HIV stands for **Human Immunodeficiency Virus.** *HIV* damages cells in the body's immune (defense) system that fight off infections and diseases. *AIDS* stands for **Acquired Immune Deficiency Syndrome**. *AIDS* seriously weakens the body's immune system leaving it unable to fight off infections and cancers. *HIV*, the virus that causes *AIDS*, is on Guam. So far there is no cure.

People can avoid becoming infected if they learn how the virus is spread and what to do to keep from getting it.

HIV/AIDS PREVENTION 1996 NEEDS ASSESSMENT STUDY

HIV/AIDS RELATED BEHAVIOR AMONG HIGH RISK GROUPS ON GUAM, AND COMMUNITY PERCEPTIONS OF THE SITUATION

April 1997

University of Guam
Guam Cooperative Extension

HIV/AIDS RELATED BEHAVIOR AMONG HIGH RISK GROUPS ON GUAM, AND COMMUNITY PERCEPTIONS OF THE SITUATION

Randall L. Workman

Thomas K. Pinhey

submitted to:

STD/AIDS Prevention Program

Bureau of Communicable Disease Control

Department of Public Health and Social Services

CD Report Number 26

HIV/AIDS PREVENTION NEEDS ASSESSMENT STUDY

Community Resources Development
Guam Cooperative Extension
College of Agriculture and Life Science
University of Guam
Mangilao, Guam USA 96923

APRIL 1997

ABOUT THE AUTHORS:

Dr. Workman is Professor of Sociology and Unit Chair of Community Resource Development, College of Agriculture & Life Sciences, UOG.
Dr. Pinhey is Associate Professor of Sociology at the Micronesian Area Research Center, UOG. and Coordinator of the Micronesian Studies M.A. Graduate Program

A REPORT OF HIV/AIDS RELATED BEHAVIOR AMONG HIGH RISK GROUPS ON GUAM, AND COMMUNITY PERCEPTIONS OF THE SITUATION:1996

Warning: This report refers to several purposive samples of men and women on Guam who fit the criteria of special categories targeted for study. The results from each data collection methodology refer to that specific group only. Please do not cite the results as if they reflect the behavior of Guam's general population.

Acknowledgments: **We want to express our utmost gratitude to the team of people who made this research possible. These include John Woodard who gave invaluable advice for the research design and helped facilitate the focus group interviews, and Ann Pobutsky-Workman who acted as a survey coordinator. Also we thank CRD Office Manager Elaine T. Cepeda, along with assistants Annie Chin and Liza Posas who assisted in the recording and transcribing of the focus group information and provided clerical support for computer data entry of the survey questionnaire, and typing of the report. We also want to acknowledge the dedicated effort of Terry Aguon, DPHSS Social Worker, and CRD assistants Marilyn Knudsen and Jennifer Matter who collected the personal interview case studies of HIV Positive Patients. Perhaps the most difficult work was carried out by the survey facilitators and street contact people who made it possible to obtain questionnaires from people at high risk. In particular, we extend our gratitude to Bernie Provido, STD/AIDS Health Educator at DPHSS and her Outreach Worker, Alex Silverio, to Debtralynne Quinata from the office of Senator Angel L.G. Santos, and to CRD workers Gilbert Russel and Renata Bordallo. Finally, we owe a "*dankulo na si Yu'os Ma'ase*" to Donna Lewis Pinhey who review edited this report.**

This study was supported in part through Interagency Work Order Request No. W5-1700-020 from the Department of Public Health and Social Services, Government of Guam, under the HIV Prevention Project, Cooperative Agreement U62/CCU902702-10-1 funded to the Bureau of Communicable Disease Control, DPHSS by the Public Health Service, Centers for Disease Control, Atlanta, Georgia.

