Health Sciences Center also depend on the data collected by this program. These data help researchers and clinicians allocate resources and direct and evaluate activities.

The Surveillance Program maintains relationships with infection control practitioners, coroners, hospice organizations, health maintenance organizations, and physicians. They provide feedback to these groups in the form of aggregate data as appropriate. The program provides technical assistance and consultation to hospitals, laboratories, private physicians, hemophilia treatment centers, correctional facility infirmaries, drug treatment centers, infection control practitioners, local health departments, public safety workers, coroners, morticians, Indian Health Care Centers, and military facilities regarding HIV and AIDS reporting and relevant issues. The program also collaborates with the Colorado Medical Society and the Colorado Public Health Association to promote HIV surveillance and to provide information to these associations.

The Surveillance Program collaborates with CDC on the implementation and evaluation of HIV and AIDS surveillance activities, including attending meetings and workshops that address repetitive HIV/AIDS activities funded by CDC.

Surveillance Program staff makes presentations as requested, as part of mobilization and other community events. The program continues to collaborate with organizations that serve persons with or at increased risk for HIV, such as drug treatment, correctional facilities, and STD and family planning clinics by soliciting their input on types of HIV surveillance data needed to conduct care and prevention planning. The program will also collaborate with community-based organizations, especially those who serve communities of color, by making presentations at annual conferences and by providing HIV data as requested.

Local data dissemination is accomplished in a variety of ways. Each quarter both local and national AIDS/HIV surveillance reports are sent to approximately 350 agencies including local health departments, public health nursing services, community-based organizations, AIDS service organizations, counseling and testing contractors, infection control practitioners, and other miscellaneous groups and agencies. The quarterly report is also available on the

Internet at www.cdphe.state.co.us/dc/hivstdprogs.asp. Additionally, a variety of persons and groups frequently request data for special purposes including grant proposals, progress reports, program planning, and evaluation activities.

The Surveillance program conducts quality control assessment and evaluation. To evaluate the effectiveness of relationships with various professional groups, the number of AIDS/HIV cases reported by physicians, infection control practitioners and others, is monitored over time. Additionally, the number of case updates (reports of death or new opportunistic infections) is monitored and credited to the appropriate reporting source.

In 2005, Denver Public Health will begin gathering data for the National Behavioral Surveillance Project. The first year will assess behavioral and attitudinal data specific to the acquisition and transmission of HIV among injection drug users (IDUs). Subsequent years will also collect data on men who have sex with men (MSM) and heterosexuals at risk. This data will serve as a means of tracking behavioral trends across time and will be one means of evaluating prevention efforts.

2. Linkage of Surveillance Data to HIV Prevention Programming

The planning and other informational uses of surveillance data are described above. In regard to more direct usage of surveillance data in furtherance of HIV prevention goals, CDC's guidance says the following: "Whether and how states establish a link between individual case-patients reported to their HIV/AIDS surveillance programs and other health department programs and services for HIV prevention and treatment is within the purview of the states."

If one of the goals of the HIV prevention system is to reach people who may have no knowledge of their risk of HIV infection,

access to and use of surveillance data can be extremely important. It is helpful to remember that current and potential clients of these services are at various stages on the "Readiness to Change" Spectrum. Some clients (or potential clients) are at the precontemplative state, with no perception that they and their partners might be at risk for the virus. Others are at the contemplative stage, willing to at least acknowledge risk and consider change in the long range. Clients at the ready-to-change stage have short-range intentions to change, if the perceived advantages outweigh the perceived costs. Clients at the action stage will attempt to change immediately, again if the advantages outweigh costs. Finally, clients at the maintenance stage need long-term support for long-term consistency in practicing their new behaviors.

Some of the clients at the precontemplative stage have no idea that they have been, or are currently, placing themselves at high risk of HIV. Because they do not perceive their risk, they are unlikely to actively seek out more information about HIV, nor recognize the personal significance of public information they may encounter. They may, in fact, continue in this stage until they begin exhibiting symptoms of late-stage HIV disease.

Data and personnel exist at CDPHE to prevent this unacceptable outcome, and the availability of surveillance data allows this to occur most efficiently. Information gathered by surveillance staff on HIV and an AIDS case report is used to initiate follow up to provide HIV disease intervention. CDPHE, and its HIV PCRS contractors (currently Boulder and El Paso County departments of public health) use reports of HIV infection to initiate PCRS. Referrals to medical care, support groups, prevention case management, community-based organizations, as well as legal and social services, are provided to clients at the time of PCRS. Additionally, through the use of

surveillance information, CDPHE and the PCRS contractors initiate active follow up to identify those person with positive HIV tests who do not return for test results to ensure those individuals receive appropriate post test counseling.

If one or more of the partners of a precontemplative individual do test for HIV, and learn that they are infected, their name and locating information will be reported to CDPHE. As quickly as possible, this person will be offered PCRS and, if they accept, will be asked to identify their sexual and injection partners, some of whom may be "precontemplative" and therefore completely unaware of their level of risk. The PCRS staff offer HIV counseling and testing to people who might otherwise never have chosen to be tested; the positivity rates among these people has been consistently much higher than any other testing clients, indicating how essential this service has been for them. PCRS has also proven to be an important gateway to further prevention, early intervention, and other essential linked services (see linkages information in Chapter Nine).

Currently, CDPHE surveillance data are shared with local health departments to enhance their ability to deliver prevention case management and care services. Availability of surveillance data could also assist in the targeting, utilization, and effectiveness of the other HIV interventions in other settings. See "Enhancement Plans for the Future," below.

3. Necessary Safeguards for the Appropriate Use of HIV/AIDS Surveillance Data

In establishing linkages between HIV prevention programming and surveillance data, CDC makes the following recommendations, with which CWT concurs:

- Surveillance and prevention programs continue to offer anonymous testing;
- Testing be voluntary and with consent;
- Public and private providers refer positive persons to care, treatment, and prevention case management services; and that provider-based referrals be timely and effective;
- States consult with providers, prevention and care planning bodies, and public health professionals in developing policies and practices to create the linkages;
- Surveillance staff and other recipients of the surveillance data be subject to the same penalties for unauthorized disclosure;
- The effectiveness of the linkage should be periodically evaluated, including assurances that the public health objectives of the linkages are achieved without unnecessarily increasing security and confidentiality risks to surveillance data or decreasing the acceptability of surveillance programs to health care providers and affected communities; providers and affected communities, including CWT, participate with the health department in planning surveillance strategies, programs, and services.

Additionally, Colorado law impacts the protection and use of surveillance data. Colorado Revised Statutes (CRS) 25-4-1401 et seq. declare HIV to be a disease dangerous to the public health and provide for reporting of HIV, the confidentiality of HIV reports and records, the protection of records and staff from subpoena, the availability of anonymous testing, the use of public health orders and emergency procedures with due process for recalcitrants and penalties for failure to report (class two petty offense, with up to $300 fine), and for breach of confidentiality (misdemeanor and fine of $500 to $5,000, or imprisonment for six to 24 months, or both fine and imprisonment).

CDPHE has strong policies and procedures for maintaining confidentiality. The CDPHE STD/HIV Programs have written guidelines for prevention and consequences for loss of confidential STD and HIV related information. All STD/HIV Program staff provided training in the statutes and must also sign a lasting Confidentiality Agreement and a Computer Usage and Data Security Policy. The maintenance of confidentiality is a required standard in worker performance plans and is contained in the Code of Ethics for HIV Prevention Providers in Chapter Two of the Comprehensive Plan, *Definitions for HIV Prevention Interventions and Standards of Practice*. Staff is prohibited from copying data sets or files with client names onto laptop computers. Should an allegation of breach be made by anyone (e.g., client, coworker, supervisor, or other person), a thorough investigation must be carried out under the direction of the Disease Control and Environmental Epidemiology Division (DCEED) director and state epidemiologist and as described in the Confidentiality Agreement.

CDPHE additionally has very strong physical security of records (paper and electronic). The DCEED is located on a floor that has restricted access; only those with security key cards and DCEED-escorted visitors may enter. Records are kept in a locked registry that has a security system with immediate connection to the local police department. All computers and electronic databases require several levels of passwords. Entry into the CDPHE building after hours requires the use of a security key card and CDPHE keeps a computer and printed record of all such entries.

4. Enhancement Plans for the Future
- Evaluate the effectiveness of the linkage; including assurances that the public health objectives of the linkages are achieved without unnecessarily increasing security and confidentiality risks to surveillance data or decreasing the acceptability of surveillance programs to health care providers and affected communities;
- Measure the number of studies and prevention programs receiving data from the surveillance program.
- Expand the Epidemiologic Profile to include more behavioral surveillance data.
- Using locally obtained data on the practice of risk behaviors, STARHS testing, and other behavioral data, and with assistance from CDC, estimates HIV incidence and prevalence in Colorado (see research section, below).
- Research ways to make use of data to the benefit of clients without violating confidentiality or trust.

B. Research

To ensure that Colorado's HIV prevention system is efficiently targeting effective interventions, there is an ongoing need to perform, compile, and communicate research. Such research may be broken into three categories, with key research questions under each category: intervention effectiveness research, research on the HIV epidemic in Colorado, and research on HIV prevention programming.

In all cases, research must strictly adhere to the highest ethical standards. Research must never betray the trust of people affected by or infected with HIV.

1. **Intervention Effectiveness Research**
- What interventions have proven most effective in changing HIV risk behavior?
- How does intervention effectiveness vary in terms of race/ethnicity, disability status, and other diversity?

2. **Research on the HIV Epidemic in Colorado**
- How many persons in Colorado are infected with HIV?
- Of HIV infected persons in Colorado, what proportion are unaware of their serostatus?
- How many incident HIV infections will occur in Colorado in 2000?
- How do we estimate incidence data without reasonable estimates of the denominator?
- How would we implement a geographic incidence study?
- How valuable are rates per 100,000 with the data we currently have?
- What are the core behavioral surveillance data essential for understanding the HIV epidemic in Colorado?

3. **Research on HIV Prevention Programming**
- What are the demographic and risk behavior characteristics of people with recent infections?
- How do we most effectively identify persons with recent HIV infection and HIV infected persons who are unaware of their serostatus?
- What are the best estimates of the prevalence and incidence of HIV infection among men who have sex with men (MSM), male and female IDU, and at-risk heterosexuals? If such estimation requires data that are not currently available, what types of studies should be undertaken to obtain such data in the future?
- What are the best estimates of risk behaviors associated with HIV transmission?
- Which identifiable subpopulations within the MSM, IDU and at-risk heterosexual populations are most at risk of becoming infected with HIV and should be targeted with prevention interventions?
- How is the overall rate of HIV infection changing? How does this vary by race/ethnicity, age, and other characteristics (income level, neighborhoods of residence)?
- How can surveillance data/studies assist prevention programs in targeting and evaluating interventions?
- What data are needed to develop a comprehensive profile of the HIV epidemic in Colorado that would serve to accurately guide program activities?
- How can we better understand the life circumstances that have led to HIV infection?
- How do we make better use of data, in a scientific manner, as we set realistic service goals for a region?
- What are the special issues of those co-infected with HIV and Hepatitis C.

C. Evaluation

We are ethically mandated to implement HIV prevention programs that are effective. Therefore, CDPHE-funded HIV prevention agencies will be expected to perform some combination of formative, process, and outcome evaluation, because mere provision of services does not mean that services are effective. Evaluation provides the vehicle to

ensure that programs are adequately meeting the needs of the people they serve by identifying barriers and successful components of HIV prevention interventions.

Further, all grantees receiving CDC HIV Prevention funds, including CDPHE and its contractors, are now bound by CDC's Evaluation Requirements.

1. CDC's Evaluation Requirement and Five-Year Evaluation Plan

Federal, state, and local agencies involved in HIV prevention are recognizing the importance of evaluation for two primary purposes: 1) to determine the extent to which HIV prevention efforts have contributed to a reduction in HIV transmission; and 2) to be accountable to stakeholders by informing them of progress made in HIV prevention locally and nationally. In response to this recognition, CDC has identified the types of standardized evaluation data it needs to be accountable for its use of federal funds and to conduct systematic analysis of HIV prevention in order to improve policy and programs. The types of evaluation data needed (but not yet available at the national level) include: the types and quality of HIV prevention interventions provided, the characteristics of clients targeted and reached by interventions, and the effects of interventions on client behavior and HIV transmission.

These data needs guided the development of evaluation requirements in CDC's Announcement 04012, which sets forth seven evaluation activities that health departments receiving CDC funding for HIV prevention are expected to implement during a five-year period beginning in fiscal year 2004. All health departments receiving CDC funding must include an Evaluation Plan along with the 04012 announcement application.

Throughout the five-year period covered by the announcement, health departments are to report on evaluation activities conducted during the previous year in their annual CDC funding applications in order to contribute to a data system for use at the national level. Evaluation data are to be collected only on HIV prevention activities supported with CDC funds, not on all activities in a jurisdiction. Similarly, the requirement applies only to CDC's health department grantees and their contractors, not to community-based organization or other prevention providers receiving funds directly from CDC.

CDC will use the data provided by health departments to CDC for three purposes:
1. To identify ways to improve HIV prevention programs nationwide.
2. To report to federal, state and local stakeholders (including communities, health departments, local and national organizations, Congress, and the Office of Management and Budget) progress made through HIV prevention programs supported by CDC funds.
3. To improve national policies regarding HIV prevention.

2. Uses of Evaluation Data

CDC and CDPHE know that some providers have significant concerns about evaluation and the potential punitive implications of negative evaluation findings. In response to that concern, it is important to note that the purpose of evaluation data collection and analysis is to assess progress and improve HIV prevention activities. Thus, while evaluation may identify weaknesses in staffing or programming, the findings should be used to respond to and minimize potential problems rather than to allocate punishment. CDC's primary interest in the data will be in the aggregate for identification of national trends and issues, while CDPHE may analyze data for individual interventions and aggregate the data to improve HIV prevention activities across local jurisdictions. It is hoped that CDC's

Evaluation Requirements and CDPHE Evaluation Standards will: facilitate new evaluation activities and reporting, and open up communication about HIV prevention evaluation so that stakeholders will be more at-ease discussing the strengths and weaknesses of their efforts in order to improve HIV prevention and benefit from lessons learned.

To ensure that the components of HIV prevention are implemented with the highest quality and contribute effectively to reducing HIV transmission, each component should be evaluated and the evaluation findings should then be used for program and policy improvement, as well as assessment of local and national progress.

Details of CDPHE's Evaluation Plan are available in Attachment D "Colorado Department of Public Health and Environment, HIV Prevention Activities Evaluation Plan, 2004," (attachment to the 04012 grant application) available on the CWT web site, *www.cdphe.state.co.us/dc/cwt/*. CDPHE will revise the Evaluation Plan again as more information becomes available regarding the much anticipated CDC Program Evaluation and Monitoring System (PEMS). Currently estimates project that the PEMS program will be rolled out in January 2005.

Chapter Eleven

Referrals and Collaboration

## A.	Introduction – The Status of Referrals and Collaboration in Colorado

When an HIV prevention system is fully functional, people who are at risk of HIV infection receive the HIV prevention service best suited to their needs, with a minimum of barriers. Because people at risk are very diverse — both demographically and in terms of readiness to deal with HIV — an HIV prevention system must be multi-faceted and constantly adapting. When a client accesses such an HIV prevention system, the entire system is called into action to serve that client's needs, not just the resources of the agency that is the first point of contact.

In numerous regions and communities of Colorado, there are no ongoing HIV prevention services onsite, but people living in or visiting that area are clearly at risk for HIV infection. Some of these people may be unaware of their risk, lacking even basic HIV information. Others may be vaguely aware of their risk, but will make no further progress without urging from someone who is both trustworthy and supportive. There may also be people who are ready and eager to make changes, but need intensive support to be successful. All of these people will continue to be unserved —perhaps while practicing very risky behavior — until an HIV prevention system at least makes an inroad into their area.

In some regions of Colorado, there are ongoing, onsite HIV prevention services delivered by agencies that operate independently of each other, with a minimal referral system in place. Onsite services are in place at only a very small number of rural

communities, which is a concern for the rural and frontier communities. These agencies invest in marketing and perform outreach to solicit clients for their own services. When a client presents a need that a neighboring agency is better able to serve, a referral may or may not be made. A list of community-wide resources should be available and distributed to clients. There have been difficulties between providers in the past that led to competition for resources and threatened referrals. This situation has improved much in recent years with better collaborations, and while some may be delivering exemplary HIV prevention services in their own right, their community does not have a true HIV prevention system. No single agency can serve the full range of needs of every client, and when referrals are sporadic or inappropriate, client needs go unmet and scarce prevention resources are underutilized.

In some regions of Colorado, two or more agencies collaborate to serve the HIV prevention needs of a particular targeted group or community. The collaborations are often formalized through memoranda of understanding*, clearly outlining the expectations and responsibilities of the collaborators. When collaborations are fully operational, clients have access to "one stop shopping" for all the services of all the collaborating agencies. Within the limits of confidentiality protection, there is sharing of client information and coordination of services to meet the full range of client needs. Duplication of service is readily

identified and eliminated. The collaboration may also include providers of services that are not narrowly defined as HIV prevention but highly related, such as substance abuse treatment, mental health, or clinical care. Yet, as with referral systems, difficulties among providers in the past may threaten collaborations and they are subject to the stresses caused from scant resources. Ongoing, healthy, broad-based collaborations come closest to fulfilling the ideal of an HIV prevention system.

A statewide HIV prevention system must strategically invest resources to meet the basic needs of at-risk people who live in or visit urban, rural, and frontier regions listed above. Not every community is suited for a broad-based, multi-agency collaboration. However, at a minimum, communities should have access to factual HIV information, support for people who need on-the-spot encouragement to begin risk reduction, and the ability to connect people to services that are most likely to meet their needs without being unreasonably far away or otherwise inaccessible. Resources may not be available to create such services for every Colorado town or city, but this only

makes the system all the more necessary. The scarce resources we have must be very strategically placed for the people who need them the most with minimal waste through duplication or under-utilization.

* The Colorado Department of Public Health and Environment defines the purpose an memoranda of understanding as the following:

> "These memoranda of understanding must, at a minimum, establish the mutual understandings and expectations of those parties on the following issues: client confidentiality; protection of confidential client information, roles, responsibilities, and accountability; conflict resolution protocols among the collaborators; frequency and adequacy of interagency communications; and the consequences if one or more of the collaborators fail to meet their expected level of service or choose to withdraw from the collaborative project."

B. Standards for Referral and Collaboration

The following standards will help Colorado move toward a true statewide HIV prevention system:

1. HIV prevention service providers should be inventoried for each county, specifically stating the geographic availability and accessibility of services. This inventory should include primary prevention providers as well as providers of comprehensive linked services and safety net services. This inventory should be reviewed and updated annually, preferably by people who are personally acquainted with local areas, issues, and services. The local inventories should be consolidated into a statewide resource database and

should be made widely available to clients and service providers.

2. In regions with few or no onsite HIV prevention services, initial efforts should emphasize the following:
   a. Public information featuring factual HIV information and toll-free or on-line referral to the closest available HIV prevention services. Where no appropriate media outlet is available, other means (posters, brochures, flyers, etc.) should be strategically utilized;
   b. Targeted marketing of Colorado Department of Public Health and Environment (CDPHE) services (especially prevention counseling

and referral services [PCRS], prevention case management [PCM], and other services that will travel to client locations when necessary). Such marketing should be directed at locations where at-risk clients are most likely to be found, such as comprehensive linked services and safety net services;

c. Assessment of the extent to which residents are willing or prefer to travel to another region to receive HIV prevention services;

d. Targeted availability of condoms and other risk-reduction materials; and

e. Connection to community mobilization efforts in the region, if any exists.

3. HIV prevention providers who are funded through CDPHE HIV prevention funds are now required to report the extent to which they make referrals to other primary and secondary HIV service providers in their area. At a minimum, all clients should receive a listing of community-wide HIV prevention services. Ideally, client needs should be assessed and they should be matched with community providers who are best suited to meet their needs, including the ability to serve them in a culturally competent, proficient, and accessible manner. Barriers to referrals should be addressed through CDPHE's contract monitoring and capacity building services. Incentives should reward those providers who support a broad, systematic, two-way referral system.

4. HIV prevention providers who are funded through CDPHE HIV prevention funds are also required to have a formal collaboration with the STD/HIV Client Based Prevention Program of CDPHE to allow for a two-way referral system.

5. Where there are multiple agencies providing HIV prevention in a geographic area, program collaborations are expected. Outreach and marketing strategies for client recruitment should be designed to serve the full collaboration, not individual agencies. Through mapping and other techniques, collaborators should target efforts where they are most needed and eliminate overlap or duplication. Capacity building, mediation, and incentives should be available to reinforce effective collaboration, improve the capacity to provide services in a culturally competent/proficient manner, and overcome barriers to improved collaboration.

C. Composition of Collaborations

Collaborations should be composed of public health departments (state, county and local), community-based organizations (CBO), social and other welfare agencies, community leaders, representatives from academia, science and medicine, activists, religion, and concerned citizens. Other funders of HIV prevention or related services should be included as well (e.g., foundations, corporations, local and state government). These entities should be brought together, if they haven't already convened, under the aegis of Coloradans Working Together: Preventing HIV/AIDS (CWT), for the purpose of providing HIV prevention services in their respective communities.

D. Role of Colorado Department of Public Health and Environment (CDPHE) in Building and Sustaining Collaborations

CDPHE has multiple roles to play in terms of building and sustaining collaboration to serve the cause of improving HIV prevention:

1. CDPHE acts as a funding source for those who collaborate in providing HIV interventions and monitors the performance of each contracted provider and the performance of the collaboration as a whole;

2. CDPHE staff and funded capacity building contractors offer technical assistance, training, and consulting on an as needed basis to contractors and to their collaborators;

3. CDPHE provides HIV interventions directly to clients, and therefore has the same responsibility as other direct providers in being a good-faith collaborator; and

4. In providing direct services and capacity building, CDPHE strives to improve its competence/proficiency in regard to culture, disability, and other diversity.

These roles have been evolving in recent years. In the spirit of community planning, CDPHE will increasingly participate as an equal partner within the collaboration framework, both in the delivery of service to clients at risk of HIV and the delivery of capacity building. Perhaps the most important facet of CDPHE's role is acting as an advisor to collaborations, particularly with regard to strategy and evaluation planning, development and implementation.

Chapter Twelve

Capacity Building

A. Introduction

The purpose of this chapter is to define capacity building and set standards of practice for capacity builders. It is also meant to provide direction and guidance so that our capacity building efforts are coordinated, appropriately focused, and efficient in use of resources.

Capacity building is a planned, structured sequence of events that may include training, consulting, technical assistance, and mentoring activities. Capacity building increases skill levels most effectively when services are tailored to meet the specific needs of each customer, and when customers are provided with continuous support and are committed to the process of building their capacity.

The state of Colorado is very diverse. Geographically, we have very sparsely populated rural areas as well as densely populated urban areas. We also have a very diverse population in terms of other dimensions of difference: race/ethnicity, disability status, deafness, age, gender, substance use, socioeconomic status, sexual orientation, linguistics, and those who are migrant, seasonal or resort workers. An HIV prevention system to serve this diverse population must be adaptable to many settings.

The CDC defines capacity building in the 2005 Community Planning Guidance as, "Activities that strengthen the core competencies of an organization and contribute to its ability to develop and implement an effective HIV prevention intervention and sustain the infrastructure and resource base necessary to support and maintain the intervention."

B. Assessment and Re-assessment of Capacity Building

Capacity building should be an active process, beginning with an assessment of community, individual, or provider needs. Such assessment should be rigorous and systematic, matching content and delivery to need, and resulting in a capacity building plan. Particularly in undeveloped areas, a "case management" approach is highly advised, with Colorado Department of Public Health and Environment (CDPHE) staff being charged with constantly monitoring the status of the statewide HIV prevention system and directing capacity building resources accordingly.

Following service delivery, the impact of the capacity building should be re-assessed. This goes far beyond the written "did you like it" survey. The focus should be on outcomes. Did the capacity building service narrow the gap between actual outcomes and desired outcomes? Is there evidence of positive changes in knowledge, attitude, and skill levels, especially in areas where the HIV prevention system has been underdeveloped?

Finally, the assessment and re-assessment of capacity building should be used to evaluate those who deliver capacity building. Efforts

that do not produce results should be discontinued or redesigned by CDPHE.

C. Capacity Building Activities

Capacity building is a planned, structured sequence of events that may include:

- Training

Imparting specific information, building skills, and providing opportunities to see how that information and skills can be applied through a variety of techniques, materials, and experiences.

- Technical assistance

Helping an individual, group, organization, or community in problem solving a specific issue and/or concern. Technical assistance is short term.

- Consulting

Longer term services – which may include training, technical assistance, facilitation, and/or mediation – and which may focus on multiple issues in greater depth and/or broader scope.

- Mentoring

Peer-to-peer capacity building to promote networking and collaboration between or among agencies and/or individuals that builds expertise and knowledge.

CDPHE staff and contractors may provide these services. Those needing capacity building may also request funds to defray costs of attending capacity building events and/or to purchase capacity building or technical services unavailable from CDPHE and its contractors. Such funds should be made available to HIV prevention workers (employees or volunteers) for the purpose of initiating, improving, and sustaining effective HIV prevention services, through a variety of capacity building activities and strategies (see chart below).

D. General Characteristics of Effective Capacity Building

1. A capacity building provider must offer capacity building activities that develop skills and attitudes. Theory-based information must have a practical application and the application must be the principal component of the capacity building experience.

2. A capacity building provider must offer one-on-one technical assistance to all participants and provide one-on-one technical assistance, as needed.

3. A capacity building provider must be able to demonstrate awareness of the barriers to service for diverse populations, including racial and ethnic groups; persons with disabilities; persons with literacy/language issues; and other diverse populations. Providers must also be able to

devise and implement strategies to overcome these barriers.

4. A capacity building provider must develop and offer curricula, programs or sessions that are flexible and responsive to the specific capacity building needs of the individual participant. Provider must also assist each participant in adapting the concepts of the curriculum, program or session to their program, agency, targeted geographic area, and/or at-risk population where applicable.

5. A capacity building provider must utilize evaluation methodology and tools that demonstrate how levels of capacity have increased.

6. A capacity building provider must describe in what ways they collaborate with other organizations that deliver similar services, both quantitatively (how frequently) and qualitatively (to what extent). Provider must also commit to continually investigating, exploring and seeking to identify opportunities for further and future collaboration.

7. Capacity building that targets volunteers and others who are not paid to provide HIV prevention may be more accessible if it's conducted outside normal business hours (i.e., evenings or weekends).

E. Focus

Capacity building must constantly be focused on improving the delivery of HIV prevention services. To effectively do this, it is essential to target the most appropriate level (individual, organization, program). In some areas or communities, where there are no organizations or programs willing and/or capable of delivering HIV prevention, the most strategic investment of resources targets individuals (see section below, "Where the HIV Prevention System is Less Developed"). In other regions, resources should be invested in building the capacity of organizations and programs as well as individuals.

Whether delivered by individuals or organizations, HIV prevention interventions must be coupled with strong, sustainable business practices. Therefore, in addition to service delivery, capacity building must strengthen the ability to conduct day-to-day operations as well. Potential topics for promoting strong business practices might include, but are not limited to, the following:

- Planning, implementing, and evaluating successful HIV prevention interventions
- Strategic planning
- Legislative process
- Public relations and the media
- Professional and/or accepted standards of practices and procedures
- Business management including financial and personnel record management
- Conflict and grievance resolution
- Collaboration and networking
- Competence in regard to culture, disability, and other diversity
- Fundraising and grant writing
- Insurance and benefits
- Communication skills
- Recruiting, managing, training and retaining staff and volunteers
- Team building
- Information management and computer skills
- Improving the HIV knowledge of service providers.

F. Emphases, Targets, and Intended Beneficiaries of Capacity Building — Specific Considerations

To create and sustain a state wide HIV prevention system, a wide variety of capacity building activities and strategies will be necessary, tailored to local characteristics. It is helpful to imagine a spectrum of capacity building activities and needs, matched to a spectrum of different types of communities, from those with entirely undeveloped HIV prevention systems to communities with highly-developed HIV prevention systems.

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Less Developed		More Developed
No paid staff No organized volunteers Low AIDS Service Organization Presence Low Local Health Department Presence Low Other Agency Support Hostile Environment Low comfort with/access to high-risk populations		Paid staff, multiple providers Organized volunteers High AIDS Service Organization Presence High Local Health Department Presence High Support from Other Agencies Supportive Environment High involvement of/access to high-risk populations

1. Where the HIV Prevention System is Less Developed

Many Colorado communities - including some with high concentrations of population - more closely resemble the undeveloped end of this spectrum. The capacity building activities to support the development and implementation of a state wide HIV prevention system must therefore emphasize moving communities along this spectrum. As a result, the following guidelines should guide capacity building efforts:

a) In setting up an initial HIV prevention system for a community, one must consider local characteristics. In some communities, it is advisable to recruit an existing agency or set up a new agency to house the new programming. In other communities, it is advisable to begin with key individuals, who may or may not address HIV as part of their occupation, and who are often volunteers (at least initially). Such individuals might include activists; people living with or affected by HIV; leaders within affected communities; and the family, friends, and other supporters of people living with HIV. These different approaches require different capacity building strategies and activities.

b) It is important to remember the potential barriers posed by fiscal policies and practices. For instance, in a community

when the key individual is a volunteer who is infected with or affected by HIV and therefore living on a very limited income, expectations concerning matching funds and bearing costs up front (often with long-delayed reimbursement) pose a serious barrier.

c) In an area with a less developed HIV prevention system, those who build capacity should not assume even basic knowledge and appropriate attitudes concerning HIV and how it is transmitted. Capacity builders should assess the need to raise the level of basic knowledge and change attitude. This is usually best accomplished through an alignment with providers of public information, community mobilization and community level interventions.

d) Training alone should not be expected to launch and sustain an initial HIV prevention system. Follow up technical assistance and consulting are essential.

e) When an initial HIV prevention system relies heavily on volunteers and part time staff, capacity building activities are unlikely to accessed if they require significant travel, time commitment, and other costs. A full array of options should be offered, suited to local circumstances, which may include flexibility in times, location, and other arrangements.

f) In many communities, HIV prevention is done as an add-on to existing staff duties in an agency where HIV is seen as a secondary issue (including but not limited to schools, substance abuse treatment centers, or primary health care). In such cases, the HIV prevention activities most likely to be implemented will be simple and easy-to-implement.

g) With limited resources, it will be necessary to prioritize capacity building based on predetermined criteria, such as the magnitude of gaps identified in this Plan and readiness to make progress toward further development of HIV prevention. Such criteria should be developed by CDPHE in collaboration with CWT.