DISCLAIMER

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INTRODUCTION

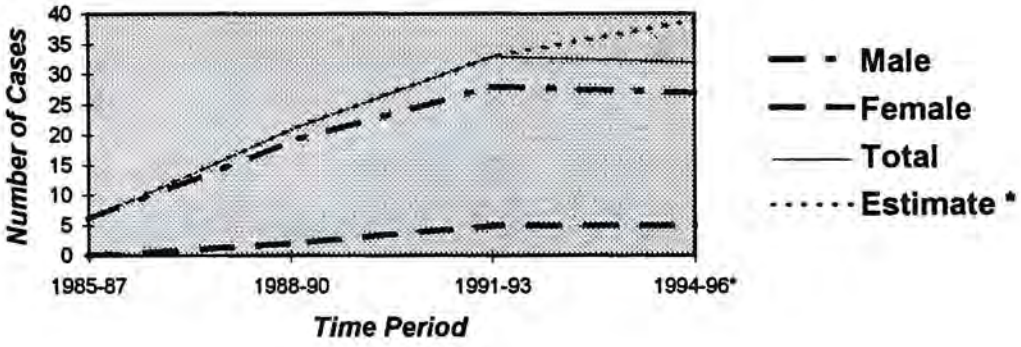
The first description of an unusual type of pneumonia in the United States among five cases of young, homosexual men was published June 5, 1981 in the *Morbidity and Mortality Weekly Report*, by the Centers For Disease Control (CDC). People began to recognize these symptoms as a disease spreading around the world. Isolated cases had been documented in the late 1970's, with evidence as far back as 1959 in Zaire, Africa, but there was no medical term to label the disease syndrome. Now, almost everyone knows it by name. In Spanish it is known as SIDA, *sindrome de inmunodeficiencia adquirida.* In English we call it acquired immunodeficiency syndrome (AIDS), which results from the Human Immunodeficiency Virus (HIV).

Within three years, Thailand recorded its first confirmed AIDS case (Brown and Xenos, 1994) and there were two suspected HIV/AIDS cases on Guam in 1984 (Aflague, 1986). The island did not have the required laboratory facilities, so these cases had to be referred off-island for testing. One case was confirmed. Even so, it does not appear as a Guam statistic, because such reporting is logged at the location where the testing occurs, not where the person resides or later moves for care and medical services. Thus, it was in 1985, after Guam was awarded a federal grant to set up an alternative test site for HIV/AIDS screening, that its first official case was documented.

Measuring the incidence and prevalence of HIV/AIDS on Guam is complicated by the fact that there are those persons who go off-island to be tested, while others living off-island return home for support after testing positive. This was very much the situation in those early years of HIV/AIDS on Guam. The number of reported cases fluctuated from one case up to four or seven cases back to only one case, and so forth, from year to year between 1985 and 1990. The numbers and rates should also be viewed with conservative caution because there are those infected persons who are not being tested, anywhere! This is a common world-wide dilemma, and official counts are believed by some authorities to identify as few as only half of the actual number of HIV/AIDS cases (Carrier, 1989). Because the incubation period between HIV infection and onset of AIDS ranges from 4 to more than 10 years (Abramson and Berk, 1990; Bongaarts, 1996), HIV persons can be carriers without showing any symptoms for most of the incubation period and unknowingly infect others.

HIV/AIDS on Guam is increasing, and it is known that many of these cases of infection are contracted on the island. As displayed in FIGURE 1, when grouped in three year time periods, the increase can be seen across the past decade. The last four months of 1996 (September-December) will reveal whether the increase will continue or begin to level off.

FIGURE 1: Reported HIV/AIDS Cases On Guam By Time Period*



SOURCE: STD/HIV Prevention Program, Department of Public Health & Social Services, Guam.
* The data are counts up to August 31, 1996. All time periods are three years except for 1994-96, which is only 2.75 years. **Therefore, the final tally for 1994-96 will be higher** (estimated between 37-39).
** In fact as of September 15, 1996, prior to final publication of this report, two more cases - one female and one male - were confirmed HIV positive which raised the total to 94 cases (81 male / 13 female).

	1985-87	1988-90	1991-93	1994-96*	**Total****
Male	6	19	28	27	**80**
Female	0	2	5	5	**12**
Total	6	21	33	32	**92**

The relatively small number of cases reported for Guam misleads many people to a false sense of security regarding the seriousness of Guam's problem. Not long ago, because there were so few reported cases among Asian Pacific communities, it was suggested that perhaps Asian-Pacific peoples were immune to the retrovirus causing AIDS (Lee & Fong, 1990). HIV was introduced into Asia much later than the rest of the world, but now, along with subSaharan Africa, it has one

of the highest rates of increase (Bongaarts, 1996). Guam is not an isolated insular area. As a hub for tourist and business travel around the Pacific Basin, Guam is in the Asian flow patterns of HIV/AIDS transmission.

Currently, three vectors or modes of transmission are known to spread the HIV virus: 1) sexual activity that results in the exchange of bodily fluids, particularly semen, 2) direct contact with infectious blood due to sharing needles during intravenous drug use, the use of contaminated blood during transfusions, or accidents; and 3) perinatal transmission from mother to infant (Becker and Joseph, 1988; Prohaska, et.al. 1990). Sexual activity includes both heterosexual as well as homosexual activity, particularly receptive anal intercourse, intercourse without use of a condom, and sexual contact with multiple partners or with one sexual partner who has multiple partners. These latter sexual activities link the different vectors of transmission whereby HIV can spread across a wide spectrum of people within a community population.

The spread of HIV/AIDS has not followed a single pattern. Rather there appears to be at least three, if not more patterns in various parts of the world. According to Tim Brown and Peter Xenos (1994), a *Pattern I* scenario was illustrated in the United States and Europe where the spread of HIV began in homosexual men in the late 1970s and then jumped to intravenous (I.V.) drug users. In *Pattern I*, heterosexual transmission of HIV tends to be at low levels. SubSaharan Africa illustrates a *Pattern II* scenario where heterosexual transmission is at extremely high levels. A *Pattern III* scenario is illustrated by the experience in Thailand. There were initially documented cases among bisexual and homosexual men. Yet, the rapid rise of infection levels really took off among I.V. drug users. From these persons, a steady rise in infection levels increased among sex industry workers, and quickly thereafter among males being treated for Sexually Transmitted Diseases (STDs). The collusion of transmission vectors is now leading to a fourth segment of the community. HIV infection is appearing among the wives and girlfriends of men with muliple partners and patrons of sex industry workers.

Although heterosexual transmission has greatly increased in the United States, a *Pattern I* country, Jon Hamilton (1995) asserts that this has not become the explosive vector that some people thought was emerging. As he writes in his article:

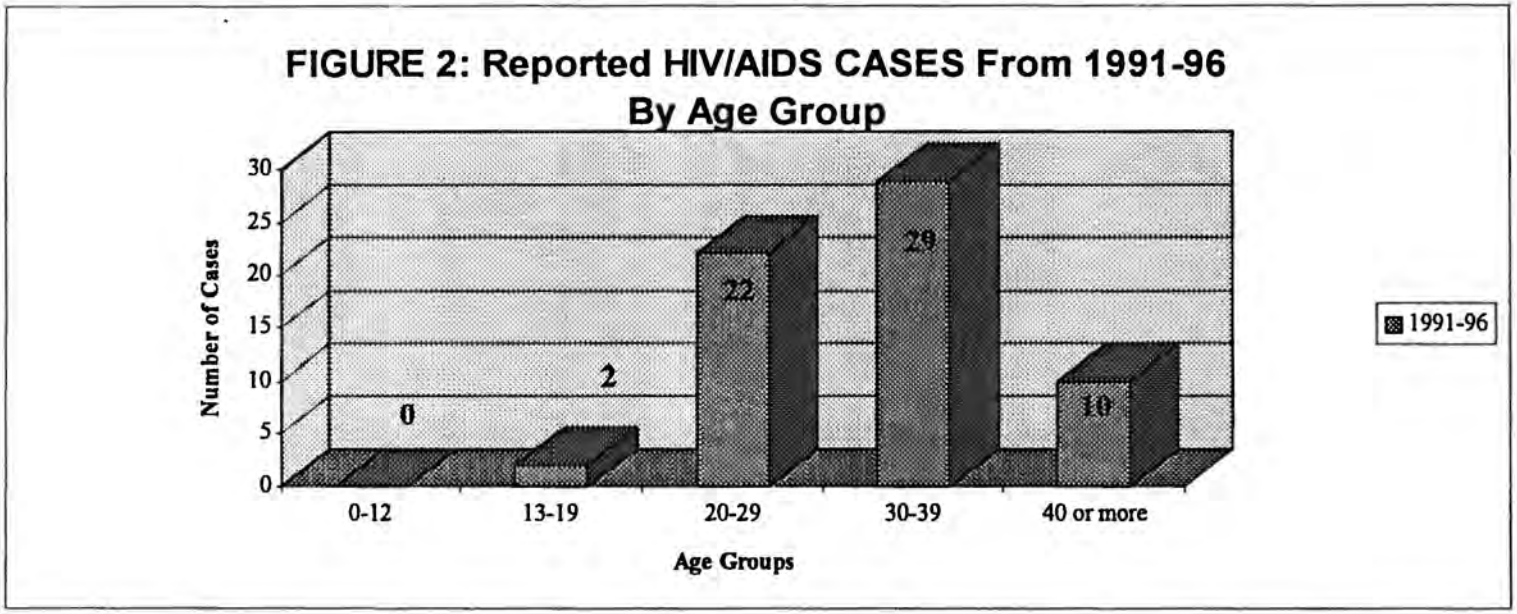
> *Subtle genetic changes to the AIDS virus may have prevented similar* (heterosexual) *spread in the U.S. and western Europe, says Dr. Max Essex, chairman of the Harvard AIDS Institute. He says all U.S. cases up to now have apparently been*

> *caused by an HIV variant known as sub-type B, which is not usually transmitted through heterosexual contact. Studies show that heterosexual spread was slow in Thailand and India when the B subtype was the culprit, but it accelerated rapidly when other subtypes arrived* (Hamilton, 1995: 55).

At this point in time no one is able to identify what will become the transmission pattern on Guam or across the Pacific Island Region. There is one apparently universal pattern around the world, which is that HIV/AIDS infects people who are in the productive prime of life. As shown in Figure 2, people testing positive for HIV/AIDS on Guam are concentrated in the stage of young adulthood from 20 to 39 years of age.

Current global research about HIV and AIDS emphasizes the importance of examining people's sexual networks relative to the possibility of HIV transmission (see Caldwell, 1993; Anarfi and Asare, 1993; and Obuagu and Charles, 1993). In addition to men who have sex with men, sex industry workers, and injecting drug users, there is a new emphasis on women at risk for HIV infection due to their partners' behavior (see Reid, 1995; Asare and Agyeman, 1993; and Heise and Elias, 1995). This new focus is due to the fact that heterosexual transmission is the fastest growing category of HIV infection globally, and women's low status in most societies makes them vulnerable to HIV infection (Heise and Elias, 1995; Reid, 1995). Sensitive to the situation on Guam and its vulnerability to this global trend, the Guam HIV Community Planning Group targeted women at risk as a new priority group for special attention in upcoming planning recommendations.

Sexual behavior and sexual networking studies are based on methods which require more detail than traditional KAP (Knowledge, Attitude, Practice) surveys. Additionally, studies which evaluate HIV/AIDS health service delivery systems require qualitative methods which are not only culturally appropriate, but also address sensitive issues of confidentiality, where respondents can discuss and clarify their assessments of services and programs.