2. Community Mobilization

HIV community mobilization is meant to help communities where there is little or no HIV prevention happening.

Community mobilization is NOT meant to be an ongoing intervention. The funding for it should last for only a specific time, and then end. If a multi-year award is made, there will be a gradual reduction of funds until the end of the award

A "community" is broadly defined as any group of people who share a sense of identity. This may mean they are neighbors in the same area of the state, or it may mean they share something else (race, ethnicity, sexual orientation, etc.) In some cases, the sense of shared identity or belonging may not be obvious. In such cases, it will be necessary to identify and build on the sense of belonging in connection with the four components of community building listed below. A critical component of a community mobilization project is specifically defining the community intended to be mobilized.

Community mobilization efforts must be conducted in a culturally competent manner,

be linguistically appropriate, and be tailored to the community in terms of culture, gender, age, sexual orientation, and educational level, with accommodations made for disabled participants.

People who mobilize communities should be able to gather needed information, motivate, facilitate, and mentor people and groups. The community mobilizer must also be able to help a community figure out all the possible ways to achieve their goals and also help them choose among these difference possibilities.

Other health issues related to HIV that the community is concerned about (such as hepatitis C, STDs, substance abuse, etc.) could also be included in mobilization efforts.

There are four major parts of community mobilization, listed below. Although communities usually begin with networking and work their way through this list, they don't finish doing one part and then move to the next part. When community mobilization is fully in place, community people are working on all four parts. Ideally, a community makes progress in all four areas, but this can be impossible to do in just one year, especially when faced with a community that has difficulty dealing with the social and political problems associated with HIV.

a) Networking
Involves making connections among people. Community members living with or affected by HIV are very important members of this network. A network includes volunteers and/or paid staff who currently do HIV prevention activities in the targeted community and expands to people in related fields (such as substance abuse, family planning, social justice, etc.) The network may also include people outside the targeted community who might support local efforts. Building a sense of belonging to a community should be one of the

outcomes of making connections among people.

b) **Assessment**

Assessment involves "sizing up" how a community is currently responding to HIV-related issues. Through the HIV prevention network, people get a clearer picture about local resources, things that people are already doing in the community, and what is standing in the way when they try to doing a better job preventing HIV. The techniques of formative evaluation are often useful for community assessment. One of the key areas to be assessed should be how much people really feel that they are part of the community.

c) **Goal formation**

Involves moving forward, being realistic about what's possible, but also challenging people to do as much as they can. These goals should meet individual and group needs and problems, building on strengths while dealing with obvious gaps. They must be very clear about which approaches to preventing HIV seem most promising, who should be delivering them, where they should be available, and how many people should get the service(s) within a given time frame. The full network - particularly those members of target audiences directly impacted by HIV - must be meaningfully involved in coming up with these goals. One or more of these goals might be about building a stronger sense of belonging to the community.

d) **Pilot testing of interventions**

Through pilot testing, communities gain hands-on expertise in providing HIV prevention services, often with the assistance of training, technical assistance, or mentoring. Community members doing the pilot test may be either paid staff or volunteers. Good records should be kept in order to learn from failures, build on successes, and propose changes to better suit the community and populations targeted.

Through pilot testing, people in the community get new skills and find out more about what will work best to prevent HIV. Strategies to strengthen the basic sense of belonging to the community might also be piloted. Pilot tests should be evaluated, and the results of this evaluation should be used when applying for resources to implement ongoing interventions.

After these four stages of community mobilization that foster community empowerment and ownership, a community's HIV prevention system is generally ready to implement and evaluate HIV prevention interventions utilizing local resources and/or resources obtained from outside the community.

3. Capacity Building Addressing Agencies or Individuals Who Serve Communities of Color

Some communities have very high percentages of people of color, but the existing HIV prevention providers in these areas have limited access to these communities. In some cases, these communities are highly underserved and therefore would benefit from the seven recommendations listed above (for communities where HIV prevention is less developed).

As the HIV epidemic in Colorado increasingly affects communities of color, the HIV prevention system must make commensurate changes in the intensity, availability, and content of HIV prevention programming. The Comprehensive Plan has a goal that the client base of each area's HIV prevention system is expected, at a minimum, to match the demographics of the surrounding communities. In some cases, people of color percentages should exceed county demographics because HIV has disproportionately affected these populations and/or the census does not adequately reflect seasonal and migrant populations. In some cases, to achieve these

outcomes, the existing HIV prevention system will need to make dramatic changes in a very tight time frame.

Capacity building has a critical role to play in promoting improved HIV prevention services for people of color:

a) Existing HIV prevention service providers who may not have extensive experience serving communities of color will need capacity building to make progress toward cultural competence/proficiency.

b) Existing agencies who have access and credibility in communities of color, and who are willing to initiate and/or expand HIV prevention services, may need capacity building in regard to delivering effective HIV prevention interventions and improving competence/proficiency in regard to other diversity (such as disability, deafness, age, gender, substance use, socioeconomic status, sexual orientation, linguistics, disabilities, and geographic settings).

c) Strategic alliances between the agencies described in (1) and (2) above can be of great assistance to both types of providers. However, capacity to collaborate must be built (see section below, "Building the Capacity to Collaborate.") and must be sensitive to the power disparities that have complicated such alliances historically.

d) In Colorado, newly established HIV-specific community of color organizations have had intensive needs for ongoing, specifically tailored, and appropriate capacity building. The need to build basic organizational infrastructure has been especially acute. These new organizations could potentially fulfill a critical role in the changing epidemic; their organizational survival should be a priority for capacity building.

4.   Structural Interventions
The social and physical environment can support or constrain behaviors related to HIV/STD risks in communities. Increasingly, SPECIFIC CHARACTERISTICS of the social environment (e.g., social norms held by peers) and the physical environment (e.g., number and types of places for congregating) are being identified as factors associated with HIV risk behaviors (Cohen, Scribner, & Farley, 2000). For example, collective efficacy (the extent to which adults in a neighborhood share and enforce a common but implicit standard of neighborhood conduct) is a powerful predictor of neighborhood violence as well as other behaviors that may be relevant to HIV risk (Sampson, Raudenbush, & Earls, 1997). The code of the streets (where informal social norms are enforced in some contexts using subtle non-verbal and verbal cues) is another dimension that may be relevant to HIV-relevant risk behavior (Anderson, 1999). Similarly, the existence of public spaces (such as parks, abandoned properties) where behavior can occur unobserved by others or where alcohol IS AVAILABLE can encourage risky behaviors including those relevant to HIV transmission AND PREVENTION (Peirce, Frone, Russell, Cooper, & Mudar, 2000; Skjaeveland & Garling, 1997).

Structural interventions to address the social and physical environment must be supported by focused research. Such research should include five key objectives: (1) examine the settings in which HIV/STD risk behaviors take place and the extent to which their physical and social characteristics contribute to HIV risk behaviors; (2) identify through observational and descriptive studies potential ways in which physical and social contexts can be modified to reduce HIV/STD risk behaviors; (3) examine the social ecology of communities to understand the social and physical dynamics of social control affecting individual HIV-related risk behaviors and the processes leading to a change in societal norms; (4) develop preventive interventions to minimize adverse physical and social environmental

effects on HIV transmission and strengthen positive effects of such settings on HIV/STD-relevant risk behaviors; and (5) identify factors in the physical and social environment that promote or impede the effectiveness of existing HIV/STD behavioral preventive interventions.

Strategies that have proven effective in changing social and physical environments related to HIV include:

- Social marketing
- Education of legislators and other elected officials, resulting in a legal environment more conducive to disease prevention
- Community awareness-raising events
- Maximizing opportunities for public participation in decision making
- Alliances with nontraditional partners (such as public welfare advocates) who are similarly challenged by social and physical environments.

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5.   Building   the   Capacity   to Collaborate

This Comprehensive Plan encourages the creation of multi-agency, multi-county collaborations to serve communities at risk of HIV. Collaboration is defined as a series of formal and informal relationships between and among individuals and organizations designed to further common goals and objectives. For more information on collaboration, see Chapter Nine in this Comprehensive Plan.

For these collaborations to be successful, training, technical assistance, consulting, and other forms of capacity building will be essential. Some essential areas of capacity building will be:

a) Assistance in developing linked or collective program plans that transcend, but are consistent with, the goals and objectives of any one agency in the collaborative project.

b) Joint training and other skills-building activities for staff of the agencies involved in the project, tailored to the unique needs of the project

c) Assistance in the development of consistent, clear messages about HIV prevention that all the agencies in the collaborative project agree to support and deliver. This involves the development of a shared understanding and common language about HIV prevention for their community. The individual collaborators have access to the target audience at different points, for example, in clinics, in outreach settings, or in schools, and it is vital that all these different contact deliver consistent messages. All consumers of

the messages - the target audience, the broader community, and key stakeholders such as the media, political leaders, and others - should get a consistent message.

d) Development of formal and informal agreements among the partners in the collaborative project so that expectations are clear from the beginning. Such agreements should include: safeguarding client confidentiality; roles, responsibilities, and accountability; conflict resolution among the collaborators; frequency and adequacy of inter-agency communication; and what will happen if one or more collaborators fail to meet their expected level of service or choose to withdraw from the collaborative project.

e) Compiling, publishing, and updating a state wide HIV prevention service inventory to raise awareness of available resources and build collaborations. The updating process should be continual.

G. Certification in HIV Prevention

Toward the goal of building and maintaining a highly qualified HIV prevention workforce, the process of establishing an HIV/AIDS/STD Prevention Worker Certification Program is in the final phases of development.

Certification will:
- Contribute to the creation of a system for consistent standard of care.
- Contribute to a measurable improvement in the quality of care.
- Indicate current competence levels.
- Assist employers to identify qualified workers in a specialized area of practice.
- Assist organizations in ensuring that standard of care reflects the most current research.
  - Attest to the attitude, knowledge, and skill levels of the service provider.
  - Enhance HIV prevention work as a profession.

This program has been developed with a strong foundation in Standards-Based Educational Theory, which embraces active participation by the "learner" at every stage of learning, development, and assessment. The certification program has been established to maximize the success of the participant at every stage of participation. Because these assessments are standards-based, individuals will have the opportunity to be fully aware of what is being assessed prior to their participation.

- Certification may be obtained in the following tracks:
- HIV/STD Prevention Generalist I
- HIV/STD Prevention Generalist II
- Prevention Case Manager
- Counseling, Testing and Referral (CTR)
- CTR Technician
- Client Recruitment (Outreach) Specialist
- Group Level Specialist
- Community Specialist
- HIV Prevention Program Supervisor

These service providers are required to adhere to the HIV Prevention Standards of Practice developed by the community planning group, *Coloradans Working Together*. An individual may achieve certification in multiple tracks after meeting all requirements.

Certification will be attained and maintained through the following process:
1. Completion of course work or equivalent.
2. Submission of application for certification.
3. Review and preparation for testing.
4. Knowledge/Attitude assessment.
5. Skills demonstration.
6. Re-certification and certification renewal.

Completion of Course Work or Equivalent
Each candidate for certification must complete the required coursework for the desired certification track. The Technical Assistance and Training Program (TATP), STD/HIV Section of the CDPHE provides most of the required classes. All classes provided by TATP are free of charge. Information on regularly scheduled classes can also be obtained by calling the registration line at 303-692-2752. The coursework requirement may be satisfied through other options, if desired, such as through completion of similar coursework or by demonstrating existing knowledge through a written test.

The TATP, STD/HIV Section of the CDPHE can provide most of the required classes at other locations outside the Denver metro area. By special arrangement, any course can be held at an agency or in the community if there are at least 10 people who plan to attend and space can be provide. Call Deryk Standring of the TATP staff, at 303-692-2641, to make such arrangements. These workshops are also offered free of charge and all are open to anyone who wishes to attend. However, the TATP staff understands that there may be significant

barriers to putting together enough participants in some areas of the state. In such cases, course information can be delivered to small groups via alternative methods, including using local consultants or alternative technical assistance. In some cases, "train the trainer" programs have also been implemented in rural areas in order to improve access to CDPHE/TATP courses. Please contact the TATP staff if you would like to pursue any of these alternative methods, at 303-692-2641, or at, *dchivinfo@state.co.us*. Further information is available on the TATP web site, *www.cdphe.state.co.us/dc///TATP/Technical AssistanceandTrainingProgram.html*.

Submission of Application for Certification
Intention to participate in the certification program must be expressed through submission of a certification application. The desired certification track will be declared at the time of application. Applications will be accepted when determination of coursework requirements has been satisfied. Further information regarding next steps in the process will be made available to each approved applicant.

Review of Course Work and Preparation for Testing
Participant guidebooks distributed during each class are excellent resources for reviewing information covered by the course work. Additional guidebooks can be provided. Facilitated, participant-driven group review sessions might also be available. An application-based understanding of the most current edition of HIV Prevention Standards of Practice developed by the CWT is essential to successful completion of the certification process.

Knowledge/Attitude Assessment

Applicants will have an opportunity to demonstrate knowledge and attitude skill sets by participating in a written assessment. The next steps will be determined after receiving detailed feedback. Three to four hours should be allowed for the assessment. Times and locations will be well publicized early enough for planning and preparation.

In order to ensure validity and consistency of the written portion of the assessment, it will be offered only at the state health department at this time. For the first round of testing, one track will become available about once every three months. After that, testing will be conducted twice a year.

Skills demonstration

The skills demonstration will be presented through three videotaped practice sessions chosen from a pool of scenarios by the participant. Other options may be required or available. A committee of trained evaluators will review and independently score each demonstration. Only those participants who achieve overall "proficient" or "exemplary" status will receive certification at that time. Many opportunities to address performance gaps will be made available.

Re-certification and Certification Renewal

Once a certificate is obtained in a given track, a process of re-certification is needed to maintain the credibility of the certificate. Each certificate is valid for a period of two years from the date of issue. Prior to the expiration of the two years, coursework must be completed to renew the existing certificate. At some point, full certification renewal will be necessary. A course list of curricula necessary for certification renewal will be available.

This program has been established with direct input and participation from the community. The framework for the program requires ongoing feedback and input to maintain the credibility of all aspects of certification.

Chapter Thirteen

Evaluating the HIV Prevention Community Planning Process

Introduction

The long term goal of Colorado's community planning efforts is best expressed through CWT's mission statement: To improve the availability, accessibility, cultural appropriateness, and effectiveness of HIV prevention interventions through an open, candid, and participatory process where differences in background, perspective, and experience are valued and essential. More specifically, the planning process has made as its objective to institute and evaluate a sustainable community planning process which is participatory and collaborative in its decision making and which ensures parity, inclusion and representation.

The following table outlines the CWT objectives, the data sources for measuring each objective, who is responsible for each activity, and how often each activity is conducted.

Evaluating the HIV Prevention Community Planning Process			
CWT Objectives	**Data Sources**	**Who**	**When**
1. Foster the openness and participatory nature of the community planning process by recruiting, training, and sustaining a broadly representative core planning group (CPG) that utilizes a time-limited consensus model of decision-making.	➤ Presence of written policies or documentation of: • Member recruitment, nomination, and selection • Meeting attendance and procedures • Orientation procedures • Conflict resolution procedures • Input from non-CPG members • Facilitation of member participation • Member training ➤ Survey of CPG members' perspectives on the process	➤ CPG, CPG coordinator ➤ CPG coordinator will administer member survey, Research and Evaluation (R&E) staff will enter/analyze data and produce a written report	➤ Annually ➤ Annually

CWT Objectives	Data Sources	Who	When
2. Ensure that the CPG reflects the diversity of the epidemic in Colorado, including emerging populations, and that areas of expertise, as outlined in the Centers for Disease Control and Prevention (CDC) guidance, are included in the process.	➤ Process for ensuring parity, inclusion, and representation	➤ CPG, CPG coordinator	➤ Annually
	➤ Anonymous demographic survey to determine what groups/expertise are and are not represented (with member profile form)	➤ CPG coordinator, R&E staff	➤ Annually
	➤ Survey of CPG members' perspectives on representation and experts' involvement	➤ CPG coordinator, R&E staff	➤ Annually
3. Ensure that priority HIV prevention needs are determined based on an Epidemiologic Profile and a needs assessment (including community sources of information).	➤ Presence of written procedures for prioritizing needs	➤ CPG, CPG coordinator	➤ Annually
	➤ Procedure for reviewing unmet needs and justifying priority needs	➤ CPG, CPG coordinator	➤ Annually
	➤ Presence of epidemiological profile and needs assessment including: • Resource inventory • Client inventory • Gap Analysis	➤ CPG, CPG coordinator, CDPHE Surveillance and R&E staff	➤ Annually
	➤ Use of Epidemiologic Profile and needs assessment for identifying interventions and populations	➤ CPG, CPG coordinator, CDPHE planning and R&E staff	➤ Annually
	➤ CPG member survey on perspectives on the quality and use of Epidemiologic Profile and needs assessment and on prioritization of needs	➤ CPG coordinator, R&E staff	➤ Annually

CWT Objectives	Data Sources	Who	When
4. In the prioritization of interventions, ensure that explicit consideration is given to priority needs, outcome effectiveness, cost effectiveness, theory (from social and behavioral science), and community norms and values.	➢ Procedure for selecting interventions	➢ CPG, CPG coordinator	➢ Annually
	➢ Procedure for prioritizing interventions	➢ CPG, CPG coordinator, R&E staff	➢ Annually
	➢ Survey of CPGs' perspectives on selection and prioritization of interventions	➢ CPG coordinator, R&E staff	➢ Annually
	➢ Intervention effectiveness report	➢ R&E staff	➢ Annually
	➢ Cost effectiveness report	➢ CPG coordinator	➢ Annually
	➢ Plan and Application Comparison Committee (PACC) findings	➢ PACC	➢ Annually
5. Strive to foster strong, logical linkages between the community planning process, plans, applications for funding, and allocation of CDC HIV prevention resources.	➢ PACC findings	➢ PACC	➢ Annually
	➢ Extent to which the CDC funding application reflects the plan	➢ CPG, R&E staff	➢ Annually
	➢ Extent to which request for proposals (RFPs), contracts, and funded programs correspond to plan	➢ Steering Committee, R&E staff	➢ Annually
	➢ Survey of CPG members' perspectives on extent of linkages between the process, plan, application, and funding	➢ CPG coordinator, R&E staff	➢ Annually

During the process of developing the 2007 HIV Prevention Grant Application (Program Announcement 04012) in the summer of 2006, the CWT Steering and Plan and Application Committee reviewed the results of the annual Community Planning Membership Survey that was completed by CWT members in June of 2006. The information provided by participants in Part Two of the survey provided CWT with a another valuable resource for evaluating CWT's planning process in order to improve CWT's parity, inclusion, and representation (PIR). CWT holds as its highest priority the perspectives, decisions, and feed back of the CPG and incorporates them into the Colorado Comprehensive Plan for HIV Prevention and the overall community planning process.

The survey, developed by the CDC, is intended to be a tool to help community groups evaluate their planning process and their ability to meet the CDC's three major goals for HIV Prevention Community Planning. Those three major CDC goals for HIV Prevention Community Planning are:

Goal One — Community planning supports broad-based community participation in HIV prevention planning.

Goal Two – Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

Goal Three — Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

The following are the aggregate results of the 2006 Community Planning Membership Survey, Part Two. The survey results were also compared to results from 2003-2005 to further help identify changes over the last three years as well as areas for improvement of PIR based on the analysis.

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Part II – Community Planning Membership Report
Completed by the CPG in June, 2006
(31 CWT members completed Part II of the Survey, an 84% response rate)

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Goal One — Community planning supports broad-based community participation in HIV prevention planning.

Objective A			
Objective A: Implement an open recruitment process (outreach, nominations and selection for CPG membership.			
Column A	Column B	Column C	Column D
Total number of "Agree" Responses to Items in Obj. A"	Total number of "Disagree" Responses to Items in Obj. A"	Total number of "Agree" and "Disagree" Responses to Items in Obj. A"	Percentage Agreement for Items in "Obj. A"
157	4	161	97.5%

Total number of "Don't Know" Responses for Objective A: 56 (25.8% of total)

Objective A Community Member Comments:
N/A

The percentage agreement for Objective A decreased slightly compared to 2005 (decrease of 2.5%), though is still higher than the 2003 and 2004 results. It is important to note that there were a high percentage of "don't know" responses, which is attributed to the fact that several new members have joined within the last three months. While these objective items are addressed in the CPG orientation, often new members do not fully understand the recruitment process.

Objective B			
Objective B: Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.			
Column A	Column B	Column C	Column D
Total number of "Agree" Responses to Items in Obj. B"	Total number of "Disagree" Responses to Items in Obj. B"	Total number of "Agree" and "Disagree" Responses to Items in Obj. B"	Percentage Agreement for Items in "Obj. B"
256	10	266	96.2%

Total number of "Don't Know" Responses for Objective B: 44 (14.2% of total)

Objective B Community Member Comments:
- Regarding B10 [expert perspective from correctional facilities], we should work on this.

Compared to 2005, there was a 4.5% increase in overall number of agreeable responses. This can be attributed to the work that the Membership Committee has done to recruit new members to assure that the CPG membership is representative of the diversity of populations most at risk. The largest percentage of disagreeable responses was related to perspectives available from correctional facilities. It has been an ongoing challenge to have expert perspectives available on issues related to the community planning process, and will continue to be an area we work on.

Objective C			
Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.			
Column A	Column B	Column C	Column D
Total number of "Agree" Responses to Items in Obj. C"	Total number of "Disagree" Responses to Items in Obj. C"	Total number of "Agree" and "Disagree" Responses to Items in Obj. C"	Percentage Agreement for Items in "Obj. C"
148	6	154	96.1%

Total number of "Don't Know" Responses for Objective C: 32 (17.2% of total)

Objective C Community Member Comments:
- Regarding C6 [meetings allow time for public comment], the time for public comment should be stated on the agenda.
- I am new to the CPG and have attended two meetings. I am not sure if all of the above is available. If so, I would like someone to get in touch with me.

The number of agreeable responses to this objective has remained relatively stable from 2005 to 2006 (a percentage decrease of 0.8%). While all of the community planning meetings are open to the public, and time is given at the end of each meeting for participants to share any items they wish to, there is not time specifically stated on the agenda for "public comment." We will discuss adding this to future agendas.

Goal Two – Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

Objective D			
Objective D: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.			
Column A	Column B	Column C	Column D
Total number of "Agree" Responses to Items in Obj. D"	Total number of "Disagree" Responses to Items in Obj. D"	Total number of "Agree" and "Disagree" Responses to Items in Obj. D"	Percentage Agreement for Items in "Obj. D"
355	5	360	98.6%

Total number of "Don't Know" Responses for Objective D: 105 (22.6% of total)

Objective D Community Member Comments:
- This CPG is also open to other sources of data not necessarily related to HIV that members may find helpful in making decisions (i.e. poverty, pregnancy rates).
- CDPHE staff was very dispassionate and un-bias in presenting this [community services assessment] information. They were also open to criticism.

The responses to this objective increased compared to 2005 results (increase of 1.2%). There was a large number of "don't know" responses, which again can be attributed to addition of several new CPG members. Additionally, the CPG commonly terms the community services assessment a "needs assessment" which might also help explain the disagree and "don't know" statements.

Objective E			
Objective E: Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.			
Column A	Column B	Column C	Column D
Total number of "Agree" Responses to Items in Obj. E"	Total number of "Disagree" Responses to Items in Obj. E"	Total number of "Agree" and "Disagree" Responses to Items in Obj. E"	Percentage Agreement for Items in "Obj. E"
108	5	113	95.6%

Total number of "Don't Know" Responses for Objective E: 11 (8.9% of total)

Objective E Community Member Comments:
N/A

Again, the responses to this objective were stable (increase of 0.3%).

Objective F			
Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.			
Column A	Column B	Column C	Column D
Total number of "Agree" Responses to Items in Obj. F"	Total number of "Disagree" Responses to Items in Obj. F"	Total number of "Agree" and "Disagree" Responses to Items in Obj. F"	Percentage Agreement for Items in "Obj. F"
85	7	92	92.4%

Total number of "Don't Know" Responses for Objective F: 32 (25.8% of total)

Objective F Community Member Comments:
- Interesting description of known effectiveness for F4.

There was an overall decrease of agreeable responses (5.6%) compared to 2005 responses. It is important to note that cultural appropriateness, relevance, and acceptability of interventions has been a common theme in this year's community planning discussions. Similarly, the diffusion of effective behavioral interventions (DEBI's) has been a central point of these discussions. The CPG had not yet identified recommended interventions at the time this survey was completed, but were in the preliminary stages of this process at the time this survey was completed.

Goal Three — Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

Objective G & H			
Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding. Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.			
Column A	Column B	Column C	Column D
Total number of "Agree" Responses to Items in Obj. G & H"	Total number of "Disagree" Responses to Items in Obj. G & H "	Total number of "Agree" and "Disagree" Responses to Items in Obj. G & H "	Percentage Agreement for Items in "Obj. G & H "
39	0	39	100%

Total number of "Don't Know" Responses for Objective G & H: 21 (33.9% of total)

Objective G&H Community Member Comments:
- This will be done at future [upcoming] meetings.

The percentage of agreeable responses to this objective remained stable (2005 and 2006 agreeable responses were 100%). Again, a large number of "don't know" responses can likely be attributed to the fact that several number members have joined the CPG and have not yet gone through the program application and comparison process (and subsequent letter of concurrence/non-concurrence).

Overall Percentage of Agreement			
Column A	Column B	Column C	Column D
Total number of ALL "Agree" Responses	Total number of ALL "Disagree" Responses	Total number of ALL "Agree" and "Disagree" Responses	Percentage Agreement for ALL Items
1,148	37	1,185	96.9%

Additional Community Member Comments:
- I feel we have a good process! I feel like our entire group has the same goal in mind and open discussion is encouraged after the one meeting that we had problems. I guess that I'm saying that our group has been able to work through conflict to continue on the task at hand
- Continue to ensure community participation.
- DEBI's tend to be too structured to be effective in a rural setting.
- This is my first year and I feel like I can make a difference.
- Some of the items described in this survey will be completed in the next two meetings.
- I am a new member of CWT and am learning the role and processes. My responses of "I don't know" are not a reflection of CWT.
- I am still relatively new so there are a lot of issues related to CPG that I am learning and becoming familiar with.
- Thank you.
- It is difficult to get others interested in the process as the CDC becomes more "heavy handed" in grant requirements (i.e. the need to make PLWH the number one priority).

Overall, there was a 0.4% increase in favorable responses from 2005 to 2006. The CPG will continue to assure that all members understand the community planning process and assure the CPG meets the community planning objectives.

PART II- Community Planning Membership Report
COMPARISON OF 2003-2006 RESULTS

Objective A			
Implement an open recruitment process (outreach, nominations and selection for CPG membership.			
2003	**2004**	**2005**	**2006**
Percentage Agreement	Percentage Agreement	Percentage Agreement	Percentage Agreement
77.5%	97.2%	100%	97.5%
Objective B			
Objective B: Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.			
2003	**2004**	**2005**	**2006**
Percentage Agreement	Percentage Agreement	Percentage Agreement	Percentage Agreement
94.7%	88.1%	91.7%	96.2%
Objective C			
Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.			
2003	**2004**	**2005**	**2006**
Percentage Agreement	Percentage Agreement	Percentage Agreement	Percentage Agreement
85.9%	97.1%	96.9%	96.1%
Objective D			
Objective D: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.			
2003	**2004**	**2005**	**2006**
Percentage Agreement	Percentage Agreement	Percentage Agreement	Percentage Agreement
91.5%	98.3%	97.4%	98.6%

Objective E			
Objective E: Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.			
2003	**2004**	**2005**	**2006**
Percentage Agreement	Percentage Agreement	Percentage Agreement	Percentage Agreement
83.8%	96.0%	95.3%	95.6%
Objective F			
Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.			
2003	**2004**	**2005**	**2006**
Percentage Agreement	Percentage Agreement	Percentage Agreement	Percentage Agreement
82.4%	97.1%	98.0%	92.4%
Objective G/H			
Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding. Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.			
2003	**2004**	**2005**	**2006**
Percentage Agreement	Percentage Agreement	Percentage Agreement	Percentage Agreement
70.0%	95.7%	100%	100%
Overall			
2003	**2004**	**2005**	**2006**
Percentage Agreement	Percentage Agreement	Percentage Agreement	Percentage Agreement
85.6%	95.6%	96.5%	96.9%

Part II – Community Planning Membership Survey Tool

INTRODUCTION

This next series of items asks your opinion regarding whether the objectives of community planning were met in your CPG during the most recent year of planning. Each objective is followed by a series of items that ask you to indicate your agreement or disagreement with the presence of a specific attribute or key step in the community planning process. If you are unsure about a particular item, please indicate "Don't Know."

INSTRUCTIONS FOR OBJECTIVE A:

This first set of items is related to Goal 1, Objective A. These items relate to how the CPG recruits and selects new members. This would include the procedures that the CPG follows to nominate and elect new members.

Please complete the items under Objective A.

Goal 1: Community Planning supports broad-based community participation in HIV Prevention Planning

Objective A: Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.

Please rate your agreement with each of the following statements.	Agree	Disagree	Don't Know
A1. The CPG **has** written procedures for nominations to the CPG.	☐	☐	☐
A2. The CPG **uses** the written procedures (above) for nominations to the CPG.	☐	☐	☐
A3. The CPG has established a nominations/membership committee.	☐	☐	☐
A4. CPG nominations target membership gaps identified by the members of the CPG.	☐	☐	☐
A5. Both CPG members and health department staff participate in membership decisions.	☐	☐	☐
A6. The CPG **has** written procedures for how to select CPG members.	☐	☐	☐
A7. The CPG **uses** the written procedures (above) in selection of CPG members.	☐	☐	☐
Comments/Questions			

_____
_____
_____
_____
_____
_____
_____
_____

INSTRUCTIONS FOR OBJECTIVE B:

The goal of this next set of items is to gain information from CPG members about parity, inclusion and representation. These items will focus on the diversity of the CPG membership and whether this diversity represents the populations most at risk for HIV infection in your community.