SOURCE: STD/HIV Prevention Program, Guam Department of Public Health & Social Services (As of June, 1996)

METHODOLOGICAL DESIGN AND PROCEDURES

A multi-method approach was used to obtain the benefits and advantages of different types of data. Each of the following sections presents the procedures employed to collect **focus group interview** data, to collect **personal case study** data, and to collect a **questionnaire survey of high risk behavioral practices**.

Focus Group Interviews

We invited key informants representing community based organizations (CBOs), human service agency programs, the HIV/AIDS Prevention Community Planning Group (HIV/AIDS PCPG) and the medical and church communities to three focus group sessions. In addition, a special group was organized consisting of men with high risk behavioral patterns. Thus, we conducted three focus group interviews of people from Guam's network of HIV/AIDS service programs and related supporting institutions, and we had a fourth group composed of people who were clientele that the network of services and institutions are meant to serve.

The groups ranged from eight persons (2 groups), a group of twelve persons, and a group of seventeen persons (55 persons total). All sessions followed a standard format pattern of:

(A) The welcome: including an explanation of why they were invited.
(B) The ground rules and clarification that we were taping the sessions.
(C) An opening question for participants to introduce themselves and express their concerns about the topic.
(D) An overview of the project and why their input was important.
(E) A series of questions designed to reveal the perceptions and opinions of the group about Guam's services addressing the prevention or treatment of HIV/AIDS.

The benefits of focus group interviews have been discussed in resources on needs assessment methodologies (Buttram, 1990; Krueger, 1988; Lynch, 1993). These groups were interactive sessions where the aim was to share and clarify concerns common within a group. Brainstorming and problem solving were discouraged; and thus the focus was on identifying needs, and the strengths or weaknesses people experienced as members of particular social networks.

The first focus group was composed of persons from Human Services involved in HIV/AIDS prevention programs. We started with this group because they represent people who will be the primary receivers and users of reported results and findings from this investigation. From the discussion and suggestions of this first session, it was decided to pursue additional focus groups centered around people from the Church Community, the Medical Community, and High Risk Adults. It was clear that the Human Service focus group identified a real need for increased

networking and communication between the institutional powers controlling island health policy. Namely, the Human Service sector, the Medical Health sector, and the Religious/Church sector. The fourth group, of course, represented people who are the client constituency who are meant to benefit from the program services of these institution s.

Personal Case Study of HIV Positive Patients

In-depth interviews were conducted using a set of systematic and reasonably detailed interview guidelines. Virtually all questions were open-ended and interviews were conducted in a flexible manner. Questions with follow-up probes were asked in a conversational style and the interviewer was free to engage in small talk about other topics when appropriate for establishing rapport.

Interviewers consisted of one male and two female interviewers, all of whom had college level education in an area of either social science or social work. They also had some formal training in social research methods. Time was spent by the senior researcher working with the team to develop appropriate interviewing questions, approaches and techniques.

In order not to inhibit frank revelation about potentially sensitive matters, names were not recorded and respondents were assured that the interviews would remain anonymous. A tape recorder was used and some notes were taken during the interview. The interviewers were instructed to write down key word comments that might be relevant for qualitative analysis. Based on these notes, the tapes and their memory, interviewers wrote up a detailed account of what was said shortly after completion of the interview. These accounts followed the interview guidelines and serve as the basis for the qualitative analysis. Examples of interview case study accounts are provided in the data section after the focus group texts.

The Selection of Respondents. The counselor/ social worker at the STD/HIV Prevention Program, DPHSS, identified potential respondents and initiated first contact for consent from Guam's current caseload of clients who had tested positive for HIV. The interview team and senior researcher agreed that an effort would be made to target a somewhat "representative" cross section of Guam's current HIV positive case load, including males and females, as well as persons differing by (1) sexual orientation and (2) various sources of infection. Informed consent forms were completed and are kept in the client's personal case file at DPHSS.