These items will also focus on the various relationships or connections the CPG has with other key players, including other government and non-government agencies and individuals with expertise relative to HIV prevention.

Please complete the next section.

Objective B: Ensure that CPG membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction and includes key professional expertise and representation from key governmental and non-governmental agencies.

Please rate your agreement with each of the following statements.	Agree	Disagree	Don't Know
B1. The CPG includes members who represent each population of the current and projected epidemic as documented in the epidemiologic profile.	☐	☐	☐
B2. The CPG has expert perspective available from behavioral/social science on issues related to the community planning process.	☐	☐	☐
B3. The CPG has expert perspective available in epidemiology on issues related to the community planning process.	☐	☐	☐
B4. The CPG has expert perspective available in evaluation on issues related to the community planning process.	☐	☐	☐
B5. The CPG has expert perspective available in service provision (i.e., intervention specialists, medical providers, counselors) on issues related to the community planning process.	☐	☐	☐
B6. The CPG has expert perspective available from health department HIV/AIDS Program staff on issues related to the community planning process.	☐	☐	☐
B7. The CPG has expert perspective available from state/local health department STD program staff on issued related to the community planning process.	☐	☐	☐
B8. The CPG has expert perspective available from state/local substance abuse treatment facilities on issues related to the community planning process.	☐	☐	☐
B9. The CPG has expert perspective available from state/local HIV Care and Social Services (i.e., Ryan White Care clinics), on issues related to the community planning process.	☐	☐	☐
B10. The CPG has expert perspective available from correctional facilities, on issues related the community planning process.	☐	☐	☐
Comments/Questions			
_____			

INSTRUCTIONS FOR OBJECTIVE C:

The next section will focus on the efforts the CPG takes to ensure that all members have an opportunity to participate in the community planning process. This includes any special efforts or strategy the CPG uses to gain input from individuals, especially those whose circumstances may restrict participation (i.e., lack of transportation, health care issues). These efforts would also include the various types of training and support provided to ensure that members have the knowledge and resources needed to make informed decisions.

Please complete the next section.

Objective C: *Foster a community planning process that encourages inclusion and parity among community planning members.*

Please rate your agreement with each of the following statements.	Agree	Disagree	Don't Know
C1. The CPG uses various methods (i.e., focus groups, panels, or committees) to gain input from high-risk groups or individuals who would be hard to recruit and/or retain as CPG members.	☐	☐	☐
C2. The CPG undertakes efforts to assist members in their continued participation in the CPG, particularly those who face challenging barriers.	☐	☐	☐
C3. The CPG has formal procedures for making decisions and resolving disagreements among members.	☐	☐	☐
C4. Throughout the planning year, the CPG provides a process for training (i.e., presentations, speakers, capacity building workshops) for all CPG members.	☐	☐	☐
C5. The CPG provides orientation and/or other appropriate support to new CPG members.	☐	☐	☐
C6. CPG meetings are open to the public and allow time for public comment.	☐	☐	☐
Comments/Questions			

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INSTRUCTIONS FOR OBJECTIVES D:

This next set of items addresses Objective D and is related to Goal 2. These items consider the resources and issues used by the CPG in defining and prioritizing risk populations and HIV prevention interventions. These resources would include the following:

1) *Epidemiologic profile:* a description of the HIV epidemic and how it impacts certain populations or geographic areas
2) *Community Services Assessment:*
    a. *needs assessment:* a process for determining the service needs of those highly impacted
    b. *resource inventory:* a detailed list of existing HIV resources and services
    c. *gap analysis:* the needs assessment and the resource inventory would be compared to each other to determine if there were populations or service needs that were not being addressed

*Both resources are used by the CPG in the priority setting process and submitted with the Comprehensive HIV Prevention Plan.

Please complete the next set of items.

Goal 2: Community planning identifies priority HIV prevention needs in each jurisdiction.

Objective D: Carry out logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.

Please rate your agreement with each of the following statements.	Agree	Disagree	Don't Know
D1. The epidemiologic profile (referred to here as the "epi-profile") used in the prioritization process contains the most updated* information as provided by the health department. See suggestions for updating the profile in "Integrated Guidelines for Developing Epidemiologic Profiles." HIV Prevention and Ryan White Care Act Community Planning. **DRAFT**	☐	☐	☐
D2. The epi-profile provides information about defined populations most at risk for HIV infection for the CPG to consider in the prioritization process.	☐	☐	☐
D3. Strengths and limitations of data sources used in the epi-profile are described.	☐	☐	☐
D4. The epi-profile contains a written explanation of the data presented.	☐	☐	☐
D5. The epi-profile was presented to the CPG members prior to voting on priorities.	☐	☐	☐
Comments/Questions			
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Please rate your agreement with each of the following statements.	Agree	Disagree	Don't Know
D6. The community services assessment **(referred to here as the CSA)** focuses on one or more most at risk populations identified in the epi-profile.	☐	☐	☐
D7. The CSA contains data that define populations' needs in terms of knowledge, skills, attitudes, and norms.	☐	☐	☐
D8. The CSA contains data that define populations' needs in terms of access to services.	☐	☐	☐
D9. The CSA describes the target populations being served (i.e., age, gender, race).	☐	☐	☐
D10. The CSA describes the interventions provided to each target population (i.e., types of activities, number of sessions).	☐	☐	☐
D11. The CSA describes the geographic coverage of interventions or programs.	☐	☐	☐
D12. The CSA specifically identifies both met and unmet needs.	☐	☐	☐
D13. The CSA identifies the portion of needs being met with CDC funds.	☐	☐	☐
D14. The CSA was presented to the CPG members prior to voting on priorities	☐	☐	☐
D15. The CSA was utilized in demonstrating linkages between the plan and the application.	☐	☐	☐
Comments/Questions			

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INSTRUCTIONS FOR OBJECTIVE E:

This objective focuses on the issues or factors that the CPG considers when prioritizing populations at risk for HIV infection.

Please complete the next set of items.

Objective E: *Ensure that priority target populations are based on an epidemiologic profile and a community services assessment.*

Please rate your agreement with each of the following statements:	Agree	Disagree	Don't Know
E1. The CPG considers available information on the size (estimated total number) of the most at risk populations.	☐	☐	☐
E2. The CPG considers the level of disease burden in the most at risk populations.	☐	☐	☐
E3. The CPG considers the prevalence (frequency of occurrence or amount) of risky behaviors in the most at risk populations.	☐	☐	☐
E4. The CPG considers the priority needs of the most at risk populations (access to services, cultural/language barriers, special health care needs).	☐	☐	☐
Comments/Questions			

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This objective focuses on the issues or factors that the CPG considers when selecting particular HIV prevention activities. In this context, prevention activities are activities that have a focus on any of the following areas: behavioral interventions, structural interventions, capacity building, and information gathering.

Please complete the next set of items.

Objective F: Ensure that prevention activities for identified priority populations are based on behavioral and social science, outcome effectiveness and/or have been adequately tested with intended consumers for culture appropriateness, relevance, and acceptability.

Please rate your agreement with each of the following statements:.	Agree	Disagree	Don't Know
F1. The CPG considers whether the prevention activities are culturally appropriate and acceptable for the most at risk populations (i.e., through focus groups, pilot testing, reviewing studies).	☐	☐	☐
F2. The CPG considers whether implementation of the prevention activity is possible (achievable) for its intended populations and in its setting.	☐	☐	☐
F3. The CPG considers whether the prevention activities were developed by or with input from the most at risk population (i.e., key informant interviews, focus groups, surveys).	☐	☐	☐
F4. The CPG considers the known effectiveness of prevention activities in averting or reducing HIV infection (Examples may include those listed or based upon the programs in the *Compendium of HIV Prevention Programs with Evidence of Effectiveness*).* *Exact replication of programs is not always appropriate within a given jurisdiction given regional and/or population-based circumstances. "Consideration of known effectiveness" includes reviewing the literature and applying a reasonable amount of tailoring to fit local circumstances.	☐	☐	☐

Comments/Questions
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INSTRUCTIONS FOR OBJECTIVES G-H:

This next set of items address Objectives GH and is related to Goal 3. These items refer to the process of comparing the relationship or connection between the comprehensive HIV prevention plan, the health department's application for HIV prevention funding and the resources allocated for HIV prevention activities.

Important Note:

The first item addresses the process used to develop or update the comprehensive HIV prevention plan for *next* year and the application that will be submitted for the same year (i.e., 2004).

The second item addresses the *prior* year's comprehensive plan. It asks you to look back in time and determine whether the interventions funded during the past year corresponded to the priorities in the prior year's comprehensive HIV prevention plan.

Please complete the next set of items.

Goal 3: Community planning ensures that HIV prevention resources target priority populations and prevention activities set forth in the comprehensive HIV prevention plan.

Objective G: *Demonstrate a direct relationship between the Comprehensive HIV prevention plan and the health department application for federal HIV prevention funding.*

Objective H: *Demonstrate a direct relationship between the Comprehensive HIV prevention plan and funded interventions/services delivered.*

Please rate your agreement with each of the following statements.	Agree	Disagree	Don't Know
G-H1. Evidence of correspondence between the comprehensive plan and the health department application to CDC for federal funding was provided to the CPG.	☐	☐	☐
G-H2. Evidence of correspondence between the comprehensive plan and funded interventions/services delivered in the *prior year* was provided to the CPG.	☐	☐	☐
Comments/Questions			
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This final section provides an opportunity for you to give additional feedback on your participation in the community planning process and to make recommendations on how to strengthen the process in the future.

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Thank You Very Much for Taking the Time to Complete this Survey

Community Planning Membership Survey
April 2004

PILOT SURVEY

Page 12

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Attachment A

Colorado HIV Prevention Services Provider Survey

COLORADO HIV PREVENTION SERVICES
PROVIDER SURVEY 2005

AGENCY INFORMATION

Agency Name _____

Street Address _____

City _____ Zip Code _____ Phone _____ Fax _____

Contact Person _____ Title _____

Contact Person's Phone _____ Email _____

1. Which of the following best describes your agency?

   a) Correctional institution (adults)   f)   Local health department

   b) Correctional institution (youth)   g)   Other local clinic

   c) Substance abuse treatment agency   h)   AIDS service organization

   d) State health department   i)   Community-based organization

   e) Other state agency   j)   Other (please specify) _____

2. Number of paid staff and volunteers conducting HIV prevention services:

   Paid staff _____   Volunteers _____

3. What languages are used in the provision of your services? _____

   What other languages would you need to use to better serve your clients? _____

4. Please indicate which of the following general types of HIV prevention interventions your agency provides. For each one provided, list the locations, days of the week and hours offered, any fees charged, the **agency-defined** target populations served, and a brief description of what those services entail (e.g. name of the intervention, # of sessions, strategies used, etc.).

Type of Intervention	Provided Yes/No	Locations	Days	Hours	Fees	Target Populations	Description
HIV counseling, testing, and referral							
Prevention case management							
Partner services							
Individual-level health education							
Group-level interventions							
Community-level interventions							
Outreach							

5. Approximately how many people will receive HIV prevention services from your agency in 2005? _____

6. In which counties do you offer HIV prevention services?

_____

_____

7. What is the age range of the clients you serve? _____

8. Approximately what percentages of the people that you serve are from the following **CWT-defined** target populations?

Population	Percent of Total Clients	Population	Percent of Total Clients
Persons living with HIV		Urban African American women	
Urban White MSM		Rural IDU	
Urban African American MSM		Urban Latina women	
Urban Latino MSM		Urban White women	
Urban White IDU		Rural women	
Rural MSM		Urban heterosexual men	
Urban African American IDU		Rural heterosexual men	
Urban Latino IDU		Other (please specify)	

9. Describe the ways that members of your agency's target population(s) are involved in the design, implementation, and evaluation of your agency's services.

10. Describe the ways that your agency tailors messages, strategies and approaches to the diverse realities of at-risk people based on ethnicity, gender, age, sexual orientation, rural/urban residence, etc.

11. Which of the following activities/features are included as part of your provision of services? For each item marked "yes", please give a brief description (e.g. who, what, when, where, how) of the activities/features involved.

Activity/Feature	Provided (yes/no)	Description
Integration of HIV prevention with related services		
Risk reduction assistance		
Serostatus disclosure assistance		
Condom/lubricant distribution		
Condom use demonstration		
Bleach kit distribution		
Use of peers		
Transportation assistance		

Child care assistance		
STD-related services		
Hepatitis C-related services		
Public information/education		
Assistance with meeting basic needs (e.g., housing, food, etc.)		
Job-related services		
Social opportunities and lower risk places to meet others		
Support groups		
Drop-in centers		
Overdose and other injection drug-related services		
Client advocacy		

Opportunities for people to "make a difference"		
Community building		
Family-related services		
Development of life skills		
Other (please specify)		

12. Use the following scale to evaluate the degree to which your agency addresses the following issues as part of the HIV prevention services and related activities described above:

1 = not at all   2 = in a very limited way   3 = to a significant degree   4 = extensively

In the "description" column please describe the ways your agency addresses each issue or give a brief explanation as to why the issue is not addressed.

Issue	Degree Addressed (1 - 4)	Description
Substance abuse, including alcohol, crack, cocaine, heroin, methamphetamine, party drugs, etc.		
Mental health, including serious mental illness, low self-esteem, depression, isolation, histories of trauma, sexual addiction, etc.		
Social connections and social support		
Meeting basic needs/ poverty-related issues		

Discrimination and stigma, including racism, sexism, homophobia, classism, positive HIV serostatus, etc.		
Cultural/community norms influencing risk behaviors		
Influence of arousal and emotion on risk behavior		
Bathhouse structure and social dynamics		
The "coming out" period		
Other influences on risk behavior		
Condom use and other risk-reduction methods		
Relationship types and partner selection		
Serostatus disclosure and partner communication around sex		
The realities of living with HIV		
Access to services		
Other STDs and hepatitis		

Reaching MSM who do not gay identify		
Spirituality		
Empowerment		
Community leadership and involvement of community leaders and religious organizations in prevention		
Broader community issues and their relation to HIV		

13. Referrals and Prevention Partners

To what types of services do you refer your clients?	
To what specific agencies do you refer your clients?	
In what ways do you follow up on these referrals?	
With what other agencies do you partner in providing services to your clients?	

14. What else would you like to tell us?

Attachment B

Community Planning Development Retreat Final Report

Community Planning Development Retreat

Thursday, October 13, 2005

WHO ATTENDED DAY ONE?

Phillip Allred, Analee Beck, Craig Chapin, Sam Gallegos, Dan Garcia, Mitch Garcia, Laura Ginnett, JoAnn Grove, John Mark Hill, Michael Hurdle, Lee Jackson, Lisa Lawrence, Cajetan Luna, Deirdre Maloney, Teresa Martinez, Michael McLeod, Roseann Prieto, Daniel Reilly, Patrick Terry, Matthew Tochtenhagen, Andrew Yale, Angela Garcia, and Anne Marlow-Geter. (Linda Boedeker joined the group at the evening reception.)

Attendance summary:

Overall there were 25 participants (not including CWT staff). Of which: 14 were CWT members, 11 were new. Of the new folks, three were from Pueblo, six from Colorado Springs, and one from Denver (one was CDPHE staff from Pueblo).

Welcome to the Fifth Annual, 2005 CWT Retreat
Living, Learning, Laughing
Introductions and Warm Up Activity – Small Group Activity followed by Full Group Discussion

Objective/Outcomes: Icebreaker and introduction that introduced new members to CWT, helped returning members learn something new about each other, relive memories of past retreats, and allowed all participants to discuss their desired outcomes of the retreat.

What do we need to accomplish in 2006?

Anne provided an introduction and overview of the goals for the 2005 CWT Retreat. Objective/Outcome: Gave a brief overview of significant activities that CWT will need to accomplish in 2006: 1.) Prioritize Target Population, 2.) Prioritize Interventions, and 3.) Developing the *2007 – 2009 Colorado Comprehensive Plan for HIV Prevention*. Focus of the retreat was to introduce new members and guests to the concept, terms, and basic activities related to prioritization. The review was intended as a refresher for CWT members that participated in the 2003 process to share their knowledge, experience, and 2006 recommendation with new members. Day one focused on becoming familiar with prioritizing target populations.

The Language of Prioritization – Part I

Small Group Activity followed by Full Group Discussion

Objective/Outcomes: Was to help participants become familiar with the basic terminology of prioritizing target populations and teambuilding.

Retreat participants broke up into four small groups made up of about four to six participants that hopefully were not too familiar with each other. These small groups remained intact throughout the first day. Using a set of "flash cards" the small groups had to correctly match as many prioritization terms with their correct definitions as possible. Small prizes were awarded to the team that had the most correct answers. Each of the four teams almost correctly matched all of the terms and definitions. (See attached correct answers.)

Prioritization – How does it work?

Group Discussion

Objective/Outcomes: Was to help participants become familiar with the basic concepts, process, and activities related to prioritizing target populations, and to become familiar with some of the recommendations from the CDC community planning guidance. The group reviewed the information in pages 1 – 11, of the day one retreat guidebook (see attached).

Prioritization Exercise – Putting the process to work.
Small Group Activity followed by Full Group Discussion

Objective/Outcomes: This was a nice, neutral small group exercise where groups worked through a prioritization activity familiar to all of us (selecting a vacation, but as a group process, utilizing such prioritization terms as weights, factors, and ranking). Introduced and reinforced terminology, and encouraged and promoted group decision-making skills related to prioritization. The full group discussed what they learned and observed at the end of the activity. The activity was well received and seemed to have achieved its objectives.

Prioritization – How did CWT make it work (last time)?

Small Group Activity followed by Full Group Discussion
Objective/Outcome: Again, in the small groups, participants reviewed how CWT prioritized target populations in 2003. Returning members searched their memory so that they could inform their group about what they recalled from the previous process and the groups very briefly skimmed through the details of the 2003 process contained in chapter six of the *2004 – 2006 Comprehensive Plan*. (See attached.) Then participants completed the worksheet on page 15 of the guidebook in order to assess what worked and didn't work in 2003.

The following were responses from the retreat participants in a final summary activity.

What WORKED in 2003 during the prioritization of target populations?

- The group did not have to make decisions about funding. (New members also received a consistent message about this in their new member orientation sessions, thereby hopefully avoiding confusion about the objectives of the process.
- Investigating and considering other process and target population models from other states. Allowed the group to consider other possibilities and assess what parts of the Colorado process worked best for CWT.
- Doing the homework (reading, completing committee worksheet, etc.) to prepare for the decision-making process
- Using the CWT committees to complete steps of the process in small groups and bringing that work back to the full group to complete the decision-making process.
- Using ground rules that the group developed at the first meeting of the year throughout the process.
- Allowing rural members to develop the rural target population lists, and urban members to develop the urban target population lists – but allowing all members to review and consensus upon the full CWT list of target populations.
- Developing and consistently applying the "test criteria" to fully describe target populations.[36]
- Providing participation incentives throughout the process.
- Using a progressive decision-making process to build the final lists of target populations. Allowed for greater participation, understanding of the data necessary to make decisions, and provided time for the group to work through the necessary data and reach conclusions about that data.
- Utilized a system of weights and factors to rank target populations.
- People made a good effort to listen to one another during the process, especially at the committee level.
- People also made a good effort to respect each other during the process and made compromises out of respect for one another.

What DIDN'T WORK in 2003 during the prioritization of target populations?

- Some members wouldn't consistently adhere to or honor the group's ground rules, which felt unfair and manipulative to other members.
- Some members refused to compromise and refused to follow the decisions made by the larger group.

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[36] The intent of the "test criteria" was to provide a consistent description for each target population and to help eliminate any overlapping descriptions of risk populations so that target populations would be mutually exclusive. Applying the test criteria also helped to clarify sub-populations of significance within the greater risk populations. Basically, the test criteria used a worksheet with columns for the following description categories, Population (P) + Behavior (B) + Characteristic (C) = Target Population Description (TP).

- Population groups that weren't receiving (CDPHE HIV prevention) funding did not participate in the process.
- Lack of adequate rural participation.
- Using outside facilitators at a critical part of process (although the group regrouped well).
- Being too time conscious during the larger CPG meetings; some members didn't get to fully/adequately speak during the process and some issues got lost due to time constraints.
- In some cases, the group was not time-conscious enough and the energy of the group was lost to the process.
- The changing directions and mixed messages expressed by the CDC during the process. Several members were intimidated by the (CDC) expectations of planning member during the prioritization process.
- Some members missing too many meetings or not participating in committee work, thereby falling behind and either making the larger group back up or making ill-informed decisions.

How should CWT make it work next time (2006)?

Full Group Discussion
Objective/Outcomes: The day was concluded by developing some guiding principles to be used by CWT in 2006 during its prioritization of target populations, and discussed possible 2006 ground rules for prioritization. (This "prep work" of developing a CWT prioritization process is essential for making the 2006 process effective and accessible to all members and communities.)

The following were responses from the retreat participants in a final summary activity.

Recommended Ground Rules for the 2006 Prioritization Process:

Start from the 2004 ground rules and see if they could just be updated for 2006. Do this as a group at the first CPG meeting of 2006 so that the full group has ownership of the ground rules.

Lessons learned/recommendations for 2006 prioritization process:
- Use the basic steps and intent of the 2003 process. The overall process worked well for CWT.
- Continue to use weights and factors to rank the target populations.
- Get/provide more information about each target populations' risk and behaviors, especially if sub-populations of people living with HIV are going to be identified and ranked.

- Don't just group communities together (during the description of target populations) just because they "sort of fit together." Be more specific or mutually descriptive of target populations.
- Strongly encourage considering listing/ranking fewer target populations. Don't add more.
- However, some thought that the necessity to more specifically describe target populations, and possibly identify and rank sub-populations of people living with HIV might necessitate dividing target populations into more groups. The group will need to try to reach some consensus around this issue at the start of the 2006 process. That is whether to cut down the number of target populations or simply refine/specify the list of existing target populations. No one seemed to want to suggest starting the process over from scratch.
- Start off by having a CDPHE person do an explanation on how the state, CPG, and CDC all fit together when it comes to putting together the plan and the priorities that eventually make their way to the organizations hoping to be funded. Maybe some kind of flow chart-type discussion on the process from CDC to the funded CBO (including the purposes of the state and the CPG) so we all know how it works.
- Remind members to focus on the populations that they represent at CWT, not agencies that they might work for or support. (Group noted that the group is getting better at this.)
- Start the 2006 process with a concise review of the 2003 process with the full CPG that allows the group to discuss the outcomes from the previous prioritization process and allow the group to identify what we missed (didn't perceive at the time) in 2003.
- Also review these "what worked, what didn't work, and recommendations" notes from this retreat at the first CPG meeting of 2006.
- Hold some kind of regional meetings or focus groups to gather more feedback from ALL communities, especially rural communities.
- Increase participation on the CWT Needs Assessment Committee.
- Start the process with a review of the CDC Community Planning Guidance and its instructions for prioritization.
- Refer to the CWT Mission Process throughout the process.[37]
- Attempt to include information in the CWT Resource Inventory that details resources beyond those funded by the CDPHE-CDC HIV prevention grant. Give an overview of funding provided by linked/related services (e.g., SAMSA, HRSA, Ryan White, NIH, etc.) in the state.
- Look at including young MSM on the list of target populations.
- Figure out if there are any gaps or glaring omissions (populations) from the 2003 process.
- Examine who wasn't (isn't) at the table and how that might have impacted the choice of target populations that were identified by the group.

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[37] *Our Mission: To improve the availability, accessibility, cultural appropriateness, and effectiveness of HIV prevention interventions through an open, candid, and participatory process where differences in background, perspective, and experience are valued and essential.*

- Review the results of the 2004 focus groups to see if there were lessons or strategies identified by CWT that need to be further implement for CWT recruitment/filling representation gaps.
- Invite other linked/related service providers to the table to participate in the process and Resource Inventory (e.g., SAMSA, HRSA, etc.).
- The group needs to have a discussion, with the CDPHE staff, about the function and impact of the CWT priorities, and how priorities set in 2006 might impact the three-year contracts that currently being considered by CDPHE.

Closing statements, questions, and evaluation

CWT Retreat Reception and Dinner.
Objective: Havin' some fun! ☺

Friday, October 14, 2005

WHO ATTENDED DAY TWO?

Phillip Allred, Gary Archuleta, Pamela Burnelis, Craig Chapin, Sam Gallegos, Dan Garcia, Mitch Garcia, Michael Hurdle, Lee Jackson, Lisa Lawrence, Cajetan Luna, Deirdre Maloney, Teresa Martinez, Michael McLeod, Rachel Plamann, Roseann Prieto, Daniel Reilly, Patrick Terry, Matthew Tochtenhagen, Andrew Yale, Angela Garcia, and Anne Marlow-Geter

Welcome to Day Two of the 2005 CWT Retreat Fifth Annual Retreat
Living, Learning, Laughing
Introductions
Objective of Day Two: Day two focused on becoming familiar with prioritizing interventions. There were three small group activities scheduled during the day, so again there were lots of opportunities for participants to get to know each other better and have some fun.

Warm Up Activity - Focus on the Southern Colorado Family

Full Group Discussion
Objective/Outcomes: Allowed the guests and current CWT member from the Southern Colorado area to highlight what's going on in their area in terms of strengths and challenges. Unfortunately a lot more challenges than strengths were identified.

The Language of Prioritization – Part II: Small Group Activity

Small Group Activity followed by Full Group Discussion
Objective/Outcomes: Was to help participants become familiar with the basic terminology of prioritizing (not ranking) interventions per target populations.

Retreat participants again broke up into four new small groups made up of about four to six participants that weren't too familiar with each other. These small groups remained intact throughout the second day. Using a set of "flash cards" the small groups had to correctly match as many (intervention) prioritization terms as possible with their correct definitions. Small prizes were awarded to the team that had the most correct answers. Each of the four teams almost correctly matched all of the terms and definitions. (See attached correct answers.)

"Prioritizing" Interventions
How does it work? How did CWT make it work (last time)?
Small Group Activity followed by Full Group Discussion
Objective/Outcomes: Was to help participants become familiar with the basic concepts, process, and activities related to prioritizing interventions for CWT's target populations, and to become familiar with some of the recommendations from the CDC community planning guidance. The group reviewed the information in pages 1 – 12 (see attached), of the day-two retreat guidebook (see attached). Also included a review of how CWT prioritized interventions in 2003, giving returning members the opportunity to search their memory so that they could inform the small groups what they recalled from the process. Then participants completed the worksheet on page 14 of the guidebook in order to assess what worked and didn't work in 2003.

So who's Debi?
A Brief Overview of the Diffusion of Effective Behavioral Interventions (DEBI), (as they relate to community planning groups)
Small Group Activity followed by Full Group Discussion

Objective/Outcomes: Introduced the participants to concepts and familiarize the groups with the DEBI interventions that are currently available. Key concepts and terminology were introduced and reviewed in the retreat guidebook and discussed. The main intent, beside teambuilding, was to review and discuss the DEBIs from the point of view of how or why CWT might include them in their prioritized list of interventions in 2006, and to do a very preliminary assessment of which DEBIs might be effective for CWT's target populations. Members reviewed pages 17 – 19 of the guidebook and then reviewed fact sheets for each of the available DEBIs. Each small group reviewed and discussed the fact sheets for three DEBIs and completed the worksheet on page 20 in order to become more familiar with the terminologies and concepts as well as consider what CWT target population each of the DEBIs might be suited to. Overall, each of the CWT target population was "matched" with at least one DEBI during this exercise. Most target populations matched with about two DEBIs and a few matched with three.

How should CWT make it work next time?

Full Group Discussion

Objective/Outcomes: Was to develop some guiding principles to be used by CWT in 2006 during the prioritization of interventions.

The following were responses from the retreat participants in a final summary activity.

Lessons learned/recommendations for 2006 prioritization process:
• Start from the point of the view that the CPG might as well consider adding the DEBIs to their list of effective interventions for the CWT target populations. It would be a better strategy to offer community–based organizations more options to choose from, rather than just excluded the DEBIs as a "protest statement." The group thought it might be wise for CWT to consider including as many DEBIs (and other interventions) into the mix of possible interventions in order to meet local needs.
• Educate CWT about the DEBIs: Start the process with an overview of the DEBIs (so that members understand the key points and intended outcomes of the interventions), and possible ramifications from the point of view of community planning, and assess the competing messages coming out from the CDC regarding directions for the planning group. Also allow the group to explore some possible options that the planning group should consider when assessing the DEBIs. This might include finding out if our partners (reproductive programs, youth services, etc.) are also using something equivalent to the DEBIs and explore how they responded to the federal messages.
• Become familiar with and assess the DEBIs during the 2006 process. Become especially familiar with the DEBIs that were provided as options during the 2005 grant process for contractors.
• Consider making a "CWT statement" in the Comprehensive Plan about the DEBIs, and why they're good for or not good for the community planning process.
• Discuss early on how CWT's inclusion of the DEBIs in the prioritization process might impact the programs funded at the end of 2005 during the competitive grant process.
• Learn from Colorado's CDC directly funded CBO (Empowerment) about their experiences with the DEBIs.
• Encourage other organizations like Colorado Organizations Responding to AIDS (CORA) and Colorado Advisory Council On AIDS (CACOA) to get involved in the process in order to get greater participation.
• The group needs to have a discussion, with the CDPHE staff, about the function and impact of the CWT (intervention) priorities, and how priorities set in 2006 might impact the three-year contracts that go into affect in the latter part of 2005.

Closing statements, questions, and evaluation

(A summary of the evaluations will be submitted separately to the CWT Steering Committee at the November meeting.)

We greatly thank all those who participated in the 2005 CWT Retreat.

The time and effort you gave was greatly appreciated.

Attachment C

Population Barrier and Suitability Issues

Population Barrier and Suitability Issues

Communities of Special Interest

Injectors

In 1997 and 1998, researchers at Denver Public Health conducted a community identification project (CIP)[38] among men who have sex with men who also inject drugs (MSMIDU). This study showed that this population is quite diverse, including men of different ethnic groups, socioeconomic backgrounds, and education levels. The population also included men who trade sex for money or drugs ("hustlers"). Overall the study showed that the population of MSM/IDU is quite unique, differing significantly from other populations of MSM or IDU, with different drug use and sexual behavior patterns and different psychosocial issues.

Multiple behaviors put MSM/IDU at particularly high risk for HIV, which is evidenced in a high seroprevalence rate (47% of the sample of 100). Though the "sharing" of needles and other injection equipment is significant, the drugs of choice, the high association of drug use with sex, and intervening psychosocial issues add to an overall context influencing high risk behaviors. MSM/IDU tend to use drugs that are more interrelated with sex. Cocaine, which was cited as the first drug of choice among the sample, is considered a "party" drug that stimulates sexual desire. It also is associated with a higher number of injections because the "high" is so brief, which can encourage more needle sharing. Methamphetamine (ranking second) is used to promote sexual stamina and is associated with prolonged sex and multiple partners. Some felt that drug-enhanced sex can become so appealing that it can lead to an addiction in itself. Therefore needle-sharing and an extensive amount of unprotected anal and other kinds of sex with multiple partners tend to go hand-in-hand with the use of these two drugs. Use of these drugs along with marijuana and alcohol were also associated with impaired judgment and lowered

inhibitions, which further inhibited the use of condoms.

Various psychosocial issues were cited as being prevalent among MSM/IDU; however, the extent of these is unclear. Problems included: an enhanced need for immediate gratification; heightened sex drives; depression; feelings of insecurity, self-consciousness, and low self-esteem (which were often tied to searches for affirmation from multiple partners); tendencies toward self-destructiveness; and attention deficit disorder. Some mentioned histories of physical, sexual, and emotional abuse as playing a part in their behaviors. Feelings of internal homophobia, lack of gay identification, and denial about having same sex relations were also mentioned as powerful influences. For those with addictions their situations were even more difficult as they were driven to bypass safety in their pursuit of drugs. Some traded sex in order to get drugs or the money to by them. Some mentioned deep feelings of depression that fueled their self-destructive behavior and feelings of fatalism about their drug use, which some felt would eventually kill them before anything else could.

As part of the study, men discussed their needs and ideas concerning HIV prevention and other types of programming. Some called for educational efforts that would increase people's perceptions of risk, including some suggestions for fear-based messages and/or ones that highlight other risks besides HIV. Ads and brochures that seem to "preach" about "playing safe" were not seen as effective, nor were messages appealing to those who are HIV positive to not infect others. Some men mentioned the importance of culturally appropriate messages at appropriate education levels. Harm reduction efforts seemed especially important to this population. The need for programs that would "meet them where they are" was stressed. These included programs that would not insist on total abstinence from drugs or unprotected sex and would promote self-esteem by emphasizing successes rather than failures. The need for needle exchange was also emphasized. Finally, community level programs that addressed norms around needle sharing and

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[38] Piper, P.; Bull, S.; and Fuhriman, M. 1998. *Community Identification Project – Men Who Have Sex With Men and also Inject Drugs, Final Report.* Denver: Colorado Dept of Public Health and Environment.

bleaching and denounced homophobia were also discussed. Major barriers to prevention efforts included a lack of trust of outsiders prevalent in this population due to their being profoundly stigmatized. Another barrier was seen in the fact that many are not interested in changing their behavior.

African Americans that mistrust institutional public health due to past abuses

Despite its impact on the African American community, AIDS is not typically perceived among African Americans as an issue requiring the same level of intervention and concern as other public health issues, such as violence and drug abuse. One frequently cited reason for this apathy – particularly regarding government-sponsored AIDS education campaigns – is the existence of a lingering "backlash" to the Tuskegee Syphilis Study, one of the most infamous studies of race and disease in the history of American science. The study was designed to observe the progression of syphilis in an untreated study population of some 399 African Americans in Alabama. A small group within the U.S. Public Health Service between 1932 and 1972 administered it. From its inception to its abrupt halt in 1972 as the result of public outrage, the directors of the study refused to acknowledge any ethical responsibility to the study's subjects or the failure to treat for syphilis when penicillin became available. The Director of Venereal Diseases at the Public Health Service from 1943 to 1948 went so far as to claim in 1976 that, "The men's status did not warrant ethical debate. They were subjects, not patients; clinical material, not sick people."[39] The trust destroyed by this travesty will take generations to rebuild. It has led to widespread beliefs that government invented and continues to spread HIV, and those associated with government cannot be trusted.

Native American/American Indian

In regard to Native Americans/American Indians, it is important to remember the wide diversity within this group, which is composed of many nations, each with its own culture and beliefs. In addition, many of the nations were highly proselytized by missionaries, and their original cultural beliefs about same-sex behavior have been partially or entirely displaced by foreign viewpoints. Therefore, no one statement can be made about "Native American gay men" that would be universally true.

In 1998, CWT commissioned a study of the issues and needs of the urban American Indian community in Colorado.[40] Major findings were as follows:

- In general, American Indians look to "Spirit" for explanations of HIV and solutions to the disease of AIDS. Public health solutions that emphasize behavior and science are mistrusted and seen as disrespectful.
- HIV is perceived as part of, or resulting from, destruction of native culture.
- HIV prevention planning has relied on modes of communication and rigid agendas that exclude other ways of arriving at understanding and reaching consensus. This discourages American Indian participation.
- Westerners do not respect native customs or medicine, and in some instances indigenous medicine men/women cannot access proper medical supplies because they lack western credentials.

Asian American/Pacific Islander

In regard to Asian/Pacific Islander (API) men who have sex with men, this broad category also contains a vast level of diversity, for which no universally true statements can be made. The Asian/Pacific Islander Coalition on HIV/AIDS based in New York City have developed the following principles they recommend when working with various API communities of MSM:[41]

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[39] Fullilove, R.E. and M. T. Fullilove. "HIV Prevention and Intervention in the African American Community: A Public Health Perspective," in *The AIDS Knowledge Base.* Internet document published by University of California San Francisco, *http://hivinsite.ucsf.edu.*

[40] Young, David. 1998. *HIV Prevention Needs Assessment of the Urban American Indian Community of Colorado.* Denver: CDPHE.
[41] Yoshikazu, H. 1999. *Network-, Setting-, and Community-Level HIV Prevention Strategies for Asian/Pacific Islanders.* New York: Asian/Pacific Islander Coalition on HIV/AIDS, *http://apiahf.org.*

- Emphasize privacy regarding HIV and sex, especially for East and South Asian cultures.
- Work with social networks and start with non-HIV issues of concern to the population
- Incorporate issues of identity, history, and culture explicitly in prevention materials. In one case, for instance, changing the color of condom wrappers from purple to red was more consistent with Chinese tradition of New Year giving and was therefore much more effective.
- Incorporate API cultural emphasis on trusting medical authorities.
- Social familiarity facilitates communication of prevention messages.
- Create social settings and spaces for community building to facilitate HIV prevention.
- When available, work with existing API gay communities, understanding the complexities of identification as both gay and Asian.
- The Internet may be a promising strategy, being popular in some Asian communities and assuring both diffusion and privacy.
- Degree of assimilation and acculturation among recent immigrants can strongly influence educational attainment, norms regarding safer sex, ideas about disease, and social settings sought out. More recent immigrants tend to have lower HIV knowledge, be more silent concerning sex and HIV, equate condoms with promiscuity, and perceive AIDS as a white disease.

The New York Asian/Pacific Islander Coalition on HIV/AIDS also provides the following insights about reaching API communities: "A consistent finding across all of the focus groups was that peer educators find traditional street outreach to be unfulfilling and rarely successful. The traditional street outreach strategy involves short, one-on-one contacts, often on a one-time basis, in which peer educators approach potential target clients on the street and hand out information and/or condoms. Peer educators reported several reasons why this technique may not be very successful. First, many API cultures frown on exchanging information having anything to do with sexuality with strangers. HIV and AIDS are associated with sexuality, and therefore any indications that materials are about HIV/AIDS were usually met with a blank or negative response. Second, peers noted that condoms are equated with promiscuity and so when it is clear to target clients that condoms are being handed out, they tend not to accept them for fear of being perceived as promiscuous. Many peers observed that this effect was worsened when potential target clients were with family members, friends, or partners. Third, peer educators have reported fatigue and dissatisfaction following such traditional outreach trips." The peer educators of the Coalition made seven additional overall suggestions to overcome barriers to HIV prevention for API MSM:

- Develop prevention materials from within-group cultural norms (don't just translate brochures designed for other cultures).
- Recruit community leaders to raise awareness about HIV prevention.
- Improve print quality and design of media materials
- Use the Internet.
- Sponsor community meetings.
- Staff retention builds trust and effectiveness when dealing with API communities.
- Serve food and provide other incentives.

Transgender and Gender Variant People

Any service – including HIV prevention – that is delivered in a rigidly gender-specific manner creates barriers for people who do not fit into narrow definitions of "male" and "female." Based on recent research, such barriers may contribute to a growing epidemic among transgender and gender variant people.

From July 1 through December 31, 1997, the Transgender Community Health Project conducted a quantitative study to assess HIV risks among a culturally diverse sample of Male to Female (MTF) and Female to Male (FTM) transgender persons in San Francisco. Major findings were as follows:

- All MTF participants reported some type of abuse and discrimination because of their gender identity or gender presentation.
- Thirty-five percent tested positive for HIV, and the prevalence among African Americans was more than double any other racial/ethnic group.
- Twenty-eight percent of HIV infected MTF individuals with a self-reported T-Cell count less than 200 were not receiving any form of HIV drug therapy
- Sixteen percent of the MTF subjects had

been in alcohol treatment, and 23 percent had been in drug treatment

- Lifetime non-injection drug use was high: 90 percent had used marijuana, 66 percent cocaine, 57 percent speed, 52 percent LSD, 50 percent poppers, 48 percent crack, and 24 percent heroin. Drugs used most frequently in the past six months were marijuana (64%), speed (3%), and crack (21%).
- Thirty-four percent of the MTF participants reported a history of injection drug use. Among these injectors, the most commonly injected drugs were speed (84%), heroin (58%), and cocaine (54%). Recent injection (past six months) was reported by 18 percent, and speed was the most commonly used drug reported by recent injectors (83%).
- Fourty-seven percent of the MTF participants who injected drugs in the past six months reported sharing syringes, 49 percent used one syringe to load another, and 29 percent shared cookers.
- Sharing hormones, and sharing needles to inject hormones, was only rarely mentioned.[42]

A series of focus groups conducted in 1996 by Transgender Advisory Committee to the AIDS Office and the San Francisco Department of Public Health found similar results. The executive summary of their report states, "In our analysis of focus group transcripts we found high rates of HIV risk behaviors such as unprotected sex, commercial sex work, and injection drug use. Participants cited low self-esteem, substance abuse, and economic necessity as common barriers to adopting and maintaining safer behaviors. Participants also stated that fear of discrimination and the insensitivity of service providers were the primary factors that keep them (and other transgender people they know) from accessing HIV prevention and health services." In terms of sexual risk, one-fifth of the sample (20%) self-disclosed that they personally engaged in unsafe sexual behaviors and over

one-third (34%) discussed unprotected sex as a major issue among their friends and in their respective community. Participants attributed unsafe sexual behavior to the following factors: low self-esteem, low self-worth, economic necessity and/or addiction, exploration of their new gender/sexual identity, dishonesty about HIV status (their own or their partner's), increased sex drive (FTMs who were taking hormones), and equating unprotected sex with a deeper relationship to differentiate it from commercial sex work.[43]

People with Disabilities

Barriers facing people with disabilities include the following:

(1) Physical barriers

Many property owners have been slow to remove barriers, despite the several years that have passed since the enactment of the American with Disabilities Act (ADA). Although the owners of these facilities deceive themselves with claims that people with disabilities do not use their facilities, or that no complaints have been issued against them, even a single step can be a powerful deterrent. Removing barriers can be inexpensive, can bring in new clients with disabilities, and can alleviate the risk of costly lawsuits. Denver has been nationally recognized for its exemplary accessibility; this may attract more disabled individuals to live in Denver, raising the need for tailored services for disabled Denver residents.

(2) Communication barriers

Much of HIV prevention assumes that MSM with disabilities can receive visual and auditory messages. This assumption has effectively roped-off HIV prevention from MSM who are blind, visually-impaired, deaf, or hard-of-hearing. In addition to this obvious barrier, there are less obvious communication barriers. Due to many reasons (including institutional bias) some MSM with disabilities have been denied equal access to educational opportunities, with resulting low literacy levels. Other disabilities, by their very nature, make reading and comprehension difficult. Unfortunately, in too many cases, materials written at a lower reading

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[42] Perina, B. A. "Clinical Issues in the Treatment of Chemical Dependency with Individuals of Transgender Experience," lecture delivered at the July 2000 Conference of the National Association of Alcohol and Drug Addictions Counselors. Report Available by calling 718/476-8480.

[43] Clements, K., Kintano, K., and Wilkinson, W. *Transgender People and HIV.* San Francisco: San Francisco Department of Public Health, AIDS Office, *http://hivinsite.ucsf.edu.*

level inappropriately assume that the readers are immature and unsophisticated, creating yet another communication barrier.

(3) Attitudinal barriers
Part of the struggle faced by MSM with disabilities involves overcoming entrenched stereotypes and abuse. Too many service providers, particularly in institutional settings, patronizingly believe that people with disabilities are not sexual, or should not be sexual. If a man with a disability is also gay, this attitude toward sexuality is even more oppressive; general discouragement of sexual expression is then reinforced by homophobia. Conversely, many men with disabilities are sexually exploited in situations where power imbalances are almost insurmountable. Some of these situations involve caregivers in institutional and home settings. Some of these situations involve partners who control not only sexual decision-making, but also shelter and food.

b) Childhood vulnerability extends into adulthood
In general, MSM most frequently endure inappropriate and ineffective sexuality education. This is even truer for MSM who have a developmental or learning disability. The following factors make special education students of all sexual orientations more vulnerable to HIV, STDs, and sexual abuse.[44] When combined with homophobia, these factors have an even greater impact, and this impact continues into adulthood:

(1) Knowledge
Students with disabilities are generally less knowledgeable than other students about their bodies and their sexuality. This leads to poor decision-making related to their sexuality and an inability to protect themselves. This lack of information can be attributed to the following causes: They have generally been excluded from sex education programs in schools; parents, who are sometimes uncomfortable teaching sexuality to their children, often feel even more insecure teaching a child who has a disability; many

students do not know when and whom to ask for help and may lack the cognitive or communication skills necessary for asking questions; students are often unable to get information from written materials, because few publications are written on their reading level.

(2) Misinformation
Some students with disabilities are more likely than other students to believe myths and misinformation because they are unable to distinguish between reality and unreality. They may also become easily confused or frightened by misinformation.

(3) Social Skills
Students with disabilities may have limited opportunity for social development. Their chances to observe, develop, and practice social skills are limited or nonexistent. Many students do not have such basic social skills as knowing how to greet others and how to show affection appropriately.

(4) Power and control
Others easily influence some students with disabilities. These students may do whatever others suggest without question, due to their dependency and desire to please.

(5) Self-esteem
Students receiving special education services may have low self-esteem. In an effort to be accepted by others or to gain attention (either positive or negative) students with low self-esteem are more likely than other students to participate in risky behaviors.

(6) Judgment
Students in special education may have poor judgment, poor decision-making skills, and poor impulse control. Without direct instruction, they are unable to recognize the consequences of their actions.

c) Special concerns regarding the mentally ill
Of all the disabilities, mental illness has been most clearly associated with HIV risk in the research literature. In one study, 792 adult outpatients at a large state psychiatric hospital were screened for HIV risk (43% female; 75% European-American, 22% African-American). Nearly half (49%) of the patients reported being sexually active in the past year, 52 percent used

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[44] Virginia Department of Education. 1991. *Family Life Education for Exceptional Youth: Why HIV Prevention Education is Important.* Reston, VA: ERIC Clearinghouse on Handicapped and Gifted Children.

alcohol, and 18 percent used street drugs. Seven percent reported having three or more sexual partners, four percent had been infected with a STD other than HIV, three percent had exchanged sex for money or drugs, and one percent had shared injection equipment. More than one-third acknowledged that alcohol or drugs was a problem. Patients who reported both sexual behavior and substance use during the past year (n = 107; 13.5% of the screened sample) participated in a more detailed assessment that revealed a high level of misinformation about HIV, modest levels of risk perception, and considerable risk behavior. Patients were worried about HIV and AIDS, but had few formal resources to reduce their risk or allay their concerns.[45] In another study, 225 adults with chronic mental illness who were sexually active in the past year outside of exclusive relationships were individually interviewed in community mental health clinics using a structured HIV risk assessment protocol. More than 50 percent of the study participants were sexually active in the past month, and 25 percent had multiple sexual partners during that period. Fifteen percent of the men had male sexual partners. In more than 75 percent of occasions of sexual intercourse, condoms were not used. When participants were categorized as at either

high or lower risk for HIV infection based on their pattern of condom use, psychosocial factors that predicted risk level included measures of participants' self-reported efficacy in using condoms, perceptions of social norms related to safer sex among peers and sexual partners, and expectations about outcomes associated with condom use, as well as participants' level of objectively assessed behavioral skills in negotiation and assertiveness in sexual situations.[46] Borderline and anti-social personality disorders have also been linked to HIV risk, mostly due to the impulsivity and high substance use rates associated with these disorders.

[45] Carey, M.P., Carey, K.B., Maisto, S.A, et al. "Prevalence of HIV Risk Behavior Among Adults Living With A Severe and Persistent Mental Illness," *International Conference on AIDS 1998,* abstract no. 23544, 12:451.

[46] Kelly, J.A, Murphy, D.A, Sikkema, K.J, et al. 1995. "Predictors of High and Low Levels of HIV Risk Behaviors Among Adults with Chronic Mental Illness," *Psychiatric Serv.,* 46(8):813-8.

Men who have Sex with Men (MSM)

1. Overall Findings from the 2000 Client Survey

Seventy-three MSM responded to the *2000 Client Survey*, in which they had an opportunity to describe the barriers they face and the characteristics of HIV prevention programs they perceive as suitable.

In terms of service suitability, six criteria emerged as statistically more important to these respondents in choosing an agency as their HIV prevention service provider:

- The agency staff makes me feel comfortable.
- The services are free or low cost.
- The agencies respect my privacy.
- The agencies are set up for gay men.
- The agency staff includes persons living with HIV
- Agency staff understands my issues.

In addition, these respondents were more likely than other respondents to only know only one agency to go to for these services.

In terms of barriers, the 73 MSM respondents did report two barriers more often than the non-MSM respondents:

- Agencies providing these services are too far away.
- The agencies in my area make me feel uncomfortable.

It is important to note that only a small number of surveyed MSM expressed these barriers, although these responses were statistically significant as compared to non-MSM respondents.

2. General Barrier and Suitability Issues for MSM

In the *2000 Client Survey*, just over 16 percent of MSM respondents indicated that they had no need for HIV prevention services or materials. A higher percentage of MSM indicated "no need" than the respondents who were IDUs or people at risk through heterosexual contact.

Why might such a relatively high percentage of a very at-risk population perceive no need for HIV prevention interventions? There might be any number of reasons, including problems with the wording of the survey question. However, in terms of barriers and suitability of services, four possible reasons are cited in research and are worthy of further consideration:

a) **Some men who have sex with men have adopted extremely safe sex or abstinence and do not perceive a need for supportive interventions.**

A certain percentage of men who have sex with men have chosen abstinence or extremely safe behaviors such as mutual masturbation. Level of acceptable risk is a highly personal choice, and some MSM are extremely risk-averse.

In some cases, men who are living with HIV want absolute assurance that they will not be responsible for any new HIV infections. For such men, even the remote risk of transmission during the safest forms of sex is unacceptable.

Although men who hold these beliefs may not perceive any current need for HIV prevention interventions, they may benefit from community support for their decisions. They may also find their choices very challenging to maintain over the long term.

b) **Oppression of men who have sex with men has been internalized as isolation and fatalism.**

In 1994, Communications Technologies conducted an extensive literature review concerning homophobia, which they defined as "the most common way of describing the cluster of stereotypical beliefs, prejudicial attitudes, animosity, and discomfort held by most heterosexuals in our society in reference to gay men, lesbians, and bisexuals." They found that homophobia is "a pervasive fact of life in the American landscape, observable in personal attitudes and public and private institutions, and reinforced by legal statutes."[47] The Public Media Center concurs: "The experience of being victimized and abused as a result of pervasive social prejudice against homosexuality is

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[47] Public Media Center. 1994. *The Impact of Homophobia and other Social Biases on AIDS.* San Francisco: Public Media Center.

virtually endemic to the experience of being gay in America."[16]

Homophobia in Colorado has been particularly virulent. The memory of 1992's Amendment Two, a ballot initiative denying "special rights" to homosexuals, still lingers in the memory of many gay men in the state, creating walls of suspicion and isolation. The subsequent reversal of the initiative by the U.S. Supreme Court did not erase the painful feelings of marginalization that many experienced in the aftermath of the vote. The state's popular media continue to emphasize the conflict between gay communities and the constituencies that reject and ostracize them. High profile political and religious leaders have figured prominently in this ongoing debate.

The 1998 murder of Matthew Shepard, the gay University of Wyoming student brutally slain due to his sexual orientation, was also keenly felt in Colorado, particularly in rural areas. This tragic event called to memory many gay men's experiences of real or threatened violence and reinforced the dangers of being openly gay in a repressive environment.

The interconnection between homophobia and HIV/AIDS is extensive and insidious, with serious implications for MSM and for other people who are living with or affected by HIV. These effects can be grouped under four headings:

- Many MSM have a sense of hopelessness about the future. Because they have never experienced any other model, these men imagine a middle and old age without family of their own and lacking an alternative support system. They mistakenly believe that only youthful, attractive, and wealthy gay men have lives worth living.
- Men who have been shamed and marginalized for their sexual orientation may expect HIV prevention programs to be dehumanizing, and will avoid them.
- Men who have internalized the message "all gay men get HIV eventually" sometimes cease attempting to avoid infection and place their hope in HIV infection becoming an increasingly manageable condition.
- From the beginning of the epidemic in the United States, AIDS has been associated with gay men, and AIDS-related stigma has disproportionately fallen on gay men. To

avoid this stigma, men may shun the "gay label" and also cut themselves off from the support of gay community.

Barriers associated with these effects are obvious. Not so obvious are the general barriers that they pose to HIV prevention efforts for all populations. The Public Media Center summarizes the situation as follows: "Just as AIDS-related stigma is the driving force behind our nation's lackluster response to HIV/AIDS, so the unaddressed issue of homophobia remains the unseen cause of the spread of AIDS-related stigma within U.S. society. We believe that until the issue of homophobia is properly and adequately addressed in America, our nation is unlikely to generate an objective, focused response to the epidemic of HIV/AIDS." [47]

c) Some MSM have adopted "harm reduction" approaches to HIV prevention, which may be difficult to reconcile with the traditional public health approach.

In focused interviewing of 124 gay men who reported an ongoing practice of unprotected sex, Levine grouped a series of responses under the heading of "justifications." On closer reading, these practices involve varying degrees of harm reduction, reducing the risk of becoming infected or infecting others with HIV. Some of these approaches included:

- Taking the insertive role, or insuring that the uninfected partner takes the insertive role,
- Performing oral sex rather than riskier anal sex
- Medical testing that indicates seronegativity,
- Social evidence of low-risk status (having unprotected sex only with people who claim to have had few sexual partners or claim to have always been the insertive partner or claim to have recently arriving from a low seroprevalence area),
- No transmission of semen and/or preseminal fluids (withdrawal before ejaculation or avoidance of insertion while preseminal fluids were present).

Clearly, all of these approaches involve some degree of risk. Traditional public health approaches to HIV prevention routinely reject all of these approaches due to the possibility of infection. Insertive partners do have some degree of risk of becoming infected; test results may

indicate negative HIV status during the "window period" when a person is both infected and infectious; people falsely report few partners and being exclusively the insertive partner; unprotected sex in low seroprevalence areas can and has resulted in infection; ejaculation can be hard to predict, making withdrawal undependable; preseminal fluids are difficult to observe and avoid. However, it is also indisputable that these harm reduction approaches could reduce the risk when compared to the alternatives (e.g., persons known to be living with HIV taking the insertive role without protection including ejaculation in their uninfected partners).

Levine's interviews took place before the advent of highly active anti-retroviral therapy (HAART). Evidence now exists that some men rely on HAART and its reduction of viral load as a harm reduction strategy for HIV prevention. See Chapter Nine for further discussion and caveats concerning this approach.

"Safer sex burnout" has become a reality among MSM that HIV prevention providers must deal with. Men who adopt "harm reduction" approaches are at least willing to minimize their risk of infection, if only slightly, over the longer term. At a minimum, people who have adopted behaviors that lessen but not eliminate HIV risk need factual information delivered in an understandable, non-judgmental, culturally competent manner. They should also be informed of the risks of other sexually transmitted diseases, some of which are incurable and are more easily transmitted than HIV (such as HPV and genital herpes). Some of these clients, even when fully informed, will continue to rely exclusively on these practices despite the risk of transmitting or acquiring HIV. Insisting on less risky behaviors may alienate such clients and have no HIV prevention benefit. Other clients, when fully informed of the continued HIV risk, will find their current level of unprotected risk unacceptable and will want support to practice safer behaviors.

d) **Some men who have sex with men have fundamental sexuality, relationship, and substance use concerns that supercede their concern about HIV.**

Some of the MSM interviewed by Levine "generally felt that their sexual conduct was risky but attributed their behavior to forces they were unable to control."[48] These forces, grouped under the following five headings, translate into major barriers for HIV prevention.

(1) The influence of alcohol or other drugs
Levine found the following: "The most commonly cited excuse for unprotected sex was the use of drugs or alcohol. Almost all of the respondents offering this excuse insisted that unprotected intercourse was atypical behavior that occurred only when they were 'high' or 'stoned.' These men contend that drugs or alcohol impaired their judgment, lowered their inhibitions, or reduced their ability to resist a partner's urging or pressure to engage in unprotected oral or anal sex."

A forum on substance use and sexual health convened in Denver in October 1999 confirmed Levine's findings locally.[49] The men who attended this forum described how alcohol and other drugs play prominent, though varying, roles within the highly diverse population of MSM, and how the reasons for and patterns of use seen among this population vary markedly. Use patterns range from very moderate social consumption to heavy weekend bingeing to true addiction. The extent of use among this population has been highly debated and often over-represented, however it does appear that substance related problems in this community do exceed those of the general population. Though the extent of alcohol use is about the same, fewer gay men abstain from use, and they tend to use later in life. They also tend to use other drugs at a higher rate.

Some men use simply because it is fun. Others are masking a mental illness or the harm caused by childhood sexual, physical and/or emotional abuse. For men who are HIV infected, substance use is often a way of escaping the harsh realities

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[48] Levine, M. 1992. "Unprotected Sex: Understanding Gay Men's Participation." In *The Social Context of AIDS.* Joan Huber and Beth Schneider, eds. Newbury Park, CA: SAGE Publications.
[49] Colorado Department of Public Health and Environment. 2000. *The Interrelationship Between Substance Use and Sexual Health in the Lives of Men Who Have Sex With Men: Results of a Community Forum.* Published by and available from CDPHE.

of having a life-threatening disease. Many men at the conference cited the pain that comes from growing up in a homophobic environment and its impact on their sense of self worth as the central reason for their abuse of substances. For some, growing up gay meant learning that everything about who they were was bad and sinful and that their lives did not matter. Few were given the tools to understand their sexuality in any positive way at an early age, which meant many grew up feeling very isolated. Drugs and alcohol allowed them to temporarily escape the pain and put aside feelings of shyness and internalized homophobia. However, for those who become addicted, low self-esteem is often exacerbated and is accompanied by another complex set of physical and emotional harms.

Other prominent factors discussed by the participants concerned social and structural factors within the gay community. Foremost among these was the key role that bars have long played in that community as centers of social activities and primary meeting places. Further confounding this has been the consistent targeting of the gay community by alcohol companies seen in the proliferation of bars and liquor stores, the sponsoring of gay events, and the glamorization of alcohol use in the gay media. Some felt that certain cultural dynamics in the gay community influenced their use of substances. An overemphasis on youth and beauty as well as conflicts over the meaning of "masculinity" influence many to feel undesirable or insecure, something that drinking and/or using drugs can help to temporarily overcome. Given that much of gay identity is tied to sex, many men feel social pressure to be hypersexual and to pursue numerous anonymous and/or casual sexual encounters as opposed to making more meaningful and intimate connections with other men even if they do not feel good about it. As one participant put it, "Drugs and alcohol lubricate sexual identity." For those MSM who do not identify as being part of a gay community substances were often used to deal with feelings of isolation and to facilitate temporary linkages with that community.

It is critical to keep in mind that the relationship between substance use and sex is complicated, and many variables need to be considered. Substance use obviously affects judgment and obscures a sense of consequences when engaging in activities that put one at risk for getting or spreading HIV. However, a more complex understanding of the interrelationship between substance use and sex-related risk is key to the development of appropriate and effective HIV prevention and substance abuse treatment programming for men who have sex with men. Many say they have sex while they are high simply because it is fun and it feels good, and they stress that it has nothing to do with dealing with feelings of shame or low self-worth. For many others, however, the relationship is much more intense and next day regrets are commonplace.

For some sex and drug/alcohol use have always gone hand-in-hand and have always been a part of their realities as MSM. Many use substances to mask insecurities and feelings of shame and to get the courage to go into environments like gay bars or bathhouses and/or to have same-sex relations. This may be especially the case for men who do not gay identify. Some claim that such use makes it possible for them to engage in activities that they normally would not pursue such as anonymous sex, anal sex, fisting, or those related to sadomasochism. Also, some men use drugs as a means to lure in partners. Many at the conference discussed the use of drugs as a way of enhancing sex. Poppers and Ecstasy are frequently used for such purposes. Men particularly discussed methamphetamine and its use in increasing sexual prowess and prolonging and enhancing sexual pleasure, often for many hours at a time. Though some claimed to be able to practice safer sex while high, for many, substance use complicated their ability to use protection or helped them to forget that protection was even an issue to consider.