Survey Questionnaire of High Risk Behavioral Practices

The present study also examined the behavior of people at risk for HIV transmission. ***'High risk behavior'*** was measured as: *self-identification by persons responding that they engage in a designated behavior known to place them at-risk of contracting HIV, the AIDS virus.*

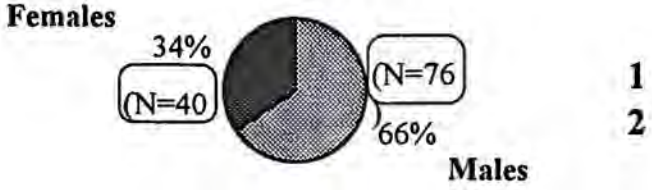
Drawing upon these priorities, the high risk behavior groups targeted for behavioral assessment by this study included: (1) **men who have sex with men**; (2) **women at risk**, including sex industry workers; (3) **persons who have ever had a sexually transmitted disease** (STD); and (4) **intravenous (IV) drug users**.

Since such behavior groups are basically 'concealed populations,' the specification of a sample size needed for reliable statistical projection to a known population is not relevant. According to John Money, Professor of Medical Psychology at John Hopkins University, "there is no possibility of obtaining a truly random probability sample for a sexual study. Too many people are too shy and inhibited, and too many are fearful of self incrimination to cooperate. There is, therefore, always a volunteer bias (Money; 1980; p.111)." The objective was to get those who are potentially at risk to respond to our questions, and they may be involved in illegal activities or socially stigmatizing behavior (such as extra marital sexual relationships or homosexuality). As one researcher pointed out, "given the illegal and deviant nature of intravenous drug use, access to intravenous drug users is difficult. Another approach to accessing drug users is through ethnographic and "street outreach" methods. Although these strategies achieve a concentrated sample of users for study, they depend upon purposive contacts who, in turn refer other contacts (Vlahov and Polk; 1988: 43-44)."

As a consequence, this survey study was qualitative in nature, using ethnographic and outreach methods to contact respondents. The aim of data collection was to record actual life experiences and practices of people who are among the audiences targeted by prevention programming. The data reported refers only to the targeted group of subjects who responded to the survey, and was not intended to provide generalizations projected to any defined population universe. Participation was voluntary and procedures ensured confidentiality. Facilitators who had access to people within the high risk groups distributed the questionnaires along with stamped, addressed envelopes and sealers. Facilitators assisted respondents with questionnaires when this was necessary. Facilitators included community workers, social workers, single males and females, local village contacts and others familiar with the targeted groups.

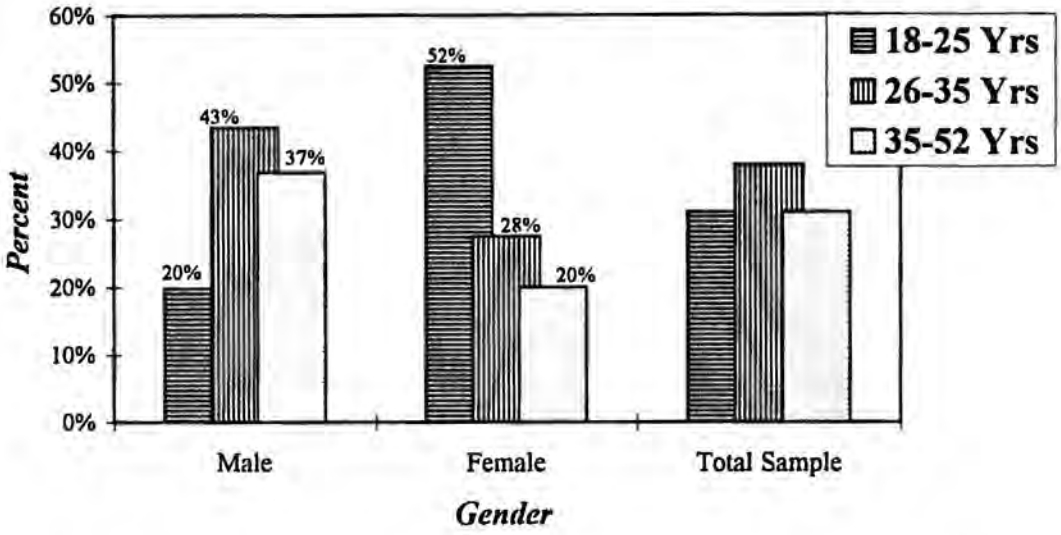
We obtained a total respondent group of 120 persons who completed usable questionnaires. Descriptive demographic profiles of all respondents and each high risk behavior group are