Issues concerning substance use and sexual health vary markedly according to factors such as ethnicity, age, socioeconomic status, geographic region, and sexual identity, and bias and discrimination are prevalent within the gay community. Drugs of choice and use patterns often vary according to ethnicity, age, and socioeconomic status and according to what drugs tend to be available in a particular area. Since much of gay community life as well as the gay media have focused on white, urban, middle-class men, others often do not feel the same connection to the community or feel that they are welcome members. Much more of the attention and resources given to the HIV epidemic and its prevention has historically been targeted to this

segment of the population as well. Transsexuals and their issues are seldom addressed within the HIV prevention arena even though their risks can be quite high. Some make their living selling sex and then use drugs to dissociate themselves from that and from the pain that comes with lack of acceptance by the wider society. Many also use and share needles to inject hormones (see further discussion of transgender issues, below). Experiences of rural men and MSM of color also varied widely (also discussed in further detail below). Overall men at the conference felt that the population of MSM was unfortunately quite segmented in spite of the commonalties which some thought should override the differences. Yet the differences in experiences could not be ignored.

Poverty and homelessness are often overlooked among MSM. Yet many addictions grow out of feelings of not measuring up to social standards, and socioeconomic differences can be powerful influences in substance use. Furthermore, substance use can make one temporarily forget that he is homeless or that he is trading sex to meet survival needs. Much less outreach has been done around HIV issues in communities of color and among the poor, leaving some with the impression that it is not a disease that widely affects them, in spite of epidemiological data showing the contrary. Young gay men also often do not see HIV as something that affects men in their age group in spite of the increasingly high infection rates. Others feel that substance use and HIV are inevitable parts of their reality as gay men that they just need to accept.

A large segment of the conference focused on the problems and the needs associated with both HIV prevention and substance abuse treatment programming. Of major concern was how to best integrate the two topics of HIV and substance use in effective programming in each of the arenas, something that most felt had not been accomplished in Colorado.
In addition to lack of funding, most providers felt it was increasingly difficult to keep the attention of gay men, and some saw a complacency within the gay community, resulting from the availability of better treatments for HIV. Though many strengths can be found in community building efforts and community level interventions, the need for basing programs on sound formative evaluation and building them from the ground up rather

than using top down planning approaches was stressed. People mentioned a general fear of incorporating diversity into programming and a failure to significantly adapt programs according to the diverse needs of men of varying backgrounds. Also stressed was a need to make the prevention messages more realistic, more inclusive, and better adapted to the multiple situations of diverse segments of the population. As examples, such messages should vary not only according to ethnicity, age, and geographic location, but also according to factors such as HIV serostatus, sexual identity, drugs of choice, and even personality types. As one participant put it, "You don't use scare tactics with a thrill seeker. They don't work".

In general, conference participants felt that most HIV prevention providers have little in-depth knowledge of substance abuse, and often do not know when and where to refer clients to substance abuse-related services. The lack of linkages to substance abuse services and ability to make sound referrals seems especially problematic. Few HIV prevention providers deal with the relationship between substance use and HIV risk to any degree of complexity, with most simply emphasizing how being high can cloud judgment around sex. Another significant problem cited was the lack of needle exchange in Colorado or viable options to needle exchange.

Suggestions for programming offered by the participants included the need for more holistic approaches to HIV prevention that linked it with other health and life issues affecting men who have sex with men, including substance use issues. Programs need to be harm reduction oriented, be based on the expressed assessments and needs of various communities, be peer led wherever possible, and be tailored according to all relevant factors. Programs need to address the principle reasons men cite for their risk behaviors in ways that are sensitive and realistic. Substance use needs to be integrated into programming in a complex, thoughtful, and non-judgmental way. Specific examples of strategies which were suggested by the group included: 1) the use of forums or support groups where men could get a chance to talk openly about what they do and their life experiences; 2) one-on-one interventions through which men could find someone to listen to them and help them sort out their issues surrounding substance use and risk (these could include the use of a buddy or mentor

system); 3) the use of role models, including men who have dealt with their substance abuse and HIV issues in a positive way; 4) substantive referrals to related services; 5) safe places to gather outside of bars, and 6) more sensitive and effective public information campaigns.

As the group looked at substance abuse treatment services, several principal themes came to light. First was the general lack of appropriate and sensitive treatment available for MSM if they are HIV negative. Some participants discussed their experiences with treatment as being highly homophobic and disrespectful, and in no way venues where they could discuss their issues openly and comfortably. Access to effective treatment was better for those who were HIV infected. A second theme concerned the lack of a harm reduction orientation within the treatment arena. Most programs are abstinence based and providers can be quite judgmental (and occasionally punitive) about continued use. There were virtually no programs available for men who still wanted to use or programs that would meet people where they are and help them back out of their use at their own pace. A third problem cited had to do with the lack of substantive HIV prevention offered as part of substance abuse programs, something that the high level of turnover among counselors exacerbates. Finally structural issues were discussed concerning the managed care system that governs the treatment system. As structured, the system is highly motivated by money, and there is little incentive to provide better services for men who have sex with men. There are also few viable mechanisms available for client complaints to be heard, taken seriously, and addressed. Suggestions from the group for more effective programming included: 1) the incorporation of both holistic and harm reduction approaches which include stronger linkages to the HIV prevention system and other related services; 2) the incorporation of HIV prevention standards into their efforts or use of referrals to specialists; 3) the basing of programs on formative evaluation with users and ex-users and the subsequent tailoring of programming; 4) the development of gay-specific, respectful, confidential, and affordable treatment; and 5) the establishment of an advocacy group that can effectively address treatment-related complaints.

(2) Sexual passion
Levine's findings were as follows: "Nearly all the men offering this excuse felt their behavior was uncharacteristic of them and attributable to uncontrollable urges, which overwhelmed their intent to use protection."[50]

When it became obvious that HIV was a sexually transmitted disease, the early messages tended to be categorical and simplistic: "use a condom every time – until there's a cure." Gay men developed an unprecedented safer sex culture in a very short time. However, it soon became clear that such a simple message was not universally accepted, often because condoms were perceived as incompatible with sexual passion. For instance, at the point in sex when the condom is used, the partners become reminded of disease and death, which are unpleasant intrusions into the sexual experience. The next evolution of the message has involved an attempt to eroticize safer sex. While this has worked with some segments of gay men, it runs contrary to the experiences of many other gay men, for whom it is not a long term sexual alternative.

It is becoming increasingly clear that the once optimistic "until there's a cure" may well stretch far into the foreseeable future. Gay men, like all other sexually active people, will choose sustainable sex lives that satisfy their needs for sexual passion, intimacy, escape, and many other complex needs. This will involve some level of risk, which must be an informed, uncoerced, carefully considered choice for both partners in every sexual encounter.

(3) Emotional needs
Levine's findings were as follows: "Some men explained incidents of unprotected sex as an expression of love, affection, or acceptance. Typically these men participated in unprotected intercourse to demonstrate their emotional feelings for their partners who were usually their lovers or boyfriends. Many described their behavior as a sacrifice made for their partners, which was attributable to understandable and even altruistic motives."[17] Some of the

[50] Levine, M. 1992. "Unprotected Sex: Understanding Gay Men's Participation." In *The Social Context of AIDS.* Joan Huber and Beth Schneider, eds. Newbury Park, CA: SAGE Publications.

interviewees expressed concern that their lovers not "feel like pariahs," and that willingness to take risks was "psychologically important for the relationship."

In the context of a relationship, sexuality builds a sense of connection and trust. Some gay men find non-sexual ways to meet these emotional needs. In other cases, men want at least one relationship in their lives to be completely accepting, for themselves and their partner. For them, the need for mutual acceptance and trust is more powerful than the need to be protected from HIV.

(4) Partner coercion, including deception, domestic violence, and rape

Levine's findings were as follows: "Other men claimed that their partners coerced them into engaging in unprotected intercourse. Generally these men perceived themselves as victims of either other men's pressure or their deceptive conduct. They insisted that they intended to use protection but that their partners undermined their resolve. . . There were two subgroups among these respondents. The first included respondents who were pressured into participating in unprotected sex. . . The second group consisted of a handful of men who were deceived into having unprotected receptive anal sex. These men usually thought the insertive partner used protection but later discovered that this was not the case." [17]

Because most domestic violence occurs against women in heterosexual relationships, the possibility of abuse within male/male relationships is ignored or minimized. However, homophobia may increase the likelihood of such abuse. Threats of being exposed as a gay man, wanting to preserve a relationship because of the difficulties in finding partners, and the ***mistaken*** belief that "gay relationships are inherently flawed" are all attributable to homophobia, particularly internalized homophobia, and lock men into coercive, unhealthy relationships.

(5) Inability to remain in the "crisis mode" indefinitely

Although not mentioned by Levine, twenty years of viewing HIV/AIDS as a "health crisis" has exhausted many gay men and their service providers. An entire generation of young MSM has only known "sex that can kill." For them, the situation is normal, not a health crisis. An increasing number of gay men are calling for a more holistic approach to gay health, with HIV being addressed along with – and in the context of – other concerns such as mental health, substance use, nutrition, and issues of aging.

3. Barrier and suitability issues for MSM who do not gay-identify

Most of the early HIV prevention materials developed for MSM assumed that the readers would identify with the label "gay." As these materials have been introduced to a more diverse audience of MSM – men who reside outside major cities, men of color, etc. – it has become clear that this assumption is invalid. There are many men who have sex with men but do not gay-identify.

Four reasons may exist for gay non-identification, each of which has different implications for HIV prevention.

a) Some MSM believe that identification as gay would preclude them from desired sexual involvement with women.

Some men perceive "gay" as meaning no sexual desire for or sexual involvement with women. This is the image of gay-ness that is most predominant in the gay media, particularly in regard to urban, well-defined gay communities. For some gay men, this image of gay-ness does not match their lives, which may occasionally or predominantly involve bisexuality. For this reason, these men reject the label "gay" and may, in fact, identify as either heterosexual or bisexual, or both. As a result, these men will reject materials and programs they perceive as designed for gay men.

b) Some MSM are at a stage in the "coming out" process that makes it difficult to admit that they are gay, to themselves and to others.

Cass[51] identified six stages of coming out. Men who have sex with men could be at any of these stages, the first two of which involve rejection of gay identity. The six stages are identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis. In stage three, the tolerance

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[51] Cass, V. 1979. "Homosexual Identity Formation: A Theoretical Model," *Journal of Homosexuality*. 4, 219-235.

phase, gay men begin to recognize the needs arising from their orientation, but they are unlikely to seek out community resources until stage four, the acceptance stage. Therefore, it might be said that four of the six coming out stages involve barriers to seeking out support. These earlier stages of coming out can be prolonged for those who live in a harshly homophobic environment.

c) **The gay movement arose within, and continues strong association with, a community of white urban men who are extremely "out" in their communities.**

As discussed in more detail below, rural men and MSM of color have a unique set of perceptions, needs, and challenges. For men of color, acceptance of the label "gay" may feel like a rejection of core aspects of their identity as African American, Latino, Asian American, or Native American. The definition of "gay sex" is also variable; for some people, as long as it's only oral sex, or as long as you are not penetrated, it is not considered "gay sex." Rural men may also see the gay community as distant and irrelevant to their daily life. Being equally "out" in their communities could subject them to physical harm and other realistic losses.

d) **Some MSM in certain circumstances, which may never reoccur.**

Some MSM only in very specific circumstances (in prison, as survival sex, etc.) or as an immediate, recreational episode that they may or may not re-experience; such experiences are often unrelated to gay identity, being more related to experimentation or immediate necessity.

4.   MSM who are also injectors
 [See page 17, Injectors.]

5.   Barrier and suitability issues for MSM of color

Eighteen of the 73 MSM who responded to the *2000 Client Survey* were men of color. These men of color cited "building community support" and "free condoms" as their most significant prevention needs, though their differences when compared to the other MSM respondents were not statistically significant. In terms of suitability, MSM of color cited very similar issues as MSM not of color: free/low cost services and respect for privacy emerged as most important. As would be expected, availability of services in languages other than English was a

strong issue for Latino MSM. MSM of color were less likely to cite the barrier "too many things going on in my life" as compared to other MSM.

Even though most substance abuse occurs within the white middle class, it is often portrayed by the media as being more prevalent among the poor and communities of color. For MSM of color, a complex history of combined social inequalities, including racism, influences a set of life experiences that are quite different from that of white men, constituting a different context for substance use and HIV risk and calling for different approaches to prevention. Many feel that the prevalence MSM who do not gay-identify is higher in these communities, offering further challenges to HIV prevention efforts. Added to this is a historic lack of trust of government institutions and its agents, which makes many men of color reluctant to access services.

In general, MSM of color must cope with two forms of oppression: oppression due to their sexual orientation and oppression due to racial bigotry. The overlap of these oppressions is particularly challenging: their neighbors of color reject them due to homophobia, and their fellow gay men reject them due to racism. Aside from this commonality, it is important to recognize the unique experiences of the diverse communities that fall under the heading "communities of color."

a)   Latino MSM

Diaz[52] summarizes four psycho-cultural factors facing Latino MSM, each of which has important HIV-related implications. Diaz coined the phrase *psycho-cultural* to underscore "the fact that cultural values and social structures become internalized in human development, giving shape to individuals' construction of their sense of self and their relation to the social world."[52] Although Diaz's research was not exhaustive, and did not reflect the realities of all communities of Latinos; his findings are

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[52] Diaz, R. M. 1997. "Latino Gay Men and Psycho-Cultural Barriers to HIV Prevention," in *In Changing Times: Gay Men and Lesbians Encounter HIV/AIDS.* M. Levine, P. Nardi, and J. Gagnon, eds. Chicago: University of Chicago Press.

corroborated by other researchers. His four factors are:

(1) Machismo's double bind
Latino youth are told, from an early age, that being male is an advantage, that masculine attributes are superior, and that "real men" must prove their status through sexual conquests involving penetrating their partners. Latino MSM who are the passive partners find this factor particularly difficult to reconcile.

(2) Passion and control
"The belief that Latino men are supposed to experience intense feelings, urges, and sensations that cannot or should not be controlled." [52]

(3) La Familia
Enormous regard for, and high value on, family life and interpersonal relations among family members. However, when families view homosexuality as sinful and shameful, it is extremely difficult for Latino MSM to confront these homophobic attitudes and possibly bringing shame to their families. More likely, Diaz notes, these men experience "internalized homophobia, a sense of personal shame, separation of sexuality and affective life, and lack of a gay referent group."[52] A strong religious orientation in the family has tended to further complicate this situation.

(4) Sexual silence
The difficulty of Latino men to discuss sexual matters arises from the Latino value of *simpatia,* which stresses the importance of smooth, conflict-free, and non-confrontational interpersonal relations. As Diaz notes, "In many cases, acting simpatico toward a desirable potential sex partner, especially an unfamiliar person, and protecting their partners from uncomfortable feelings seems to take precedence over protection from HIV infection." [52] Simpatia can also result in silence around sexual abuse and infidelity.

In addition, research indicates that Latino culture includes a fairly powerful homophobic component. In a national survey of unmarried Latino adults, 62 percent reported that sex between two men was definitely not acceptable. Men must often choose between their culture and their sexuality, so that some men turn to the mainstream gay community for support, thus losing their Latino identity, while others remain immersed in a culture that views their behavior as reprehensible, often hiding their sexual orientation from family and friends. Internalized and community homophobia may contribute to a negative self-concept and rejection of their sexual behavior in Latino gay men, which can lead to anonymous sexual encounters and sex under the influence of drugs and alcohol. Homophobia in Latino men reporting sex with men is correlated with sexual discomfort, which in turn is correlated with lower confidence in their ability to use condoms. Currently, levels of homophobia mean that Latino young people with homosexual feelings and fantasies will feel fearful and rejected by their peers. Consequently, many may experience severe depression, leading to suicidal ideation or attempts, or they may engage in more risky behaviors, such as drug and alcohol use and anonymous sexual encounters.[53]

b) African American MSM
Peterson[54] conducted similar reviews of existing studies to determine the factors associated with high risk MSM behavior among African American men. Factors where African Americans tended to differ from other MSM were cited as follows:

(1) Low perceived risk
African American MSM have tended to view AIDS as a white, gay male and IDU issue, and even those who identify as gay or bisexual have tended to report a lower willingness to change behavior. This perception has been confounded by widespread misinformation about HIV, its origins, and its prevention that competes with public health messages delivered by mistrusted institutions (see further discussion below).

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[53] Van Oss Marin, B. and C. Gomez. 1998. "Latinos and HIV: Cultural Issues in AIDS Prevention," in *The AIDS Knowledge Base.* Internet document published by University of California San Francisco, *http://hivinsite.ucsf.edu.*
[54] Peterson, J. L. "AIDS-related Risks and Same Sex Behaviors among African American Men Who Have Sex with Men," in *In Changing Times: Gay Men and Lesbians Encounter HIV/AIDS.* M. Levine, P. Nardi, and J. Gagnon, eds. Chicago: University of Chicago Press.

(2) Social background

Variations in social background, especially education and income, may have important consequences for African American MSM. Some studies have shown that African American gay and bisexual men with lower income, less education, and more unskilled occupations were more likely than others to engage in unprotected anal intercourse.[54] However, higher income and advanced education do not automatically translate into HIV knowledge and behavior change.

(3) Mistrust of institutional public health due to past abuses

[See page 18, African Americans that mistrust institutional public health due to past abuses.]

(4) Strong avoidance of stigma

There appears to be a heightened concern about sexual identity among African American MSM, which Peterson attributes to "acceptance of Judeo-Christian views in African American religion and traditional gender roles in the African American family."[54] Other studies have noted the tendency of African American men to attribute their same-sex behavior to reasons other than homosexual orientation (e.g., recreational homosexual behavior to satisfy physical pleasure, situational homosexual behavior for economic reasons [commercial sex work or imprisonment]). Other behaviors associated with avoidance of "gay stigma" include engaging in frequent anonymous sex or preferring to take the insertive role in oral and anal sex. Studies have also shown that African American MSM are more likely than other MSM to report their self-identity as bisexual.[55] Some African American men shun any and all labels, and thus avoid the associated stigma.

(5) Inconsistent roles of African American churches

As stated in the Linkages Chapter of this *Plan*, African American churches could play a powerful leadership role in the fight against HIV. However, over the course of the epidemic, while some churches have been helpful and proactive,

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[55] Peterson, J.L. and A. Carballo-Dieguez. 2000. "HIV Prevention among African American and Latino Men Who Have Sex With Men," in *Handbook of HIV Prevention,* J. Peterson and DiClemente, eds. New York: Plenum Publishers.

other churches have contributed to complacency, shame, and misinformation about HIV. Churches have found it particularly challenging to address underlying issues of homosexuality and drug use.

(6) Sexual venues and social networks

Peterson emphasizes that an African American man's degree of gay-identification dictates his choice of venues and networks and that "the rates of HIV risk behavior may vary among the locales in which homosexually active African American men meet to form sexual liaisons because the norms regarding sexual behavior differ across social contexts and consequently affect the tendency toward sexual risk taking."[54] For instance, men who meet their potential partners in bars are more likely to have engage in higher risk sex than those men who meet their partners through friends, even when adjusting for alcohol consumption.

(7) Resources for help-seeking and social support

Some studies indicate that African American MSM are less likely to seek HIV-related help, and are more likely to turn to peers or health professionals (e.g., physicians). HIV positive African American MSM were especially unlikely to turn to family for support. In seeking out services, African American MSM have avoided situations where they would be the only African American participants.

c)   Native American/American Indian MSM
[See page 18, Native American/American Indian.]

Just as the public health approach to HIV comes into conflict with native ways, so also do western notions of "gay" and "straight." The term "two-spirit" is a relatively new term, but it draws on an ancient native tradition. Implicit in the term is a fluidity of identity, neither rigidly feminine nor masculine, and not defined by sexual behavior alone. As one American Indian put it, "We started to use this term because we didn't feel comfortable in many cases in simply defining ourselves by the colonizer's culture, which said that you were now going to be either gay or lesbian or bisexual. The idea of the Kinsey scale from zero to six, zero being completely heterosexual and six being completely homosexual, it seems to be part of the definition of being gay or lesbian or bisexual. You're at

one point on the line. Well, in our communities, in many of our communities, the tradition of sexuality is that you're at one point on a circle, and that all the points are connected, and you can be at any point on that circle at any one period in your life, and you don't necessarily have to be at one end of the line. And I think that's a major difference between many of our cultures and the cultures of the colonizers, is that it is a circular and connected sense of tradition as opposed to a linear, with really no options and no way for the ends of the spectrum to ever be connected."[56]

d) Asian American/Pacific Islander MSM
[See pages 18 – 19, Asian American/Pacific Islander]

6. Barrier and suitability issues for rural MSM

Thirty of the 73 MSM who responded to the *2000 Client Survey* were rural men. These men cited "building community support" and "groups" as their most significant prevention needs, though their differences when compared to the other MSM respondents were not statistically significant. Rural MSM expressed more need for needle exchange, substance abuse treatment, and discussion of other STDs as compared to their urban counterparts. In terms of suitability, rural MSM cited very similar issues as urban MSM, but "agency hours of operation" and "agencies not turning them into the police" emerged as more important for the rural respondents. As would be expected, the greatest barrier for rural MSM was agencies being located too far away. Rural MSM also noted a high level of concern over privacy as a service barrier, as compared to urban MSM. Rural MSM express a desire for service provider staff who are, themselves, living with HIV; this imposes major challenges to rural providers, who are hard-pressed to recruit qualified staff.

Gunter[57] substantiates rural MSM concerns about privacy. He points out that "confidentiality is a difficult issue within the rural environment. Because of the limited geographic boundaries and 'incestuous' nature of the systems, personal associations, work and leisure time activities and work patterns are usually well known to all in the community. The high level of visibility places the individual in jeopardy, particularly when receiving health and welfare services." Gunter also stated that in rural communities, due to funding problems, many agencies utilize paraprofessionals and volunteers as staff members. In these agencies there is a legitimate fear on the part of the individual seeking services that he/she may be disclosed by these paraprofessionals to others both within the agency and to community members. "For some reason, paraprofessionals, volunteers and nonprofessional workers in rural communities appear not to feel bound by the rules of confidentiality." It must be noted that Gunter's indictment of paraprofessionals is by no means universally true, and professionals have also been guilty of violating client rights to confidentiality.

In general, the damaging effects of a homophobic environment and isolation from "gay community" have had a devastating impact on rural men who have sex with men. The need for rural providers to be diligently non-judgmental and honoring of confidentiality is paramount.

Men who have sex with men in rural areas often do not feel the same freedom to be open about their sexual orientation as men in cities do. Some can be totally lost in knowing what to do with their attractions to other men in communities that can be so unaccepting. There are rarely any designated places where men can meet (such as bars or coffee houses) and providing access to condoms and other means of protection can be problematic in an environment where it is critical to maintain one's confidentiality. Less information about HIV and its prevention is

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[56] Harris, Curtis and Leota Lone Dog. 1993. "Two Spiritied People: Understanding Who We Are As Creation," *New York Folklore,* Vol. XIX, Nos. 1-2, pp. 155–164.

[57] Gunter, P. 1988. "Rural Gay Men and Lesbians: In Need of Services and Understanding," in *The Sourcebook on Lesbian/Gay Health Care, Second Edition,* M. Shernoff and W. Scott, eds. Washington, DC: The National Lesbian/Gay Health Foundation.

available in these environments as well. Overall, it is extremely difficult to specifically target MSM in rural areas, and providers often find it more feasible to target their services in an "orientation-neutral" manner, and including women among intervention participants. Venues such as alcohol and other drug treatment and corrections may also provide access to higher risk MSM, but are still generally "orientation-neutral".

Many rural MSM go to the cities to party with other men, but often do so without the same knowledge and tools as their urban counterparts.

Two issues concerning confidentiality can also impact the effectiveness of certain methods of intervention. First it tends to be a barrier to Group Level Interventions (GLI) in communities where it is unacceptable to identify with a group so stigmatized by the local population, and secondly it tends to be a barrier to GLI to discuss matters of personal risk in group settings where every one knows each other. In such cases, information obtained from interviews and focus groups in District four and eight has shown that potential clients prefer Individual Level Interventions (ILI).

Need for safer sex materials distribution/availability based on needs assessment results, low socio-economic status of rural communities and confidentiality issues.
Rural communities need availability of safer sex materials even if that must be provided as a "stand alone" intervention.

Due to difficulties in reaching specific target populations combined with very limited funding availability, adding HIV prevention interventions to existing programs for substance issues, domestic violence and other mental health issues, where viable, would be advised. Collaborations with these other providers might take the form of training their personnel on HIV issues for incorporation into the programs or by directly providing an "HIV segment" for the existing programs. Where these types of arrangements have been successfully implemented, providers of the existing behavioral change programs have reported increased interest by participants enhancing program effectiveness.

7.   Barrier and suitability issues for young men who have sex with men
As noted in a position paper issued by Advocates for Youth, "Homophobia and fear of encouraging sexual activity among young people make many adults even more reluctant to address sexual health in regard to young MSM. Because of the social stigma attached to a gay or identity and the threat of violence, many young men conceal their same-sex sexual behavior."[58] Their heterosexual male peers are particularly homophobic and AIDS-phobic; in recent surveys, college student males responded more often than females that "people with AIDS got what they deserved" and that "AIDS is proof that homosexuality should be illegal."[59] Significant numbers of lesbian, gay male and bisexual youths report having been verbally and physically assaulted, raped, robbed and sexually abused, making them particularly leery of any situation where they might be forced to self-disclose. Trust, particularly of adults, is difficult for the youth to give and for adults to earn under such circumstances. These are clear barriers when trying to reach YMSM with effective, appropriate HIV prevention interventions.

Young MSM practice behaviors that could result in HIV infection, sometimes at greatest rates than adult MSM. In a 1994 study among San Francisco's Young MSM, 28 percent of those 17 to 19 years-old and 34 percent of those 20 to 22 years-old reported engaging in unprotected anal intercourse during the previous six months.[15] A similar study in Los Angeles later found 55 percent of young MSM reporting unprotected anal intercourse in the previous six months. [15] In a 1996 study, 38 percent of young MSM reported having unprotected anal sex, and 27 percent reported having unprotected receptive anal sex. [15] More recent research is even more troubling. The Young Men's Health Study published July 12, 2000, involved over 3,400 young MSM in seven US metropolitan areas and had the following major findings:

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[58] Advocates for Youth. 1999. *Young Men Who Have Sex With Men: At Risk For HIV and STDs, www.advocatesforyouth.org.*
[59] Advocates for Youth. 2000. *Adolescent Males: Sexual Attitudes and Behaviors.* Published online, *www.pcisys.net/~health_ed/adolescentmales.html.*

- Prevalence of HIV was much higher than expected, 7.2 percent overall
- HIV was significantly higher among the African American youth, those that reported mixed or other race, those who had more than 20 partners, and those who reported anal sex with a man.
- Only 18 percent of those who tested positive as part of the study knew their HIV status beforehand.
- 41 percent reported having had unprotected anal intercourse in the prior six months
- 13 percent of the HIV-infected young MSM who knew they were infected still had unprotected, insertive anal intercourse during the past six months.[60]

Adolescence and young adulthood are times of experimentation and overwhelming role confusion, especially for gay youth. Of male adolescents who reported same-sex intercourse, one study found that 54 percent identified themselves as gay, 23 percent as bisexual, and 23 percent as heterosexual. In part, this is due to the nature of the "coming out" process when one's peers display high degrees of homophobia (see discussion above). Other youth may have not yet considered the question of sexual orientation, or are simply experimenting with different sexual behaviors, too often without condom use.[31]

Many young MSM perceive AIDS to be a disease of older gay men, often lack peer or other social support to encourage safer sex behavior, often do not consider their peers to be at high risk, and believe they can determine the HIV status of others by their appearance. Some YMSM lack adequate communication and assertiveness skills to negotiate safer sex. Some feel unable to refuse unwanted sex or feel compelled to exchange sex for money, food, or shelter.[31]

A 1998 nationwide study of 15 to 22 year-old young MSM indicates that predictors of unprotected anal intercourse include the following:

- finding safer sex difficult to practice,
- having suffered forced sexual contact,
- being high on amphetamines or alcohol during sex,
- having little social support,
- having a steady sex partner in the past six months,
- having only male sex partners in the past six months,
- feeling that there is little or no chance of avoiding HIV infection.[31]

Street youth have particularly difficult barriers to overcome. Transportation is difficult; moving a program even a few blocks, away from areas where they congregate and live, can be an insurmountable barrier. Young MSM practicing survival sex must constantly fear police harassment as well as violence in other forms. As with other homeless people, these young MSM have more fundamental needs that supercede their need for HIV interventions, such as food, shelter, and safety.

Schools are one of the few venues available to educate large groups of adolescents about HIV/STD prevention. However, local school district policies restrict sex education in schools and limit what teachers, health educators, and invited speakers can say to students, including discussing condom use, drug use and homosexuality. A Colorado law also requires parents to "opt in" students for sexuality education classes, and this is expected to discourage attendance in these courses. Exclusive insistence on abstinence, which predominates as a matter of policy at Colorado Department of Education and other statewide and local agencies, is not conducive to open and frank discussions of HIV shown to be critical components of effective programming.

Older MSM were targeted from the early 1980's with materials and programs designed to address their particular risk behaviors. Young gay and bisexual males today have not experienced an amount of personal loss of friends and lovers that would compel them to modify their risk behaviors.[31]

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[60] Valleroy, L., MacKellar, D., Karon, J., et al. "HIV Prevalence and Associated Risks in Young Men Who Have Sex With Men," *Journal of the American Medical Association,* Vol. 284, No. 2, July 12, 2000, pp. 198–204.

8. Transgender and gender variant people
[See page 19 – 20, Transgender and Gender Variant People.]

9. Disabled MSM

a) **General barriers faced by MSM with disabilities**

The first barrier that MSM with disabilities must face is the perception that they do not exist. This is partly due to the fact that predominant images of gay men come from popular gathering places (many of which are inaccessible) and the gay media (which portray extremely narrow views of beauty). Gay community has not fully embraced the gay disabled, contributing to social isolation and its damaging effects on health. Disabled persons may also be more prone to the use of drugs (prescription and non-prescription) for the alleviation of pain, and drug use has been demonstrated to be highly related to HIV risk.

Other barriers faced by MSM with disabilities can be found on page 20 – 21, "People with Disabilities."