Figure 3: Percentage Distribution of the High Risk Survey Sample By Gender



SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
The sample consisted of 120 persons, with 4 not reporting their gender.

Figure 4: Percentage Distribution of the Survey Sample By Age and Gender



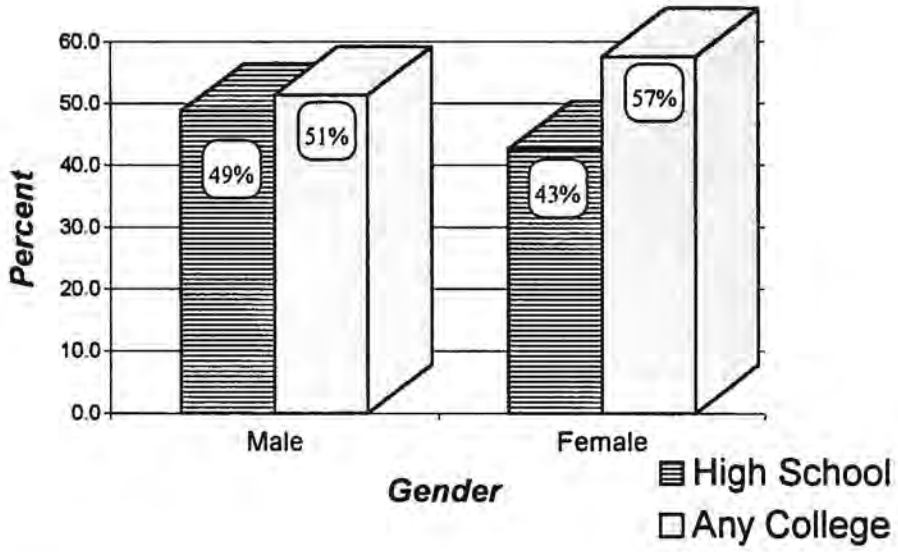
SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
The Survey Sample consisted of 120 persons, 76 male and 40 female (and 4 gender unknown).

presented in Appendix Data Tables Nos. 1 through 4 (pages Xx-Xx). The purposive, ethnographic approach led to several characteristics of the total group that need to be clarified. The targeted high risk behavior groups overlap within the total sample since some subjects identified themselves as exhibiting several high risk behaviors. Even the grouping of persons by gender and sexual preference (i.e., male/male sex versus male/female sex) were only mutually exclusive - *in general*. We encountered one male and two female subjects who specified themselves to be bi-sexual. Nonetheless, a majority of each group was composed of persons who only exhibited that risk behavior.

The total group of respondents was also largely composed of males (see Figure 3), and the women subjects tended to be younger than the male subjects (see Figure 4). However, the female and male respondent groups were about equally distributed across levels of educational achievement (see Figure 5). These characteristics are not truly due to *sampling bias*, as commonly understood, rather the risk behaviors we examined - homosexuality, IV drug use, and STDs - tend to be male dominated domains. What is more important for readers to understand is that our purposive "sampling" method was centered on each specific risk-behavior community. It is the old "apples and oranges" analogy. Just because we obtained a number of apples, a number of oranges, and a number of bananas -- each representative of their "type" or "kind" -- there is no meaning in putting these all in one bag and talking about a *population* of fruit. Nonetheless, there

is meaning, and trustworthy insights about each particular "kind of fruit", by looking at the set of representative apples, or oranges, or bananas. In this study we have different kinds of "people at-risk of HIV" and we examined the characteristics among each set of people who exhibited a particular risk-behavior.