A quote from an article written by a gay man with mental illness summarizes it as follows: "I know the experience of crying for help and no one hearing . . . Being gay with mental illness puts us in a difficult position. The gay community stigmatizes us for being mentally ill, and the mental health communities stigmatize us for being gay. Though things are getting better, we remain a forgotten, service-less population. Like all stigmatization, the labels hide the fact that many who attend the ZS groups [for gay men with mental illness] are highly educated, connected and attractive. Gay services have successfully secured services for gay health problems, and mental health advocates have promoted improved mental health services, but neither one have addressed the special needs of gay people with chronic mental health problems alone."[61]

10. Barrier and suitability issues for HIV positive MSM

Until recently, MSM living with HIV received little visible support for practicing safer sex. As primary prevention campaigns are developed for MSM living with HIV, their messages must not promote stigma or discrimination against HIV infected people, nor make people feel shamed for their desires to be sexual. Sexuality is part of a normal, healthy life – for positives and negatives.[62] Sexuality is tied to complex human needs, including the need for intimacy and love. HIV infected MSM wrestle with competing emotions, including altruistic concern for their communities; burnout from years of thinking about their infection; uncertainty about the expectations of their partners; and loss of control in sexual situations due to coercion, economics, power imbalances, or drug and alcohol use (see above). Any HIV prevention provider must be prepared to adopt harm reduction strategies that do not simplistically demonize "bare backers," but instead utilize behavioral interventions with MSM who are diagnosed with other STDs and deal competently with drug use, mental illness, and other deep seated factors.

MSM who are living with HIV are a tremendous, vastly underutilized resource in HIV prevention. As these men experience improving health status due to HAART, many are returning to the workforce. Their experience, drive by necessity, has given them powerful insights into the social, cultural, and personal factors that contribute to HIV risk; they are also extremely knowledgeable about the complexities of living with HIV and remaining adherent to medications. Such skill and insight could expand and improve our HIV prevention and care efforts. However, few of these men are actively recruited as staff members of HIV-related agencies.

Public policy set by federal, state, and local governments has a direct effect on the lives of MSM with HIV and on the ability to deliver meaningful prevention to them. On a structural level, policymakers need to examine the opportunity to use treatment programs as settings for HIV prevention interventions.

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[61] Coffman, B. 1999. "Being Gay and Mentally Disabled," *New York City Voices,* Jan/Feb, 1999, *www.newyorkcityvoices.com/jan99d.html.*

[62] Morin, S., Coates, T., Shriver, M. 2000. *Designing Effective Primary Prevention for People Living With HIV.* San Francisco: AIDS Research Institute, University of California, San Francisco.

Unsafe Heterosexual Contact

1. Overall Findings from the 2000 Client Survey

Twenty-two people at risk through heterosexual contact (HET) responded to the *2000 Client Survey*, in which they had an opportunity to describe the barriers they face and the characteristics of HIV prevention programs they perceive as suitable.

Compared to the other respondents, the HET respondents were significantly more likely to indicate three HIV prevention needs: counseling, testing, and referral; free condoms/dental dams; and discussion of other STDs.

In terms of barriers, statistically significant items voiced by the HET respondents were as follows:

- Agencies are too far away
- Inconvenient service times
- Service cost too high
- Only deal with HIV, not other issues
- Concern for privacy
- Too many things going on in client's lives
- Agencies don't understand client's issues.

In terms of program characteristics that make them suitable for HET, statistically significant items voiced by the HET respondents were as follows:

- Services come to me or are close
- Free/low-cost services
- Injector-specific agencies
- Women-specific agencies
- Agencies won't turn me in to police
- Agencies won't turn me in to INS
- Staff speaks my language.

During 1999, a community identification project (CIP) was conducted in Denver by researchers from Denver Public Health and the Empowerment Project with a subgroup of HET at significant risk: low-income women of color who use crack and other forms of cocaine.[63] In assessing the needs for programming for these women, certain factors appear particularly

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[63] Colorado Department of Public Health and Environment. 1999. *Summary of the DPH/Empowerment CIP with Low-Income Women of Color Who Use Crack and other Forms of Cocaine.* Denver: CDHPE.

critical. Foremost is the need for programs to address a complex set of needs in conjunction with HIV prevention. These would include basic needs such as food, housing, childcare, and transportation. Training, education, and employment-related assistance could also play a key role in helping women to become more self-sufficient and less dependent on unhealthy relationships. Access to appropriate and effective substance abuse treatment as well as mental health services could help women break the cycle of addiction, combat depression, and raise self-esteem.

Women participating in this Denver CIP frequently expressed a need for support from other women who are empathetic and who could offer them structure and on-going (intensive, at times) assistance in meeting their goals. Women who have similar life experiences to theirs were deemed the most appropriate in providing such support. Programs must emphasize the role of addiction and address HIV risk along with other risks, focusing, in part, on the root causes of sexual risk behavior. Other program-related ideas include considering the role of families (both positive and negative), addressing the impact of abuse and loss, and recognizing the power relationships facilitated by addiction. When possible and appropriate, HIV prevention could also be facilitated by engaging families in drug prevention with young children, intervening early with victims of abuse and loss, and capitalizing on the aspirations that women have for their children.

2. General Barrier and Suitability Issues for Women Who Have Sex With Men

Any woman who has unprotected sex with a man is at theoretical risk of becoming HIV infected. However, there are several factors that move this risk from the theoretical to the actual. The first factor is the HIV status of her partner. Some men – those who inject drugs, and those who also having sex with other men – are more likely to be infected because of where HIV is concentrated in Colorado. Other factors relate to the socio-cultural context for a woman's life, imposing barriers on her ability to make life-affirming choices, including the choice to seek out HIV prevention resources. For purposes of

planning, we will look at five of these major socio-cultural factors as if they were distinctly separate from one another: low socioeconomic status, trauma from early and ongoing abuse, substance use, mental illness, and power imbalances in relationships. In actuality, these five factors are complexly interrelated. When they are "layered" in a woman's daily reality, they conspire to produce chaos, dehumanization, and, too often, HIV infection.

a) Low socioeconomic status

Every decision about change involves a cost, and for women living in poverty, immediate probable costs often outweigh theoretical future costs, leading to a continuation of her vulnerability. Worth[64] describes the immediate probable costs as:

- Disruption in a relationship through violence,
- Loss of economic support,
- Loss of a 'father figure' for her children,
- Loss of a place to live.

In light of immediate, devastating costs such as these, HIV infection and death due to AIDS seem like improbable future costs to a woman living in poverty. To survive a life of extreme poverty, a woman soon learns to make choices that allow her to survive today's threats while suppressing thoughts about tomorrow's possible threats, to avoid sinking into despair.

The 1999 CIP[41] describes how sex is often what women in poverty use to obtain the drugs and/or money they need. In many cases, low self-esteem combines with certain demands of survival to discourage women from using protection when they have sex, though this is not always the case. Risk reduction strategies such as condom use, washing after sex, having oral sex (instead of vaginal or anal), limiting needle sharing, and cleaning needles are used occasionally by some.

b) Trauma resulting from early and ongoing abuse

As mentioned above in section a, women who have survived sexual coercion are significantly more likely to engage in behaviors that place them at higher risk of HIV infection. This finding was confirmed by the 1999 CIP, which found that sexual risk behavior among these women was driven by the complex interaction between their history of abuse and trauma, addiction, and low self-esteem. A large percentage of the women in the study reported a history of physical, sexual, verbal, and/or emotional abuse. Some had also suffered the traumatic loss of a loved one. This history, combined with the dynamics of addiction, had led to low self-esteem and frequent suicidal tendencies in many of the women interviewed.[41]

Multiple studies have shown that the majority of women living with HIV have lived lives of domestic abuse, including mental and emotional abuse, predating their HIV infection. One of these studies concluded that long histories of physical and drug abuse "leave many women believing that they cannot control their lives or bodies – especially in transactions with men involving sex or drugs." National studies show that 78 percent of sex workers interviewed underwent forced sexual intercourse before the age of fourteen.[65] Unfortunately, in Colorado, HIV education and intervention is an optional, but not mandated component of domestic violence programming.

Growing up in an abusive household, particularly when drugs or alcohol are involved, enhances vulnerability to HIV. A number of reasons for this vulnerability have been noted, including: a) lack of parental modeling of healthy relationships; b) a strong sense that abandonment is possible or probable if one does not submit willingly; c) a pattern of being silent about abuse, neglect, and betrayal; d) sex and affection being viewed as rewards or punishments; and e) high prevalence of incest in households where one or both parents are alcohol or drug dependent.[66]

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[64] Worth, D. 1989. "Sexual Decision Making and HIV/AIDS: Why Condom Promotion among Vulnerable Women is Likely To Fail," *Studies in Family Planning* 20(6, part 1): 297-307.

[65] Farmer, P; Connors, M.; Fox, K.; and Furin, J., eds. 1996. "Rereading Social Science," in *Women, Poverty, and AIDS: Sex, Drugs, and Structural Violence*, P. Farmer, M. Connors, and J. Simmons, eds. Monroe, ME: Common Courage Press.

[66] Starhawk. 1996. *Characteristics of Adult Children of Alcoholics.* Available online at wysiwyg://zoffsitebottom.61

c) Substance use

The 1999 Denver CIP found a strong relationship between substance use and women's vulnerability to HIV.[41] Substance abuse and addiction influenced by childhood trauma and/or dysfunctional relationships were common threads linking the women in the CIP. For many, substance use became the means of escape at an early age from immediate trauma and painful memory of past trauma.

For a woman with children, drug use is a particularly painful double bind. To escape its grip, which harms both herself and her children, she must admit her drug dependence to mistrusted institutions, which can result in the loss of custody of her children. As the 1999 CIP noted, "for the women with children, a continued source of stress was seen in how their drug use jeopardized both their rights to their children and their parenting abilities."[41]

Findings from national studies further underscore the complex relationship between drug use and HIV risk among women:

(1) Women are likely to begin or maintain cocaine use in order to develop more intimate relationships, while men are likely to use the drug with male friends and in relation to the drug trade.

(2) The onset of drug abuse is later for females and the paths are more complex than for males. For females there is typically a pattern of breakdown of individual, familial, and environmental protective factors.

(3) Abuse and substance use are closely related for women. Approximately 70 percent of women in drug abuse treatment report histories of physical and sexual abuse with victimization beginning before 11 years of age and occurring repeatedly. A study of drug use among young women who became pregnant before reaching 18 years of age found that 32 percent of the women had a history of early forced sexual intercourse. These adolescents, compared with non-victims, used more crack, cocaine, and other drugs (except marijuana), had lower self-esteem, and engaged in a higher number of delinquent activities.

(4) Although many women who partner with injection drug users are not themselves injection drug users, they are often users of other drugs including crack/cocaine.

(5) Addiction to crack among women is associated with high-risk sexual behaviors, such as the exchange of sex for drugs or money with concomitant increased risk for HIV infection and other sexually transmitted diseases.[67]

d) Mental illness

Early studies provide evidence of unprotected sexual activity among women with mental illnesses, as indicated by the tripling of the birth rate among women with psychotic disorders since deinstitutionalization. Studies of family planning in the 1970s and early 1980s further substantiate this, indicating that most women with mental illnesses who are sexually active do not use contraceptives.[68] This may relate in part to their lack of access to family planning services and gynecological care. In studies of sexual behavior related directly to HIV and AIDS, there is some indication that women with mental illness tend to have more partners than men. Among psychiatric outpatients, 42 percent of the sexually active women reported more than one partner, as compared to 19 percent of the men.[68] Kim and colleagues found that, among a sample of psychiatric inpatients with a history of crack cocaine use, women continued to have more partners than men despite a reduced sex drive following regular crack use. This may relate to the fact that these women exchange sex for drugs or the money to buy them.[46]

Trauma and substance use, as described above, are highly related to mental illness. Abuse and trauma shape a woman's perceptions of reality. If untreated, trauma can result in the severe psychological condition known at Post Traumatic Stress Disorder. Seeking to avoid any possible return of the abuse or trauma, women can become isolated, dissociated, and in search of a "protector." Tragically, this can also make them more vulnerable to future manipulation and abuse. In addition, women who experience a

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[67] Center for Substance Abuse Prevention. 1997. *Making the Connection Between Substance Abuse and HIV/AIDS for Women of Color and Youth*, www.health.org/sa-hiv/facts.htm.

[68] Goldfinger, S.M.; Susser, E.; Roche, B; and Berkman, A. 1996. *HIV, Homelessness, and Serious Mental Illness: Implications for Policy and Practice*. Delmar, NY: National Center on Homelessness and Mental Illness.

major depressive episode, generalized anxiety syndrome, panic attack, or agoraphobia (fear of being in an open space) in the past year are several times more likely to also have been dependent on non-prescribed drugs in the past year. [67]

e) Power imbalances in relationships

Sexism pervasively affects the lives of women in Colorado. Increasingly, some women are rising above this oppression and defying the forces that constrain them. However, for some women, barriers to self-determination are daunting, and the forces constraining them overwhelm the forces supporting them. These women are the most vulnerable to HIV. Women of all socioeconomic classes struggle with sexism, but the oppression falls disproportionately on women in poverty. As one report put it, "The common denominator for poor, drug-using women appears to be their limited power to control the course of their lives. Women fare much worse than men not because of their gender but because of sexism: unequal power relations between the sexes. More often than not, assertion of power (no matter what context) is not even an option for poor women." [65] Simply put; women in poverty stay entrapped in abusive relationships with men because they have few other options.

Locally, the 1999 CIP found that some women had supportive families, but for many, family and partners were sources of violence and, often, the catalysts for the initiation and maintenance of drug and alcohol use. A woman with dependent children is particularly vulnerable to domestic abuse, including abuse that involves HIV risk. She will endure high level of abuse if she believes the alternative –homelessness, in particular – will be worse for her children. [41]

Therefore, it's important to realize that women have sex with men under a wide variety of circumstances. If one naively assumes that her only male sexual partner is her husband or long-time boyfriend, with whom she needs to learn "assertiveness skills" or simply "walk away from a bad relationship," our services run the risk of being irrelevant to her living situation. She may, for instance, be exchanging sex for drugs or money, or she may be in a relationship based primarily on exploitation and violence. [27]

f) Social isolation

Compared to other groups who have been disproportionately affected by HIV (gay men and IDUs), women living with or directly affected by HIV tend to have more difficulty finding peers with whom they can share concerns and from whom they can receive support. However one defines "peers" – age, culture, socioeconomic status, etc. – there are few groups and individuals reaching out to women and earning the trust of women.

3. General Barrier and Suitability Issues for Men Who Have Sex With Women

a) Low perception of personal risk

Perception of personal risk has long been associated with changing risky sexual practices. In the case of men who have sex with women, this perception is often very low; many men who have sex with women do not feel that they are at risk of HIV infection, even if the sex is unprotected. To some degree this perception is based on a widely held but erroneous belief that AIDS is exclusively a disease of gay men and injectors; thus, homophobia dissuades heterosexual men from seeking any prevention services. To some degree, however, this perception is also based on biological reality. Certain studies suggest that per-exposure transmission from man to woman during genital-genital intercourse is two to five times more efficient than from woman to man. Other investigations have prompted researchers to argue that HIV is up to 20 times more efficiently transmitted from men to women than vice versa. HIV is more highly concentrated in seminal fluids than in vaginal secretions and may more easily enter the bloodstream through the extensive convoluted lining of the vagina and cervix. Vulnerable penile surface area is much smaller – in circumcised men without genital ulceration, only the urethral meatus is involved; in uncircumcised men, this area as well as the skin under the foreskin are potentially vulnerable.[69]

If men are less likely to become infected from their female partners, and they know they are

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[69] Simmons, J.; Farmer, P.; and Schoepf, B. "A Global Perspective," in *Women, Poverty, and AIDS: Sex, Drugs, and Structural Violence*, P. Farmer, M. Connors, and J. Simmons, eds. Monroe, ME: Common Courage Press.

less vulnerable, fear of infection is unlikely to prompt their safer behavior. For the more risk-averse men, any degree of risk will be unacceptable, and they will protect themselves and their partners. For other men, only an exaggeration of risk will be sufficient, placing HIV prevention providers in a position that challenges their ethical responsibility to be accurate.

This biological reality calls into question recent legislation, in Colorado and elsewhere, which depicts female sex workers as "reservoirs of HIV" and "vectors" who pose imminent risk to uninfected, unsuspecting male customers. In reality, these women are at far greater risk of *becoming infected* by male customers who use physical and economic coercion to discourage condom use.

Of course, fear of HIV infection is not the only motivation for practicing safer sex. Some men are concerned about other possible consequences of unprotected sex: other STDs (including incurable viral STDs such as HPV and genital herpes) and unintended pregnancy are realities that men do face, and many men have peers who have faced these challenges. This calls upon STD clinics, family planning, and pregnancy prevention programs to not only target men, but to also employ behavioral interventions utilizing motivations that are meaningful to these men.

Some men also genuinely care about their partners and do not want to infect them. If they know they are infected with HIV, or have uncertainty about their infection status, they will correctly and consistently use condoms because they feel it is the right thing to do.

b) Substance use

Studies have consistently shown that injection drug use is the most common way that heterosexual men become infected. However, use of other, non-injected drugs have also been correlated with higher HIV rates among these men.

Why do heterosexual men use substances? In fact, heterosexual men (like gay men and women) use substances for a wide variety of reasons. The following non-exhaustive possible list of reasons was compiled by Milton Luger: some wish to relieve boredom; some think it

exciting to taste forbidden fruits; some find that drugs relax them and diminish their stress and anxiety and prevent premature ejaculations; some think that they need the stimulation of the drug for the energy and drive to tackle difficult tasks; some use drugs to feel more at ease socially, to lubricate their communication skills, and to convince themselves that they 'belong,' despite some perceived personal shortcomings and lack of self-confidence; some are convinced that drugs make them more aware of issues and give them 'insights' into, and a better understanding, of their baffling world; some seek hedonistic, pleasurable experiences with drugs; some are convinced that they are less hostile and angry under the influence of drugs; some mentally disturbed individuals self-medicate in an attempt to control their personal emotional chaos; some continue using drugs to avoid withdrawal symptoms; some use drugs to punish others of significance in their lives, whom they find it difficult to confront directly about past sexual, physical or emotional abuse; some have so much psychic pain from such abuse early in their lives that drugs help temporarily to block out the resultant feelings of worthlessness and self-hatred; some are convinced that they deserve the relaxed, winding-down effects of drugs after competing in their daily cut-throat jobs; some need drug euphoria to convince themselves that they are not failures; some are basically anti-social and rebellious in nature - drugs satisfy their need to make that statement; some individuals wish to drop out of a society in which they believe they have no stake, encouragement or future. Substance abuse also gratifies the need of some families to keep one of its members infantilized, dependent, or as a target for their scape-goating. These are the families who sabotage efforts at treatment. Furthermore, drug use serves the unscrupulous, criminal, and corrupt elements in society who reap its vast profits.[70]

c) Heterosexual men, masculinity, and safer sex

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[70] Luger, M. 1989. "What Needs do Drugs Gratify? Alternative Ways of Meeting Those Needs." Presentation at the November 1989 Drugs, the Law, and Medicine Summit, *www.adocfund.org/library/drugs/drugs_summit.html*.

To fully understand the dynamic between men and their female sex partners, one must understand the nature of masculinity, which varies considerably by culture and by region. No universal statement about masculinity can be made. However, in many cultures, a dominant form of masculinity is "culturally exalted." While not all men conform to this dominant version, those who do not often find themselves discriminated against. Those who do subscribe to it benefit from what Connell calls "patriarchal dividend," which includes honor, prestige, the right to command, and material advantage over women.[71] This, in turn, strongly colors gender relations and sometimes imposes barriers for intervening in practices that are risky.

Greater freedom, power and control characterize male sexuality across a wide spectrum of different cultures. Consider the following list of issues arising from "culturally exalted masculinity" and "patriarchal dividend:"

(1) Some men cite "masculinity" to legitimize not only unequal roles and relationships between women and men, but also between men. They encourage us to see men who challenge this situation as effeminate, weak, subservient or immature. Despite being ostracized, some men will continue the challenge to change prevailing gender relations and inequalities. Other men will be silenced by the criticism.

(2) Cross-cultural research suggests that men, in general, usually have a greater lifetime number of sexual partners and that there are clear double standards regarding the behavior of men and women. For example, while in many cultures women are expected to preserve their virginity until marriage, young men are encouraged to gain sexual experience. Indeed, having had many sexual relationships may make a man popular and important in the eyes of his peers.

(3) Male sexuality is often thought of by both men and women as unrestrained and unrestrainable, and among some men an STD is considered a badge of honor that confirms manhood.

(4) In some cultural contexts, the roots of homophobia are not about sex per se, but more about "men taking the role of women" and thus becoming subservient.

(5) Heterosexual anal sex is commonly assumed to be a method of preserving virginity and preventing pregnancy. However, recent studies suggest that for some men at least, anal sex may also be symbolic of increased power and control over women. For men interviewed, anal sex was seen as a 'conquest' to be equated with 'taking' a woman's virginity for a second time.

(6) Some have suggested that masculinity itself is threatened by condom use. There are several reasons for this: first, if condom use is requested by a woman this allows women to define the terms of sexual engagement; second, condom use may involve men having to deprioritize their own sexual pleasure; third, for men to demonstrate a degree of control over sexual behavior may be feminizing since male sexuality is most usually understood as uncontrollable; and finally, risk-taking in itself is considered to be typically masculine.

(7) Some men may be reluctant to use condoms with regular sex partners because this necessitates addressing fidelity issues, both in terms of admitting additional sex partners or condoning multiple partners of female sex partners.

(8) Non-penetrative sex is rarely an option in heterosexual relationships since vaginal sex tends to be understood as adult sex, and other forms of sexual pleasure may be seen as a kind of backsliding into adolescence. This may explain, at least in part, why HIV prevention programs very rarely suggest "giving up vaginal sex" as a viable risk-reduction option for heterosexuals, but commonly suggest "giving up anal sex" as a viable option in programs designed for men who have sex with men.

Rivers[49] summarizes the situation as follows: "In order to avoid the problems which come from failing to conform to dominant gender stereotypes, women risk the damage associated with conformity. Men on the other hand may find that by conforming to stereotypical versions of masculinity, they place themselves and their partners at heightened risk. These contradictions need to be exposed so as to identify the dividend that accrues to both women and men when

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[71] Rivers, K. and Aggleton, P. 1999. *Men and the Epidemic.* London: Thomas Coram Research Unit, Institute of Education, University of London,
www.undp.org/publications/gender/mene.htm.

existing gender roles are transformed or cease to be obeyed. By working to show how many men do not meet idealized forms of masculinity, discussion about how some men are marginalized can begin to take place."

In a similar vein, Cornwall[33] observes "If gender is to be everybody's issue, then we need to find constructive ways of working with men as well as with women to build confidence to do things differently."

d) MSM who have sex with women
AIDS case reports and behavioral studies based on convenience samples suggest that behaviorally bisexual men use condoms inconsistently with male and female partners, seldom disclose their bisexuality to their female partners, and are more likely than exclusively homosexual men to report multiple HIV risk behaviors. Male bisexuality may present greatest HIV risk in the context of a) male prostitution, b) injecting drug use, c) sexual identity exploration, and d) culturally specific gender roles and norms such as those that may characterize some African American and Latino communities in the United States.[72] For instance, a survey of men who have sex with men and women found that 54 percent of their female partners did not know about their homosexual activity and 65 percent of the men had engaged in unprotected sex with their female partners.

e) Male injectors who have sex with women
According to published research, most male IDUs are sexually active and heterosexual, and significant proportions have multiple female partners.[73] In one sample, while white males were about as likely to have an IDU partner as a non-IDU partner, only a third of the African-American males reported having a female IDU partner during the preceding year, while 85 percent reported having a female non-IDU partner. African-American males were more likely than white males to have sex with a non-

IDU female and were more likely than whites to have multiple non-IDU female partners. This is NOT to say that women of color are less likely to be infected. Rather, it means that white males were more likely to have multiple IDU female partners.

Several studies have reported the low use of condoms among heterosexual male IDUs. Ross and colleagues compared IDUs across sexual orientation groups and reported that, compared to gay and bisexual male IDUs, heterosexual male IDUs were the least likely to use condoms. Reported rates of condom use vary by study; however, most report nonuse at more than two-thirds.[51]

Watkins and colleagues[51] compared in- and out-of-treatment IDUs on their sexual risk behaviors. Out-of-treatment IDUs reported significantly more partners than in-treatment IDUs and more often exchange sex for money or drugs. Alcabes and colleagues[51] also compared in-treatment to out-of-treatment IDU samples and found that the out-of-treatment IDUs tended to be younger, male, and African American. However, associations between HIV-1 seropositivity and a series of demographic and drug-using characteristics were similar in direction and magnitude among subjects currently in treatment and those not in treatment. Lewis and Watters[51] reported that sexual risk-taking behavior in a sample of IDUs was associated with recent increases in both injecting and smoking cocaine.

4. Barrier and suitability issues for people of color

a) Latinos/as at risk through heterosexual contact
Researchers Marin and Gomez[74] have noted the following characteristics of Latino culture that relate to HIV risk and barriers to risk reduction:

(1) Men in Latino communities may have more sexual partners
When surveyed, Latina women report fewer sexual partners in the previous twelve months as

[72] Doll, L.S. and Beeker, C. 1996. "Male Bisexual Behavior and HIV Risk in the United States: Synthesis of Research with Implications for Behavioral Interventions," *AIDS Education and Prevention*, 1999 June, 8(3): 205-25.
[73] Stephens, R.C and Alemagno, S.A. *Injection and Sexual Risk Behaviors of Male Heterosexual Injection Drug Users.* NIDA Monograph 143.

[74] Van Oss Marin, B. and C. Gomez. 1998. "Latinos and HIV: Cultural Issues in AIDS Prevention," in *The AIDS Knowledge Base.* Internet document published by University of California San Francisco, http://hivinsite.ucsf.edu.

compared to non-Latino whites of either gender or Latino men. Marin and Gomez conducted a nine-state phone interview that found twice as many married Latino men reported multiple sexual partners in the previous year as non-Latino white married men (18% versus 9%). In addition, the interview found that 60 percent of unmarried Latino men reported multiple sexual partners in the past 12 months.[52]

(2) Condom use is not popular among Latinos and Latinas

Latino men and women who have multiple partners are equally likely to report condom use with a secondary partner, but they are far less likely to use condoms consistently with a primary partner. Studies suggest that men in Latin American countries perceive condoms as more appropriate outside of marriage. Less acculturated Latinas report carrying condoms less frequently and using condoms less as compared to more highly acculturated women. Those Latinas who reported less condom use with steady male partners also reported higher expectations that the partner would be angry if condom use were requested, were more likely to use some other birth-control method, had less confidence in their ability to use condoms, reported a more negative attitude toward condom use, had fewer friends who use condoms, and had less knowledge of how to use a condom than those who reported more condom use.[52]

(3) Anal sex, while not exclusive to Latinos and Latinas, is perhaps more common among Latinos and Latinas.

A national representative survey of men's sexual behavior found Hispanic men far more likely than non-Latinos to report anal sex, with more partners, and occurring more frequently.[52] In a broad national study conducted by Laumann,[75] 12.5 percent of Hispanic women reported engaging in anal sex in the last year, compared to 8.4 percent of White women and 6 percent of Black women. Laumann's study also showed that 18.9 percent of Hispanic men reported engaging in anal sex in the last year compared to 8.3 percent of White men and 9.7 percent of Black men.

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[75] Laumann, E.O.; Gagnon, J.H.; Michael, R.T.; and Michaels, S. 1994. *The Social Organization of Seuxality: Sexual Practices in the United States.* Chicago: University of Chicago Press.

(4) Discomfort discussing some sexual matters, especially condom use, is part of Latino culture.

Privacy issues appear to be more sensitive in Latino culture than in non-Latino white culture. Sexual issues are often avoided even between sexual partners. In traditional Latino households, the "good" woman is not supposed to know about sex, discouraging her to bring up subjects like AIDS and condoms. Latinos report significantly more discomfort regarding sexual matters than non-Latino whites. In a national survey, 19 percent of unmarried Latinos surveyed reported feeling uncomfortable discussing condoms with a sexual partner, a rate of discomfort significantly higher than among non-Latino whites.[36] Such sexual discomfort and embarrassment has been associated with less frequently carrying condoms and with lower perceived ability to use condoms.[52] Despite a strong emphasis on family interactions, Latinos are currently less likely than other groups to provide their children with critical information about sex and AIDS.[52] Overall, this barrier appears related to four areas: sexual socialization, lack of information about sexuality, degree of openness about sexual behaviors, and other pressing issues.[52]

(5) Latinos tend to subscribe to very traditional beliefs about gender roles.

According to traditional gender role beliefs, Latino men are to be highly sexual.[48] In a survey of the 10 states in which 87 percent of Latinos reside, 69 percent of unmarried Latino adults agreed that "Men want to have sex more often than women" and 51 percent disagreed that "Men can control their sexual desires as easily as women."[52] There is strong evidence that traditional gender roles in Latino culture condone sexual coercion.[52] In a 10-state survey, 30 percent of men reported lying to get sex, while more than 50 percent said they insisted on sex when their partner wasn't interested (and a comparable proportion of women reported their partners insisted on sex when they weren't interested).[52] Those men who reported more traditional gender role beliefs also reported greater sexual coercion, defined here as lying and pressuring a women to have sex when she's not interested. Marin and Gomez express their concern about a core set of beliefs, including "beliefs about the inability of men to control sexual impulses and the belief that women

should please men rather than consider their own desires and needs, beliefs that simultaneously make men more coercive and women more submissive. These beliefs are so widespread that many Latino men and women would probably not perceive as coercive a situation in which a man insists on sex when the woman is not interested." Latino men who reported multiple sexual partners in the 12 months prior to interview reported even greater levels of traditional gender roles and sexual coercion than those who reported only one partner.[52]

b) African Americans at risk through heterosexual contact

(1) African Americans mistrust institutional public health due to past abuses ostensibly preventing sexually transmitted diseases.

[See page 18, African Americans that mistrust institutional public health due to past abuses.]

Interventions obviously targeting African Americans (such as condoms with "African motif" wrappers) are viewed with suspicion, and when AIDS drugs produce side effects, they are suspected as causing AIDS.

(2) African Americans are disproportionately affected by social upheaval and displacement, which are directly linked to enhanced vulnerability to drug use and HIV.

HIV among Colorado's African American citizens is highly concentrated in urban Denver. Wallace[54] has studied social upheaval in rapidly changing urban environments such as Denver, and has come to a number of conclusions about its relationship to the HIV and substance use epidemics among African Americans.

Such communities are overwhelmed with a multitude of social ills, from violence to homelessness, and residents find it difficult to rally scarce resources to deal with concerns like HIV, which seem to be less immediate. With people moving quickly in and out of neighborhoods, little community cohesion develops. Programs must attempt to constantly educate and re-educate an ever-changing community, and such programs are also extremely difficult to establish and maintain in neighborhoods that lack people who plan to remain for the long term. When people do move to other locations, they often take a long period of time to adjust to their new neighborhoods. During this transition time, they tend to be socially isolated from friends, peers, extended family, and potential service providers.

(3) African American male IDUs tend to have non-IDU sexual partners.

As mentioned previously, only a third of the African-American males in one study reported having a female IDU partner during the preceding year, compared to about half of white male IDUs.[51] In the same study, 85 percent of African American IDUs reported having a female non-IDU partner. African-American males were more likely than white males to have sex with a non-IDU female and were more likely than whites to have multiple non-IDU female partners.

(4) Although poverty is highly linked to HIV in heterosexuals of all races and ethnicities, poverty rates among African American women living with HIV are notably higher.

In a study of 2,898 persons living with AIDS in 11 states (including Colorado), African American female people living with AIDS (PWAs) infected heterosexually were more likely to have completed less than 12 years of education (51%), be unemployed (89%) and be living in households with incomes under $10,000 (81%). In comparison, these same rates were much lower among white women living with HIV (31% with less than 12 years of education, 81 percent unemployed, and 49 percent living in households with less than $10,000 income). In both cases, however, these rates were much worse than national averages for women (22% with less than 12 years of education, 7% unemployed, and 15% living in households with less than $10,000 income).[76]

In a California study, it was found that the cumulative incidence of AIDS among African American, Latina and White women is highest for women residing in zip codes with the lowest median household income level. However, the survey also found that for African American women, residing in the higher income zip code areas did not appear to reduce the risk of AIDS compared with those living in a lower income zip code areas. As zip code income level

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[76] Diaz, T.; Chu, S.Y.; Buehler, J.W.; et al. 1994. "Socioeconomic Differences Among People With AIDS: Results From a Multistate Surveillance Project," *American Journal of Preventive Medicine,* 10(4), pp. 217–22.

increased, the cumulative incidence of AIDS did not steadily decrease among African American women. This was only true for African American women; AIDS incidences significantly decreased as income increased for all other racial/ethnic groups of women.[45]

(5) Young African Americans continue to be challenged by gang and social activities that involve drug use and substantial HIV risk.

House parties, sometimes known as "orgy parties," are increasing in popularity in African American communities. Gang initiation is also a common occurrence. Both of these activities often involve young people involved in high risk sexual and drug use behaviors, usually without condoms or other risk reduction.

Substantial drug experimentation is driving this increasing "party culture." New mixtures of cocaine, codeine, and fruit juices or soft drinks have come into vogue. These drugs can enhance sexual risk taking and encourage sexual exploitation of women.

c) Native Americans/American Indians at risk through heterosexual contact

[See page 18, Native American/American Indian.]

The general health status of Native Americans is lower in almost every national health indicator. Substance use, primarily alcohol use, accounts for most of the top ten causes of early death, either directly or indirectly. STDs such as gonorrhea, syphilis, and chlamydia are, on average, twice as high for Native Americans as for the US population as a whole; in some areas, the rates are seven to ten times higher. Sexual activity starts early, as evidenced by teen pregnancy rates; 20 to 25 percent of Native American babies are born to mothers 18 years of age or younger. As noted by the National Commission on AIDS, "STD rates may be higher for Native Americans because of high rates of substance use, overall poor socioeconomic conditions, and lack of access to the level of health care enjoyed by other Americans. It has been only within the past year that any movement has occurred within the Indian Health Service to begin an aggressive

campaign to prevent STDs and to intervene early in the course of the infection."[77]

d) Asian Americans/Pacific Islanders at risk through heterosexual contact

[See pages 18 – 19, Asian American/Pacific Islander] Additional principles recommended when working with API at risk through heterosexual contact:

- Target settings associated with health (e.g., traditional Chinese pharmacies).
- For API women, protecting family and community may be a compelling reason to reduce risk. In addition, strategies should consider empowering women with their male partners present, incorporating parenting skills, and targeting entire residential buildings or apartment complexes where there are many API families living.
- Leadership may be where it is not usually expected (e.g., grocery store owners in API neighborhoods).
- To work through API social networks, repeated contact is essential.
- Power imbalances and gender role ideology are particularly evident in some API cultures, particularly among recent immigrants.

5. Barrier and suitability issues for rural residents

Rural communities can provide their members both strong support and strong condemnation at times. In rural areas, low perceptions of HIV risk, traditional moral values, conformity to community norms and intolerance of diversity can be strong. In some cases, HIV education for the community in general is hindered due to homophobia, racism, sexism, and stigmatization of people with AIDS, homosexuals, minorities and drug users.[78] Over time, stigma attached to one or more of these groups rises and falls, but never disappears entirely.

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[77] National Commission on AIDS. 1992. *The Challenge of HIV/AIDS in Communities of Color: The American Indian and Alaskan Native Community,* *http://hivinsite.ucsf.edu/topics/native_americans/2098.2b78.html.*

[78] Center for AIDS Prevention Studies, University of California, San Francisco. 1997. *What Are Rural HIV Prevention Needs?* San Francisco: UCSF.

Confidentiality can be hard to maintain in rural areas, yet is crucial for many residents due to fear of stigmatization. Testing for HIV, accessing HIV-related care, discussing sexual practices with clinicians, obtaining drug treatment, or buying condoms in local stores-all important preventive activities-can be difficult to do confidentially in rural areas.[59]

Two issues concerning confidentiality can also impact the effectiveness of certain methods of intervention. First it tends to be a barrier to Group Level Interventions (GLI) in communities where it is unacceptable to identify with a group so stigmatized by the local population, and secondly it tends to be a barrier to GLI to discuss matters of personal risk in group settings where every one knows each other. In such cases, information obtained from interviews and focus groups in District four and eight has shown that potential clients prefer Individual Level Interventions (ILI).

Health care providers are the primary source for health education and prevention counseling in many rural areas. However, rural clinicians may believe that HIV is not a problem in their area, may not conduct proper risk assessments of patients, and may not properly diagnose cases. Rural physicians may also be reluctant to become known as "the AIDS doctor" for fear of scaring off other patients.[59]

In addition to addressing prevention issues in their own areas, rural service providers must also address issues surrounding residents who travel to urban areas and may engage in high risk sexual or drug using behavior while there. Rural health care and prevention providers are also burdened by the migration of HIV positive patients who may have become infected in urban centers and returned home to rural areas for family support.[59]

Geographic and climactic conditions can hinder access to preventive services, especially in rural Colorado. Many rural residents do not have access to transportation, and for those who do, rugged topography, severe winters and long distances between towns can mean traveling several hours for medical care, HIV prevention, or social services.[59] Due to rural economic conditions, establishing new services is often not feasible, nor is it possible to expand services that are highly related to HIV, such as one-on-one

counseling and services for women in abusive relationships. It is certainly not because such services are not needed; for example, Laumann's large-scale study of sexual practices found a higher rate of forced sex reported by rural women (18%) compared to urban women (16%).[53]

Schools are one of the few venues available to educate adolescents about HIV/STD prevention in rural areas, but are even more likely to be closed off due to the factors described in section six, below.

For many seasonal migrant farm workers, poverty, lack of access to health care services and isolation have hampered HIV prevention efforts. Recent anti-immigrant laws, including mandatory HIV testing, have driven many at-risk migrant workers into an underground way of life and have made it hard to offer services to these workers.[43]

Need for safer sex materials distribution/availability based on needs assessment results, low socio-economic status of rural communities and confidentiality issues.
Please see notice regarding need for safer sex materials in rural areas as described on page 34.

6) Barrier and suitability issues for young men who have sex with women and young women who have sex with men

Unprotected sexual intercourse puts young people at risk not only for HIV, but also for other sexually transmitted diseases and unintended pregnancy. Currently, adolescents are experiencing skyrocketing rates of STDs. Every year three million teens, or almost a quarter of all sexually experienced teens, will contract an STD. Chlamydia and gonorrhea are more common among teens than among older adults. Some sexually active young Latinas and African American women are at very high risk for HIV infection, especially those from poorer neighborhoods. A study of disadvantaged out-of-school youth in the US Job Corps found that young African American women had the highest rate of HIV infection, and that women 16 - 18 years old had 50 percent higher rates of infection than young men. Another study of African American and Latina adolescent females found that young women with older boyfriends (three

years older or more) are at higher risk for HIV.[45]

Adolescence is a developmental period marked by discovery and experimentation that comes with a myriad of physical and emotional changes. Sexual behavior and/or drug use are often a part of this exploration. During this time of growth and change, young people get mixed messages. Teens are urged to remain abstinent while surrounded by images on television, movies and magazines of glamorous people having sex, smoking and drinking. Double standards exist for girls, who are expected to remain virgins, and boys, who are pressured to prove their manhood through sexual activity and aggressiveness. And in the name of culture, religion or morality, young people are often denied access to information about their bodies and health risks that can help keep them safe.

A recent national survey of teens in school showed that from 1991 to 1997, the prevalence of sexually activity decreased 15 percent for male students, 13 percent for White students and 11 percent for African American students. However, sexual experience among female students and Latino students did not decrease. Condom use increased 23 percent among sexually active students. However, only about half of sexually active students (57%) used condoms during their last sexual intercourse.[79]

Not all adolescents are equally at risk for HIV infection. Teens are not a homogenous group, and various subgroups of teens participate in higher rates of unprotected sexual activity and substance use, making them especially vulnerable to HIV and other STDs. These include teens that are gay/exploring same-sex relationships, drug users, juvenile offenders, school dropouts, runaways, homeless, or migrant youth. These youth are often hard to reach for prevention and education efforts since they may not attend school on a regular basis, and have limited access to health care and service-delivery systems. Youth who are not in school have higher frequencies of behaviors that put them at risk for HIV/STDs, and are less accessible by prevention efforts. A national survey of youth aged 12 - 19 found that nine percent were out-of-

school. Out-of-school youth were significantly more likely than in-school youth to have had sexual intercourse, have had four or more sex

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[79] Advocates for Youth. 2000. *Adolescent Males: Sexual Attitudes and Behaviors,* www.pcisys.net/~health_ed/adolescentmales.html.

partners, and have used alcohol, marijuana and cocaine.[60]

School district policies restrict sex education in schools and limit what teachers, health educators, and invited speakers can say to students, including discussing condom use, drug use and homosexuality. A Colorado law also requires parents to "opt in" students for sexuality education classes, and this is expected to discourage attendance in these courses. Exclusive insistence on abstinence, which predominates as a matter of policy at Colorado Department of Education and other statewide and local agencies, is not conducive to open and frank discussions of HIV shown to be critical components of effective programming.

a)   Young men who have sex with women
Overall, messages delivered to and internalized by young men pose serious challenges to anyone attempting to minimize their risk of acquiring or infecting their female partners with HIV. Young men are seldom mentored about respectful sexual behavior, that sex should never be abusive to themselves or their partners. Instead, for too many of these young men, consequences are minimized and sexual exploits are celebrated with no discussion of responsibility.

While males initiate sexual activity earlier than females, overall patterns are similar, with dramatic increases in sexual activity occurring at age 14 for males and age 15 for females; the percentages become equal around age 16. Adolescent males are four times more likely than adolescent females to report having three or more sexual partners; those who report more than two sexual partners in the last year are significantly less likely to use condoms consistently. Almost 20 percent of teen males report never using condoms while only 30 percent use them at every sexual encounter. In a national survey, only seven percent of teen males reported their partner using female-controlled contraceptive methods. Both young men and women agree that when condoms are used, males generally are the ones to obtain and provide them.[60]

Adolescence and young adulthood are times of experimentation and overwhelming role confusion. Of male adolescents who reported same-sex intercourse, one study found that 54 percent identified themselves as gay, 23 percent

as bisexual, and 23 percent as heterosexual. In part, this is due to the nature of the "coming out" process when one's peers display high degrees of homophobia. Other youth may have not yet considered the question of sexual orientation, or are simply experimenting with different sexual behaviors.[80] Too often, this form of exploratory sex is not protected.

Only about half of young males in one survey discussed sexuality issues with a parent compared to 75 percent of young females. Parent and daughters communicated far more frequently than parents and sons on sexual facts, sociosexual issues and morality. Only 45 percent of teen males surveyed said they had studied the topics of biology, birth control, AIDS, and negotiation skills; five percent said they had studied none of these topics.[60]

Adolescent males (84%) are significantly less likely to report feeling comfortable refusing sex than are females (91%). Among college students, males are less likely than females to believe that men are always responsible for their own actions regardless of how sexually provocative they find a situation. Adolescent males (26%) are significantly more likely than females (seven percent) to feel pressure from friends to have sex; whereas teenage women report more often feeling pressured into sex by male partners. Thirty-two percent of teenage males say they have non-forced sexual experiences that they have regretted, compared to eight percent of teen females. [60]

A survey of California high school students found that more males than females knew about STD prevention and correct condom use. Seventeen percent of teenage males report worrying about AIDS "all the time" and 22 percent worry "frequently". Only six percent think they have a "very strong" or "strong" chance of HIV infection. Frequency of worry about AIDS was significantly associated with condom use. One survey found that over 90 percent of high school males thought preventing HIV was equally (46%) or more (48%) important than preventing pregnancy. As knowledge

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[80] Advocates for Youth. 1999. *Young Men Who Have Sex With Men: At Risk For HIV and STDs, www.advocatesforyouth.org.*

regarding AIDS increased, the young men placed less importance on pregnancy prevention. [60]

A 1993 survey found that 76 percent of boys have been sexually harassed in school compared to 85 percent of girls. While girls are likely to suffer more emotional effects from harassment, boys are more likely to be harassed in locker rooms, to be called gay, and to avoid telling anyone. National estimates indicate that 15 percent of males have been sexually abused as children compared to the estimate of 28 percent for females. *Male victims of childhood sexual abuse are at twice the risk of HIV infection as male non-victims and are at increased risk of substance abuse.*[60]

Adolescent males are three times more likely than females to accept the rape myths common in our culture and to find coerced sex more acceptable in more situations. Such rape myths include belief that their female partners provoked the rape and that they will be able to evade consequences even if accused of rape. While 70 percent of male college undergraduates in one study did not believe that date rape was a serious offense, another study found that educating adolescent males about rape can be effective in changing attitudes about coercive sex. [60]

b)   Young women who have sex with men
Young women who have sex with men experience many of the same barriers and challenges mentioned earlier in this chapter. Domestic abuse, both physical and emotional abuse, is a pervasive reality, particularly when their boyfriends are older than they are. They experience pressure to submit to sex or become unpopular, and the boundaries between girlhood and womanhood are becoming increasingly blurred. They receive messages, directly and indirectly, that being female is inferior. They receive messages that virginity is highly prized – and that it can be preserved through risky, unprotected anal sex. They also receive contradictory messages – that being a virgin indicates that a girl is not popular with the boys.

Voices of a Generation: Teenage Girls on Sex, School, and Self, a report released by the American Association of University Women (AAUW) Educational Foundation, describes and analyzes differences among girls' responses by race, ethnicity, and region. This report is based on Sister-to-Sister Summits sponsored nationwide by AAUW to bring together teenage girls ages 11 - 17 to talk openly with each other about the most important issues they face today. From November 1997 to November 1998, girls participating in these summits answered six questions about their daily lives. The report is a detailed analysis of responses by 2,100 girls.[81]

According to the report, girls want to learn how to say no to sex and still say yes to intimacy. Sex and pregnancy are the number one issues facing teenage girls today. While the majority of girls list sex and boys as major issues in their lives, only a handful of girls discuss "love" or "sexuality." One girl suggests that schools should "educate everyone that there are other ways of showing affection besides sex." Girls say they need the tools to learn how to say no and how to negotiate emotionally charged relationships.

The report also reports that girls admit that sexual pressure comes not just from boys but from other girls, from their friends, and from the media. Astoundingly, the only age group not to mention "pressure to have sex" at all is the 11 year-olds. While the pressure on teenage girls to have sex at an early age knows no ethnic, racial, or geographic bounds, African American and Hispanic girls cite pregnancy as an issue in their lives more than white and Asian American girls and do so at a younger age. African American and Hispanic girls describe pregnancy as a "choice," though not one they generally condone, while white and Asian American girls describe it as an "accident" and caution against the "risks" and "dangers" of sex. These results call for strengthened linkages with pregnancy prevention programs.

Only a small number of girls voice concern about birth control, abortion, and AIDS despite all their talk about sex. As noted in *Voices of a Generation*, "Girls want to learn how to say 'yes' to relationships without automatically saying 'yes' to sex. They don't want sex to be an all or nothing issue. They're missing the middle ground of affection, intimacy, and relationships."

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[81] American Association of University Women. 1999. *Voices of A Generation: Teenage Girls on Sex, School, and Self.* Washington, DC: AAUW Educational Foundation.

Teenage girls face many conflicting pressures – pressure to fit in, to look and act a certain way, to have sex, do drugs, and drink. The pressure to be popular and cool competes against the hidden "authentic" self that many girls admit they repress to be included. White and Asian American girls talk about the "pressure to fit in" far more than Hispanic and African American girls. A number of girls talk about the climate of sexual harassment in schools. Girls frequently cite incidents of boys as young as 12 or 13 calling girls "bitches," "sluts," and "whores" or making crude requests for sex. One 13 year-old writes: "Once someone told me to have sex with them, and when I didn't because I'm not that kind of girl ... they called me a bitch and a lesbian."

Girls feel torn between a traditional view of femininity and the contemporary realities of being a woman. As one girl writes, "Girls need a clear definition of girls or women. We are encouraged to be assertive through TV, magazines, and some adults, but we're punished indirectly by the world when we do." The report also finds that many girls point their fingers at the media for promoting a very narrow, restrictive image of women and girls as skinny, sexually alluring, and popular to the exclusion of more important attributes and values. A summit participant writes, "...Media messages tell us to be a certain shape and size, our friends and peers want us to like certain things, our parents wish we'd act a specific way. With all the different messages from all different angles, it is sometimes hard for a girl just to find the person she really is."

Many girls note that the problems and issues they face are related to boys. The girls propose innovative boy-girl summits to address these issues together and better learn to understand each other.

Girls need real tools to help them navigate the stormy waters of teen sexuality. They call on schools to move beyond "just say no" and abstinence training to help them better understand the complex social and emotional nature of relationships, not just the basic anatomy and biology of sex.

7. Transgender and gender variant people
[See page 19 – 20, Transgender and Gender Variant People.]

8. Disabled people at risk through heterosexual contact
a) General barriers faced by people with disabilities
[See page 20 – 23, People with Disabilities.] In addition, disabled persons may be more prone to the use of drugs (prescription and non-prescription) for the alleviation of pain, and the drug use has been demonstrated to be highly related to HIV risk.

9. Barrier and suitability issues when one or both sexual partners are living with HIV
A recent study of 175 serodiscordant opposite-sex couples[82] revealed important information about the barriers they face, which fall under four general headings:
- Communication about HIV
- Keeping sex alive
- Involving/engaging the male partner
- Providing support and counseling to the HIV negative partner.

a) Communication about HIV
"Outside" response to a couples' serodiscordance was a common concern. Stigma was experienced at the level of family, friends, and community. Some struggled with the public exposure of the relationship, and many felt unsupported in their relationship by some family members and friends: Difficulty with disclosure of both the HIV positive partner's status and the mixed serostatus in the relationship were frequently mentioned. Internalized stigma impacted couple's ability to communicate about HIV in their relationships.

Managing HIV meant managing identification in the relationship as either the HIV infected or uninfected partner. Differences in roles and identities of the HIV negative and HIV positive partner was alienating at times and impeded communication about HIV.

b) Keeping sex alive
Many participants received skills and support through the Partner Study to lead a healthy and active sexual life after the HIV diagnosis of a

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[82] van der Straten A; Vernon KA; Knight KR; Gomez CA; Padian NS. 1998. "Managing HIV among serodiscordant heterosexual couples: serostatus, stigma and sex." *AIDS Care*, Oct, 10(5):533-48.

partner. This was an important validation for those who felt pressure to end all sexual activity or their relationship because of HIV. Many HIV positive partners described a process of sexual abdication immediately after testing HIV positive.

There were many couples in which HIV positive partners reported worry and fear about infecting their HIV negative partners. This presented an on-going struggle with the role of sex in the relationship. Even participants who consistently practiced safer sex, described the struggle between the "rationality" of lower risk safer sex and the "irrationality" of fear and guilt associated with sexual intercourse with negative partners.

The Partners Study helped alleviate sexual loss through risk reduction counseling, regular HIV testing for the negative partner, and epidemiological knowledge about HIV transmission. This knowledge helped to normalize HIV in sexual relationships, combating stigma and increasing relationship comfort.

Overall, HIV risk management strategies ranged from the adoption of consistent safer sex practices for some couples to the perception of immunity from HIV infection for others. Regular study visits provided an opportunity to talk about HIV and a "reality check" that helped maintain safer sex practices for some couples. Participants described the challenge of translating the knowledge about HIV into their sexual relationship as a double-edged sword that could help or harm their ability to consistently practice safer sex. Couples use of knowledge of HIV transmission illuminated the conflict between generalized epidemiological facts and behavior in a single serodiscordant relationship. Ever changing "facts" about HIV also created problems within couples in the management of HIV (such as inconsistent messages about the relative safety of oral sex).

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c) **Involving/engaging the male partner**
Both women and men interviewed explained that the woman partner in the relationship was responsible for involving her male partner in the study. Study participation helped women to engage otherwise unresponsive male partners. Study participant's statements were particularly enlightening in this regard:

"It [the Partner Study]was his only contact with anything to do with HIV. It was very minimal, but at least it was something and I think that's it. (HIV positive woman)"

"It was very difficult to get my husband to do anything. So it was the only thing actually that I could do for myself and indirectly he could benefit. (HIV negative woman)"

"My husband's not a real social creature and, so I think it was really important for him to be involved in just getting this information, but I think it was really important to me. I tend to be the conduit through which we stay connected to things. (HIV negative woman)"

Though not specifically cited in the study, other possible reasons for male reluctance to fully participate in HIV prevention programs might be fear of losing one's female partner and being unable to find a new one and discomfort accessing services from a "gay-identified" provider.

d) **Providing support and counseling to the HIV negative partner**
The management of HIV was a "couple issue." Yet, many participants reported feeling that appropriate couple services, particularly for heterosexuals, were unavailable. This was particularly true of HIV negative women who expressed a great need for counseling and support.

Sharing of Needles and Other Injection Paraphernalia

1. Overall Findings from the 2000 Client Survey and 1997 Community Identification Project

Ten injectors responded to the *2000 Client Survey*, in which they had an opportunity to describe the barriers they face and the characteristics of HIV prevention programs they perceive as suitable. This is a very small sample, and generalization should be done only with caution.

As might be expected, the injector respondents expressed a strong need for free, clean needles and affordable, respectful substance abuse treatment. These respondents were also over five times more likely than non-injectors to indicate a need to meet with a counselor one-on-one to deal with life problems that are more important to them than HIV (i.e., PCM).

In terms of service suitability, two criteria emerged as more statistically more important to these respondents in choosing an agency as their HIV prevention service provider:
- The agencies are set up for injectors.
- I know the agencies won't turn me into the police.

In terms of barriers, the ten injector respondents were over six times more likely than non-injector respondents to voice the barrier "The agencies only deal with HIV, and I need other services, too."

In a separate 1997 community identification project (CIP) studying injectors in nine Colorado communities, respondents cited a number of additional barriers:
- No perceived need for services
- Lack of money
- Not knowing where services are
- Services perceived as ineffective
- Lacked of medicated detoxification in the state
- Stigma associated with going to health care settings
- Won't access services until desperate for help
- For female IDUs, fear of losing their children.

When asked what would make services more suitable, respondents cited the following:
- Lowering of costs

- Granting clients more respect
- Assuring clients that there will be no consequences
- Syringe exchange available
- Expanded hours of service, possibly at night or on weekends
- Better inpatient treatment
- Increased advertising
- More convenient locations
- Better referral system.[83]

2. General Barrier and Suitability Issues for Injectors

Pervasive social and cultural attitudes about drug use impose strong barriers dissuading injectors from accessing prevention services and subsequently reducing risky behaviors.

a) Barriers due to the perceptions of drug use and drug treatment practices

To effectively prevent HIV infection due to the sharing of needles and other injection paraphernalia, it is necessary to have some level of understanding of drug use and drug dependence. Without extensive training, HIV prevention providers cannot be expected to become drug treatment and drug prevention experts. However, without at least minimal grounding in the broader field of addictions, HIV prevention providers may take approaches that are neither effective ways to minimize the harm of drug use nor compatible with effective HIV prevention.

Over time, various models have dominated the addiction field, each of which has shaped treatment practice, especially at the time of its pre-eminence. The earliest model, the Moral Model, focuses on drug use as sinful and/or criminal behavior, implying that drug users required moral direction and social sanctions. The Temperance Model, which emphasizes the harmful nature of the drug itself, and the need for prohibition and other supply reduction followed this chronologically. The next model, the Disease Model, holds that people who are addicted to drugs have irreversible constitutional abnormalities, for which lifelong abstinence is the only answer; the Alcoholic and Narcotics

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[83] Wolff, Wendy. 1997. *Cooperative Research Project.* Denver: Colorado Dept of Public Health and Environment.

Anonymous movements arose from this model. The Disease Model has been subsequently expanded to include educational, psychotherapeutic, operant conditioning, and biomedical interventions provided in a medical or quasi-medical manner (diagnosis, prescription, cure or long-term supervised disease management). The main alternative to the Disease Model has been the Sociocultural Model, which attempts to modify environmental factors and cultural norms that are associated with drug use, mostly through community interventions and social policy change. In recent years, hybrids of the Disease and Sociocultural Models have emerged, acknowledging that addiction is, in fact, an individual disease with complex cultural and environmental aspects that must also be addressed.

The Harm Reduction Model flows from this new, hybrid approach. The Harm Reduction Coalition describes the key aspects of this model as follows:

- Accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them, and both affirms and seeks to strengthen the capacity of people who use drugs to reduce the harm associated with their drug use.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's

vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.[84]

Although the efficacy of the Moral and Temperance Models in treating drug addiction is poorly supported by research, with some research indicating harmful results, these early models are still very commonly encountered, both in popular opinion and in drug treatment practice. These models continue to dominate the criminal justice system (law enforcement, sentencing, probation, etc.) and are often the rationale underlying repressive laws and regulations. Programs built on these models tend to alienate and marginalize users, complicating the delivery of effective HIV prevention. For instance, one of the reasons commonly cited for the sharing of needles is the fear of being arrested for possession of drug paraphernalia, which involves painful detox and withdrawal; to avoid arrest, users would rather rent or share equipment, regardless of resultant HIV risk. Other effects of repressive laws are cited in section d, below.

Not all injectors share needles and other drug paraphernalia. Studies have shown a number of characteristics to be more likely for injectors who share compared to injectors who do not share:

- Multiple drug use
- Use of a "shooting gallery" (locations, usually in urban areas, where injectors go to rent equipment when they do not have access to their own)
- Higher score on drug use severity test,
- Cocaine use (mostly because the shorter effect time of cocaine requires more frequent injection)
- Amphetamine use
- Younger in age (in the 1997 Colorado community identification project, described below, 62% reported starting injecting at age 14 - 21)
- Perception that peers will be insulted by refusal to share
- Heightened sensitivity to withdrawal symptoms

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[84] Harm Reduction Coalition. 2000, *www.harmreduction.org/prince.html*.

- Psychiatric symptoms (especially somatization, interpersonal sensitivity, depression, hostility, and anxiety)
- Economic motivation to share
- Do not own injection equipment
- Fatalism about eventually developing AIDS.[85]

In 1997, CDPHE commissioned a community identification project (CIP) studying injectors in nine Colorado communities.[69] This study identified a number of barriers to behavior change arising from injecting practices themselves. For instance, syringe re-use is very common, and is linked to both community norms and equipment availability. Almost half of the users in this study reported giving or loaning syringes to someone else between one and 480 times in one month. Only 22 percent reported using a new syringe every time. Reported reasons for re-using syringes were:

- Having no money to purchase syringes
- The point on the syringe is better once you use it a few times
- Wasteful not to re-use a syringe
- Only use it with my shooting/sexual partner or by myself
- Store hours are inconvenient
- Don't want to run out.

Among those who reported using someone else's syringe, the most commonly cited reasons were:

- Too concerned about getting high
- Friend had a syringe so they didn't need their own
- The place to get a new syringe was too far away or too inconvenient
- The illegality of carrying syringes, and fear of facing detox in jail
- In a hurry, or it was a spur of the moment decision.

Different levels of risk are associated with different injectable drugs. Heroin injection is the drug most commonly associated with IDU; however, cocaine and other stimulant use is common among people living with or at high risk of HIV. Cocaine abuse is associated with a high risk of HIV infection because of greater frequency of cocaine injections as compared with opiate use. Because of its shorter half-life and lack of depressant effects, cocaine can be injected ten or more times per day, in contrast to the usual three to five times per day in heroin addiction. The link between cocaine use and HIV transmission may be especially strong among heroin addicts because they may be more likely to inject cocaine than smoke it, thus increasing the chances for infection with shared needles.

Methamphetamine abuse is a serious and growing problem in the United States. Deaths involving methamphetamine use have increased 61 to 73 percent between 1992 and 1993. Methamphetamine has been closely tied to increased high risk HIV behaviors; in fact, methamphetamine users have the highest rates of HIV seroconversion of any group of drug users in San Francisco. The risk for HIV infection is due to several factors. Methamphetamine's activating effects may enhance sexual behavior for some individuals and increase impulsivity and sexual risk-taking. Among the reported sexual effects of methamphetamine use are prolonged intercourse and more frequent sex with casual partners. In cities such as San Francisco and Seattle, injection is the dominant route of administration. When methamphetamine is injected, it can lead to the exchange of blood if syringes or other injection materials are shared. Moreover, methamphetamine use appears to be especially popular among gay men, who already have higher rates of HIV risk behaviors than the population at large. Studies have shown that among gay and bisexual men, those individuals who use methamphetamine have significantly higher levels of HIV seroprevalence than other groups at risk. In a study by Harris et al.,[86] for example, HIV infection was three to four times higher among methamphetamine injectors than among those who did not use methamphetamine. Methamphetamine is prominent among substance-abusing men who reported a close association between drug use and high-risk sexual behaviors, such as unprotected receptive anal intercourse. Methamphetamine use may also serve as a conduit for the spread of HIV from gay men to heterosexual drug users as the latter come into needle-sharing contact with gay or bisexual men.[87]

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[85] Stephens, R.C and Alemagno, S.A. *Injection and Sexual Risk Behaviors of Male Heterosexual Injection Drug Users.* NIDA Monograph 143.

[86] Harris NV, Thiede H, McGough JP, et al. "Risk factors for HIV infection among injection drug users: Results from blinded surveys in drug treatment centers, King County, Washington, 1988-1991." *J AIDS* 1993;6(11);1275-1282.

[87] Batki, S and Sorenson, J. "Systems of Care for HIV-Infected Injection Drug Users," in *The*

As mentioned above, when Colorado injectors were asked why they did not utilize drug treatment and other services, a common response was "these services are ineffective." To some extent, these sentiments are substantiated by outcome effectiveness research. With the exception of heroin, other injectable drugs do not have treatment that involves chemical replacement, and efficacy of different treatment approaches varies widely. For instance, in regard to cocaine addiction, 60 percent of cocaine-addicted clients who attended a relapse prevention program in New York were continuously abstinent from cocaine during the six to 24-month follow up period, but only 36 percent of cocaine-using clients of a neurobehavioral therapy program were abstinent from cocaine six months after entering treatment.[88]

For heroin users, methadone is currently available in Denver, Boulder, and Colorado Springs. Some clients of methadone programs have successful outcomes, stabilizing the effects of their addiction while avoiding the harmful effects of tainted heroin. There also appear to be strong HIV prevention benefits from the availability of methadone; multiple studies have concluded that length of time in methadone treatment results less likelihood of becoming infected with HIV.[89] However, there are numerous barriers and difficulties associated with methadone which interfere with its effectiveness as an HIV prevention strategy:

- Cost can be a serious barrier, averaging $140 per month in the Denver area. Subsidies exist for injectors living with HIV, but not for those at high risk who are HIV negative. Non-payment of fees results in serious consequences, including sudden loss of access to methadone and rapid (often very painful) detox procedures; when payments are late, the situations is discussed not only with the administrative staff, but will also be raised by the therapist, leading to the perception that "money is what really matters to the clinic."
- Some providers of methadone exhibit a high degree of bias against drug users (see further discussion below).
- Appropriate dosing is critical. Inappropriately low methadone doses have been associated with HIV infection, because patients on lower methadone doses are more likely to be currently injecting.[74]
- Methadone is not a cure for drug addiction; it is a highly addictive chemical substitute for heroin. Withdrawal from methadone is as difficult, if not more difficult, than withdrawal from heroin. Methadone also has serious side effects over time, such as liver damage.
- In the for-profit methadone clinics, the other necessary services are often minimalized as cost-saving procedures, or an additional fee is required.
- For those who want to live "drug free," the success rate following detox from methadone is not hopeful; more than 80 percent of addicts resume drug use within one year after stopping methadone treatment.[73]

In regard to the other effects of drug use in the life of an injector, the 1997 CIP report stated the situation as follows: "Drug use is paradoxical. On the one hand, drug users commented on how it is related to uninhibited sexual activity, temporary feelings of self worth, sense of community, and the avoidance of difficult situations. On the other hand, though seldom recognized by the users but expressed in other terms, drugs act to prohibit long term intimate relationships, discourage real belonging, and add to feelings of worthlessness. Further, when users are high, condom use is often neglected. Moving beyond the behavioral to understanding the significance of patterns and practices of drug use will be essential if HIV intervention agencies are to succeed. Merely handing out condoms, or syringes for that matter, does not encourage the type of change in the individual or the social scene that is necessary for developing a reduced risk community." [69]

The most common strategy employed when needle exchange is not available has been distribution of bleach kits and instruction on use

AIDS Knowledge Base. Internet document published by University of California San Francisco, *http://hivinsite.ucsf.edu.*

[88] Government Accounting Office (GAO). 1996. *Cocaine Treatment: Early Results from Various Approaches,* www.druglibrary.org/schaffer/govpubs/gao/cocaine_treatment.htm.

[89] Ward,J.;Mattick, R.; and Hall, W. 1992. *Key Issues in Methadone Maintenance Treatment.* New South Wales, AU: University of New South Wales Press.

of bleach to disinfect injection equipment. To prevent both HIV and HCV infection, up to three minutes of soaking and rinsing is now advised. This relatively time-consuming process poses a formidable barrier; only extremely motivated injectors will take the time necessary for this technique to be effective.

b) The social network of IDUs

A common prevention message delivered to injectors has been "Do not share." One of the barriers involved in the acceptance of this message is the social nature of injection drug use, both sharing of drugs and sharing of equipment. In the 1997 Colorado CIP, 88 percent of respondents reported sharing and/or buying drugs with other people in the past 30 days versus by themselves. Only four percent of respondents said that they never shared drugs with others. Of the 88 percent who shared or purchased drugs with someone else, 73 percent shared with a relatively small network of one to four people; only eight percent shared or purchased with 10 – 20 people. Typically, the circle of drug users stays the same over time; 63 percent of respondents reported getting high with the same group of people over the past six months. [69]

"Shooting galleries" appear to be less common in Colorado than in other, more urban locations such as Los Angeles or New York. The 1997 CIP states, "The individuals interviewed claimed that the places they typically inject were either their own home, a friend/relative's house, and/or hotel." This is further confirmed by the finding that only 15 percent of the injectors reported that they rented or bought a used syringe, a common practice in shooting galleries. [69]

As mentioned above, drug sharing is a very common practice in Colorado. Grund[90] suggests deep roots for drug sharing: "Sharing drugs facilitates contact and communication, smothers conflict, and reinforces enduring relationships... Ultimately, drug sharing is aimed at maintaining the subculture." If the equipment used to divide and mix the drugs is shared, there is a danger of HIV transmission.

In couples, Murphy[91] points out that needle sharing may substitute feelings of sexual intimacy and represent an intimate part of their relationship. Some female injectors are dependent on their male partners to inject them, with the male partner exerting control over her access to drugs and injection equipment. The 1997 CIP also found that it was "very common for a sexual partner to also be an injector." Some interviewees also reported that they shared with people other than their main partner, but did not tell their main partner about this additional sharing. [69]

Needle sharing appears also to be related to initiation to injecting drug use. In part, this is because novice users seldom have their own equipment (initial injection usually being unplanned and spontaneous). It may also constitute a rite of passage, movement from non-IDU to IDU status. [71]

c) Pervasive bias against drug users

In the 1997 Colorado CIP, a number of injectors reported that "the moment service providers see track marks on a client's body, this is the moment that respect gets diminished."[69] The bias against drug users, particularly injectors, is pervasive in our communities. As mentioned above, this is partly a remnant of the Moral Model, which condemns drug users as sinful or criminal. Clearly, this bias creates barriers for injectors who must self-identify in order to access HIV prevention and substance abuse treatment services.

A experience described by a Denver injector reflects the high degree of bias that dehumanizes and alienates injectors from health service providers. Due to tainted heroine, his arms had become highly infected and required immediate surgery. Just as the surgeon at the publicly funded hospital was beginning the operation, he told the injector, "I am an excellent surgeon, but I wonder if it's worth it for me to be doing this surgery on an addict like you." This injector's complaints, filed through the appropriate official channels, were dismissed and ignored.

The popular media often perpetuates the following roots of bias against drug users with little or no chance for dispute or clarification:

[90] Grund, J-P. 1993. *Drug Use as a Social Ritual: Functionality, Symbolism, and Determinants of Self-Regulation.* Rotterdam: Instituut voor Verslavingsonderzoek, 177-195.

[91] Murphy, S. 1987. "Intravenous Drug Use and AIDS: Notes on the Social Economy of Needle Sharing," *Contemporary Drug Problems,* 14:373-395.

(1) Fear of criminality associated with drug use
To fund the expense of purchasing drugs, injectors do resort to illegal acts, especially property crime. Gang activity, and its violent aftermath, are also linked to drugs. Injectors, even former injectors in methadone programs, are often cast in this negative light.

(2) Belief that "people get what they deserve"
Support for behavior health resources is generally lower than support for other health resources. A sizeable portion of our society sees drug addiction as willful behavior that can be changed if sufficiently desired by the addict. Those who die from the effects of drug abuse or from HIV or HCV are thus seen as "getting what they deserve" for not changing as they should.

(3) Classism
A sizeable portion of injectors are homeless or living in very low socioeconomic conditions. Predominant public opinion tends to be highly critical of public entitlement programs, as evidenced by widespread support for welfare reform and scaling back and narrowing of benefits for the disabled. Programs for poor injectors are seen in a similar, negative light.

(4) Racism
Although Caucasians in Colorado actually constitute the largest single segment of the injector population, there is a popular misconception that drug use is predominantly a people of color issue. General bias against people of color therefore acts against meeting the needs of injectors in general.

Biases such as these drive injectors into hiding; many injectors will avoid contact with HIV prevention or drug treatment agencies for fear of being oppressed. When they do make contact with a provider, they will look for evidence of these biases, and many will walk away, preferring the dangers of substance use to the corrosive effects of institutional abuse.

d) Effects of restrictive laws
The 1997 Consensus Statement issued by the National Institutes of Health states the following position on needle exchange, with which CWT concurs:

"An impressive body of evidence suggests powerful effects from needle exchange programs. The number of studies showing beneficial effects on behaviors such as needle sharing greatly outnumber those showing no effects. There is no longer doubt that these programs work, yet there is a striking disjunction between what science dictates and what policy delivers. Data are available to address three central concerns:

4. Does needle exchange promote drug use? A preponderance of evidence shows either no change or decreased drug use. The scattered cases showing increased drug use should be investigated to discover the conditions under which negative effects might occur, but these can in no way detract from the importance of needle exchange programs. Additionally, individuals in areas with needle exchange programs have increased likelihood of entering drug treatment programs.
5. Do programs encourage non-drug users, particularly youth, to use drugs? On the basis of such measures as hospitalizations for drug overdoses, there is no evidence that community norms change in favor of drug use or that more people begin using drugs. In Amsterdam and New Haven, for example, no increases in new drug users were reported after introduction of a needle exchange program.
6. Do programs increase the number of discarded needles in the community? In the majority of studies, there was no increase in used needles discarded in public places.

There are just over 100 needle exchange programs in the United States, compared with more than 2,000 in Australia, a country with less than 10 percent of the US population. Can the opposition to needle exchange programs in the United States be justified on scientific grounds? Our answer is simple and emphatic-no. Studies show reduction in risk behavior as high as 80 percent in injecting drug users, with estimates of a 30 percent or greater reduction of HIV. The cost of such programs is relatively low. Needle exchange programs should be implemented at once."[92]

It is unfortunate that, in Colorado, political expediency has prevailed over science and sound public health practice in regard to needle exchange. To reiterate the NIH position – Needle

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[92] *Interventions to Prevent HIV Risk Behaviors. NIH Consensus Statement* 1997 Feb 11-13; 15(2): 1-41.

exchange programs should be implemented at once.

As mentioned previously, the possession of injection equipment in Colorado is illegal. As a result, injectors hesitate to carry their own equipment, leading to more sharing, and thus more HIV risk.

Criminal justice and public health have extremely different approaches to HIV. Increasingly, as part of their "war on drugs," the criminal justice system has been demanding expanded access to drug treatment records. Those who violate a judge's expectation of total abstinence from drug use are often reported by drug treatment facilities for violations, and thereby suffer severe consequences. Public health is about the support of healthier behaviors, not punishment – but, too often, providers of services are legally obliged to do things that jeopardize their ability to practice effective public health.

Given the high degree of stigma attached to injection drug use and HIV, the passage of laws or regulations that may ultimately breach confidentiality are likely to alienate injectors from the HIV prevention system. Injectors are particularly sensitive to laws that allow the criminal justice system to access and make use of information divulged to HIV prevention providers in order to pursue sentence enhancement or prosecution.

e)   Special concerns of women who inject
Women who inject are less likely than their male counterparts to enter treatment. Recent research suggests that these women are often single mothers who are forced to earn money through commercial sex work or directly from the drug trade. They suffer severe discrimination both inside and outside the drug subculture. A partner who injects may also victimize them, keeping women locked in relationships of sexual abuse as well as continued drug use. Therefore, their abstinence from injection drug use would necessitate major life restructuring, and most HIV prevention programs are ill equipped to assist in meeting the resultant multitude of needs.

Among injection drug users, women who have sex with women have higher HIV rates than do women who have sex with men only. A study of female IDUs in 14 US cities found that, compared to heterosexual women, women who

have had a female sex partner were more likely to share syringes, to exchange sex for drugs or money, to be homeless and to seroconvert.[93] In light of this evidence, women who have sex with women are at risk through injection behaviors, and programs must be tailored to their unique needs.

3.   Barrier and suitability issues for people of color
In general, people of color who are also injectors must cope with two forms of bias: the bias against drug users and the bias arising from racism. Aside from this commonality, it is important to recognize the unique experiences of the diverse communities that fall under the heading "communities of color."

a)   Latinos and Latinas who inject
In regard to Latino injectors, the *2000 Epidemiologic Profile* reveals a disturbing trend: 39 percent of the HIV cases diagnosed among injectors in 1998 – 1999 were Latino, reflecting an increasing trend among IDUs.
According to a report issued by the National Council of La Raza,[94] barriers faced by Latino injectors are formidable, and include the following:

(1) Barriers due to stigma
Many Latino drug users, especially undocumented individuals, lead secretive lives desperately trying to avoid the discovery and consequences of their addiction. For example, many drug users fear that if their addiction is known, their partners will leave them. This lack of disclosure makes it harder to target and reach a sex partner with prevention education.

Many Latino drug users are reluctant to participate in HIV/AIDS programs because they fear others will assume they are HIV positive or they will have problems with the police. Many avoid drug treatment programs because they may have been admitted several times before or may have been picked out for abusing drugs on the

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[93] Young RM, Weissman G, Cohen JB. (1992). Asessing risk in the absence of information: HIV risk among women injection drug users who have sex with women. AIDS and Public Policy Journal, 7:175-183.
[94] Peters-Rivera, V.; Martinez, G.; Drone, A. 1995. *Injection Drug Use in the Hispanic Community.* Washington, DC: National Council of La Raza.

premises and fear that staff will treat or judge them harshly.[80]

(2) Special concerns of undocumented and recent immigrants

Undocumented individuals may be less likely to seek services because of their fear of deportation. Even those who have documented status may face deportation if they are found in violation of the law, which is a real concern to drug users who, besides using illicit substances, may be selling them in order to earn money.

Isolation from their families, ethnic group, and culture may contribute to the drug addiction of some Latinos and Latinas who leave their homeland to come to the mainland United States. Marginalization is highly stressful and may result in feelings of alienation and loss of identity, placing Latinos in this situation at a greater risk for drug abuse. [80]

(3) Barriers faced by Latinas

Female drug users in the Latino community may need special services, such as child care, to successfully participate in HIV/AIDS programs. In a national study of drug treatment facilities, most Latino clients receiving substance abuse treatment are male. This may be due to the fact that most programs are specifically designed for males and do not address barriers to treatment many women face. For example, many women with children have nowhere to leave them during drug treatment, especially residential care. Feelings of embarrassment or disapproval of a jealous partner may also deter women.[80]

(4) Barriers faced by non-English speaking Latinos

Latino drug users with limited English skills may find it difficult to use available mainstream social services. There may be no Spanish-speaking staff to help them, and they may be intimidated if they do not speak English well. Many also may have limited literacy skills and are unable to fill out necessary forms without appropriate help. [80]

(5) Barriers due to predefined notions of "drug use"

Latinos in Colorado, especially recent immigrants, also inject vitamins, antibiotics, and other medicine, reflecting a common practice in Mexico. In some cases, needles are shared extensively, especially within families. HIV prevention programs built exclusive around "illicit drug use" will fail to address these other risky behaviors.

(6) Barriers due to lack of cultural-specific substance abuse treatment

As stated by Victoria et al, "Hispanic drug users may have limited access to mainstream drug treatment facilities. According to national data on drug treatment facilities, Latinos in drug treatment received fewer substance abuse services than drug users as a whole. According to the 1991 figures, aftercare follow up, family therapy/counseling, and crisis intervention were the services least available to Latinos. Only 56.5 percent of Latino clients received aftercare follow up services compared to 7l.7 percent of all clients. Only 60.4 percent of all Latino clients received family therapy/counseling compared to three-quarters (75.9%) of all clients. Latinos (42.0%) were also less likely than the total client population (56.4%) to receive crisis intervention services. The services most available to Latinos were individual therapy/counseling, group therapy/counseling, and referrals, usually available through community-based programs."

Providers must recognize the importance of family and cultural values such as 'respecto,' 'dignidad,' 'orgullo,' 'verguenza,' 'machismo,' and fatalism when addressing the issue of HIV/AIDS and injecting drug use. Providers should use their professional reputation and knowledge to help overcome community prejudices against drug users to provide effective outreach.

Latinos have tended to underutilize drug treatment facilities, but much of this underutilization may be explained by treatments that are inappropriate to Latino culture. In some ways, Latino culture can be incompatible with help-seeking for a drug problem. In Latino culture, difficult and embarrassing problems like drug abuse are solved within the family whenever possible. Traditional approaches to drug treatment (detoxification, methadone maintenance, and therapeutic communities) may be very unattractive to Latino drug users. Methadone maintenance has been criticized as an "easy way out," because the client remains addicted, which contradicts a "macho" image. In therapeutic communities, the recovering-addict community becomes the addict's "family," which is culturally inappropriate for Latinos who

place special emphasis on their families and cannot substitute them easily. [80]

b) African Americans who inject
The barrier and suitability issues for African American injectors include the following:

(1) Disproportionate impact of repressive laws and their enforcement
African American communities frequently have been the target of police drives to enforce drug laws. According to federal crime statistics, among whites there were five arrests per year per 100 users of heroin and cocaine in 1996; among blacks, there were 20 arrests per 100 users. In other words, the arrest rate for black users was four times higher than the arrest rate for white users.[95]

As stated in a recent national report, "We can now begin to see why the number of injection-related new AIDS cases is so high among blacks: arrests for possession are higher. This means that the legal system, via the police, is more likely to confiscate the personal needles of blacks. Also, because black users know (correctly) that they are vulnerable to arrest, these users are likely to "choose" not to carry their own clean needles. Users who do not carry their own needles all too often end up sharing the needles and blood-borne diseases of others."[78]

(2) Mistrust based on past abuses of African Americans by institutional public health.
[See page 18, African Americans that mistrust institutional public health due to past abuses.]

(3) Barriers due to lack of cultural-specific substance abuse treatment
Effective substance abuse treatment for African Americans should explicitly incorporate African American culture into the treatment experience. Such opportunities are rarely available to Colorado's African American communities.

(4) African Americans are disproportionately affected by social upheaval and displacement, which are directly linked to enhanced vulnerability to drug use and HIV
HIV among Colorado's African American citizens is highly concentrated in urban Denver.

Wallace[80] has studied social upheaval in rapidly changing urban environments such as Denver, and has come to a number of conclusions about its relationship to the HIV and substance use epidemics among African Americans.

Such communities are overwhelmed with a multitude of social ills, from violence to homelessness, and residents find it difficult to rally scarce resources to deal with concerns like HIV, which seem to be less immediate. With people moving quickly in and out of neighborhood, little community cohesion develops. Programs must attempt to constantly educate and re-educate an ever-changing community, and such programs are also extremely difficult to establish and maintain in neighborhoods that lack people who plan to remain for the long term. They also create an ecological niche for shooting galleries and other anonymous injection sites, where large scale sharing threatens to quicken the spread of HIV and HCV.

When people do move to other locations, they often take a long period of time to adjust to their new neighborhoods. During this transition time, they tend to be socially isolated from friends, peers, extended family, and potential service providers.

c) Native Americans who inject
[See page 18, Native American/American Indian.]

The general health status of Native Americans is lower in almost every national health indicator. Substance use, primarily alcohol use, accounts for most of the top ten causes of early death, either directly or indirectly.[96]

d) Asian Americans/Pacific Islanders who inject
[See pages 18 – 19, Asian American/Pacific Islander] An Additional principle recommended when working with API injectors:
- Power imbalances and gender role ideology are particularly evident in some API

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[95] Day, D. *Health Emergency 1999: The Spread of Drug-Related AIDS and Other Deadly Diseases Among African Americans and Latinos.* Princeton, NJ: The Dogwood Center.

[96] National Commission on AIDS. 1992. *The Challenge of HIV/AIDS in Communities of Color: The American Indian and Alaskan Native Community,* http://hivinsite.ucsf.edu/topics/native_americans/2098.2b78.html.

cultures, particularly among recent immigrants.

4. Barrier and suitability issues for rural residents

As shown in the epidemiologic profile, HIV infection due to injection drug use is on the rise among rural residents. Injection drug use takes place in all regions of the state.

The 1997 CIP included interviews with injectors in four rural Colorado counties: Weld, Larimer, La Plata, and Mesa.[69] Two of these sites, Fort Collins and Mesa county, involved sufficient numbers of injectors to have separately-reported results within the larger report. The generalizability of these findings to all rural areas cannot be assumed, but the findings do give insight to how rural injectors might differ from urban injectors.

The typical Fort Collins injector was found to be socio-economically different than the typical urban street user. Of the Fort Collins injectors interviewed, 29 percent reported full-time employment, and 14 percent reported regularly performing day labor as a living. Twenty-one percent of the interviewees reported selling or re-selling drugs as their primary source of income. Many of these interviewees lived in their own home or apartment (43%), although a significant number did report living on the street. All of these interviewees also reported that their last injection episode was in a private location (party, dealer's house, own home, friend's home).

Ninety-two percent of the Mesa County injectors interviewed were over 30 years of age, which is significantly older than the average age of the other interviewees in the study. There appeared to be very extensive connections among the injectors in this rural region; many of the interviewees claimed to know approximately 30 other injectors in their area, and some knew over 50. Injection tended to be in their own home (58%) more so than in a friend's home (25%). The rate of HIV testing for these interviewees was also very low. Only one of the twelve Mesa county interviewees had been tested; in comparison, more than 80 percent of the urban interviewees claimed to have been tested for HIV, and the vast majority of these interviewees reported testing multiple times.

The 1997 CIP also noted the extent to which urban residents travel to rural areas to purchase or inject drugs. For instance, when asked where else they have purchased and/or injected drugs, residents of metro Denver listed Alamosa, Bailey, Breckenridge, Canon City, Carbondale, Central City, Deckers, Durango, Elizabeth, Fort Collins, Glenwood Springs, Grand Junction, Idaho Springs, La Junta, Pueblo, and Telluride.

In a general sense, many of the barriers listed above are also true for rural injectors, with additional complications:

a) Rural areas have tended to lag behind urban areas in their movement from the Moral and Temperance Models to the more modern viewpoints concerning drug use and treatment.

b) County sheriffs and rural police departments often have very large jurisdictions with few personnel. As a result, rural areas can be attractive to those who manufacture, distribute, and use injectable drugs, particularly methamphetamine.

c) Availability of drug treatment is much more limited in rural areas, and often involves extensive travel.

d) Methadone is only available in the Denver area, Boulder, and Colorado Springs.

e) Concerns about IDU and AIDS stigma are heightened in rural areas, where anonymity cannot be taken for granted.

f) Most of the HIV prevention models developed for injectors are designed to be implemented in inner city, street-level venues where injectors congregate. Such identifiable, accessible venues do not exist in the vast majority of rural areas, where users are more integrated into the wider community and are even more likely to be injecting in private homes.

Two issues concerning confidentiality can also impact the effectiveness of certain methods of intervention. First it tends to be a barrier to Group Level Interventions (GLI) in communities where it is unacceptable to identify with a group so stigmatized by the local population, and secondly it tends to be a barrier to GLI to discuss matters of personal risk in group settings where every one knows each other. In such cases, information obtained from interviews and focus groups in District four and eight has shown that potential clients prefer Individual Level Interventions (ILI).

Need for safer sex materials distribution/availability based on needs

assessment results, low socio-economic status of rural communities and confidentiality issues.

5. Barrier and suitability issues for young injectors

The 1997 Colorado CIP involved extensive interviews of young injectors (defined as age 25 or younger for this study). Major findings are listed below.[69]

Drug use starts out by providing youth with satisfaction, entertainment, and excitement; however, it can lead to chronic use where the majority of one's energies are focused upon getting the drug. For most of the youth, HIV was not listed as a top priority, particularly for the "street kids," for whom bigger concerns were: where will I stay tonight, who are my friends, where can I get some food, how can I get more drugs, does he like me, etc.

These youth reported that they are relatively unconscious or unaware of their injection practices, as long as "things flow along freely." As the report notes, "In order to bring syringes into focus a whole new interpretive frame needs to be developed around them that goes beyond AIDS. In needs to be more important and understandable to these clients."

For these young injectors, violence and personal safety were major concerns, overshadowing HIV. In particularly, violence from older homeless men, sex partners, and police were noted. Abuse was a common occurrence, often related to sex and drug use, but the youth felt uncomfortable reporting this abuse to service agencies. Young MSM were particularly hesitant to report abuse at the hands of a male sex partner.

Many of the street youth expressed a strong need for social and psychological support. Some of these youth used pets (dogs, rats, snakes, etc.) as psychologically significant sources of support and companionship; however, non-acceptance of pets was cited as a barrier in seeking services from agencies and outreach workers. These youth also complained about a lack of agency support for their desires for intimacy or community, which their drug use partially provides in their lives. The street youth made a sharp distinction between "genuine" and "wanna-be" street youth. The needs of the two groups are quite different, though the risk

behaviors may be the same.

For these young injectors, HIV programs run the danger of becoming overly identified with the systems that they went into the streets to avoid. When this identification occurs, the programs lose their credibility. Some homeless shelters check the youth for outstanding warrants, for instance. This has resulted in some youth avoiding the programs or refusing to share any information that might "get them into trouble."

In summary, the report notes that "kids must be convinced they are entitled to better or different lives. Repeated and consistent consciousness raising activities on drug use and sexual activity are needed. Few service agencies were reported to have helped to make them feel better about themselves. Instead, what happens is they usually feel they have failed."

6. Men who have sex with men who are also injectors
[See page 17, Injectors.]

7. Transgender and gender variant people
[See page 19 – 20, Transgender and Gender Variant People.]

8. Disabled people who are injectors
[See page 20 – 23, People with Disabilities.] In addition, too many service providers patronizingly believe that people with disabilities could never have a substance use problem. Conversely, many people with disabilities live in situations where power imbalances are almost insurmountable, and thus limited ability to leave situations where drug use has become uncontrolled. These choices are particularly difficult when they involve caregivers.

9. Barrier and suitability issues for injectors living with HIV

As noted in Chapter Seven of the Comprehensive Plan, if infectiousness is related to the amount of virus in the blood, IDUs on HAART may be less likely to transmit HIV to their injecting partners. However, this potential prevention benefit will never be realized if injectors are not provided the same access to state-of-the art care as non-injectors. The following excerpt from Canada's *National Action Plan for Injection Drug Use* summarizes Colorado needs, as well: "Addressing the multiple difficulties in seeking appropriate, accessible treatment for a substance use problem

can be overwhelming, as it can also be for HIV infection. Attempting to do this when both conditions are present, and particularly if other issues such as mental illness are also present, can seem insurmountable. Individuals with these conditions may have to confront discriminatory and/or uninformed attitudes on the part of treatment providers, and availability of appropriate treatment spots is frequently limited. Decision-making regarding the best treatment approach is often taken out of the hands of the individual for fear, on the part of the health care providers, that an injection drug user will not comply with treatment regimes. Pain may not be well-managed by physicians unwilling to prescribe adequate medication to someone with a history of substance use, fearing the risk of overdose. It must be recognized that injection drug users living with HIV are individuals, suffering in a myriad of ways, and in need of the best possible interventions, tailored to their unique situations. They retain all the rights of every other citizen, and must therefore be given equal access to a continuum of services, as well as the dignity of making their own decisions. If lack of compliance with a drug treatment is feared, then the patient must be supported to ensure adherence to the treatment regime, just as any other individual is, whether diagnosed with diabetes, epilepsy or another condition. Bias against treating IDUs is unjustified and unacceptable."[97]

As discussed at length above, injectors must cope with significant bias. If HIV prevention adds to the bias against injectors living with HIV, our HIV prevention efforts will be harmed. Therefore, it is particularly important that efforts for injectors living with HIV adhere to the principles of Harm Reduction mentioned above. Particularly important are principles relating to giving users a real voice in programs, focusing on quality of life, taking a non-judgmental and non-coercive approach to services, and deepening our understanding of other social inequalities related to vulnerability (poverty, class, racism, social isolation, past trauma, sex-based discrimination, etc.)

For injectors living with HIV, improving the availability, effectiveness, and client-centeredness of methadone and substance abuse treatment programs serves both a humanitarian purpose and a public health purpose.

Injectors living with HIV are also a largely untapped resource for HIV prevention. Who better to reach out to people at risk through sharing of needles than a current or former injector living with HIV who is also well-trained in HIV prevention interventions? Employing injectors living with HIV could also be a tremendous source of empowerment, as the benefits of HAART make them well enough to re-enter the work force. Our HIV prevention system could channel all that they have learned toward the noble purpose of preventing future infections, when other potential employers would hold their drug use history against them.

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[97] Canadian National Task Force on HIV, AIDS, and Injection Drug Use. 1997. *HIV/AIDS and Injection Drug Use: A National Action Plan*. Ottawa, Canada: Canadian Centre on Substance Abuse, Canadian Public Health Association, and Health Canada, *http://fox.nstn.ca/~eoscapel/cfdp/hivaids.html*.