Figure 5: Survey Sample Education By Gender



SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study.*
The Survey Sample consisted of 120 persons, 76 male and 40 female respondents (and 4 gender unknown).

It should be noted that the facilitators, to a large extent, determined the composition of the study's respondent sample. A larger number of facilitators should ensure a more representative "sample" of subjects, and of course, reduce facilitator bias in the study. We feel that we were able to get a trustworthy sample by using the existing network of community groups, and an expanding cadre of facilitators who knew the community very well.

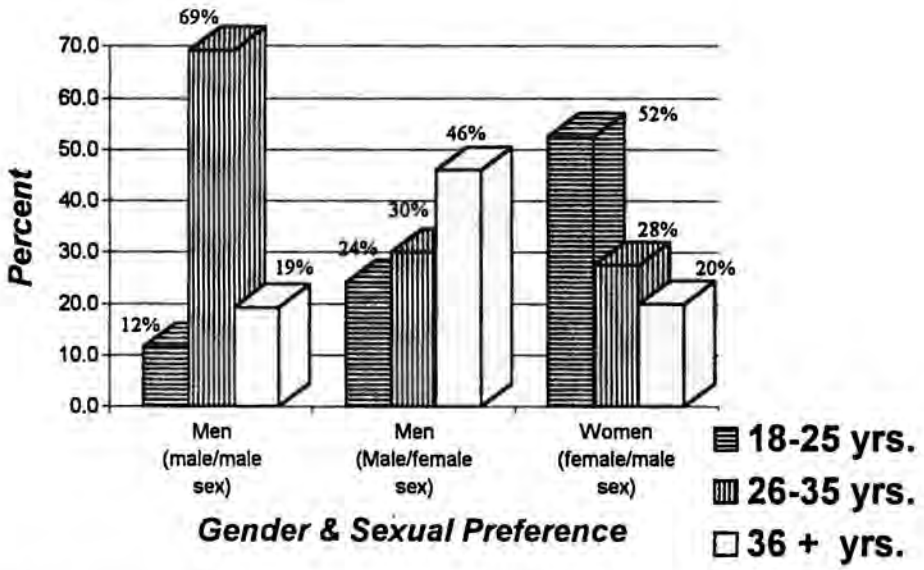
Age and education profiles of risk groups designated by sexual preference behavior (i.e., male/male versus male/female sex) have been presented in Figures 6 and 7. The respondent group of men who engage in male/male sex were concentrated in the 26 to 35 year old age group (69 percent). As shown in Figure 2 (page 5) this is the age cohort showing the highest concentration of HIV/AIDS cases on Guam. This particular community of people at high risk tended to have achieved a higher level of education than the other risk behavior groups. About three-fourths (73 percent) had attended some college or graduated. In contrast, heterosexual men at risk who

responded were more likely to have only attended or graduated from high school (60 percent), and almost half (46 percent) were 36 years of age or older.

Most of the heterosexual men who responded belonged to risk behavior populations who either had had a sexually transmitted disease (STD), or were intravenous (IV) drug users. Figures 8 and 9 display the age and education characteristics of the at-risk group of persons who had ever had an STD. The STD risk group was about equally composed of men (57 percent) and women (43 percent), and about half (58 percent) were also IV drug users (see Appendix Table 3, page x). This particular at-risk group tended to be older than other respondents (55 percent over age 36 years, and one-fourth were age 26 to 35 years). They were equally distributed between those who had attended college and those with only a high school education.

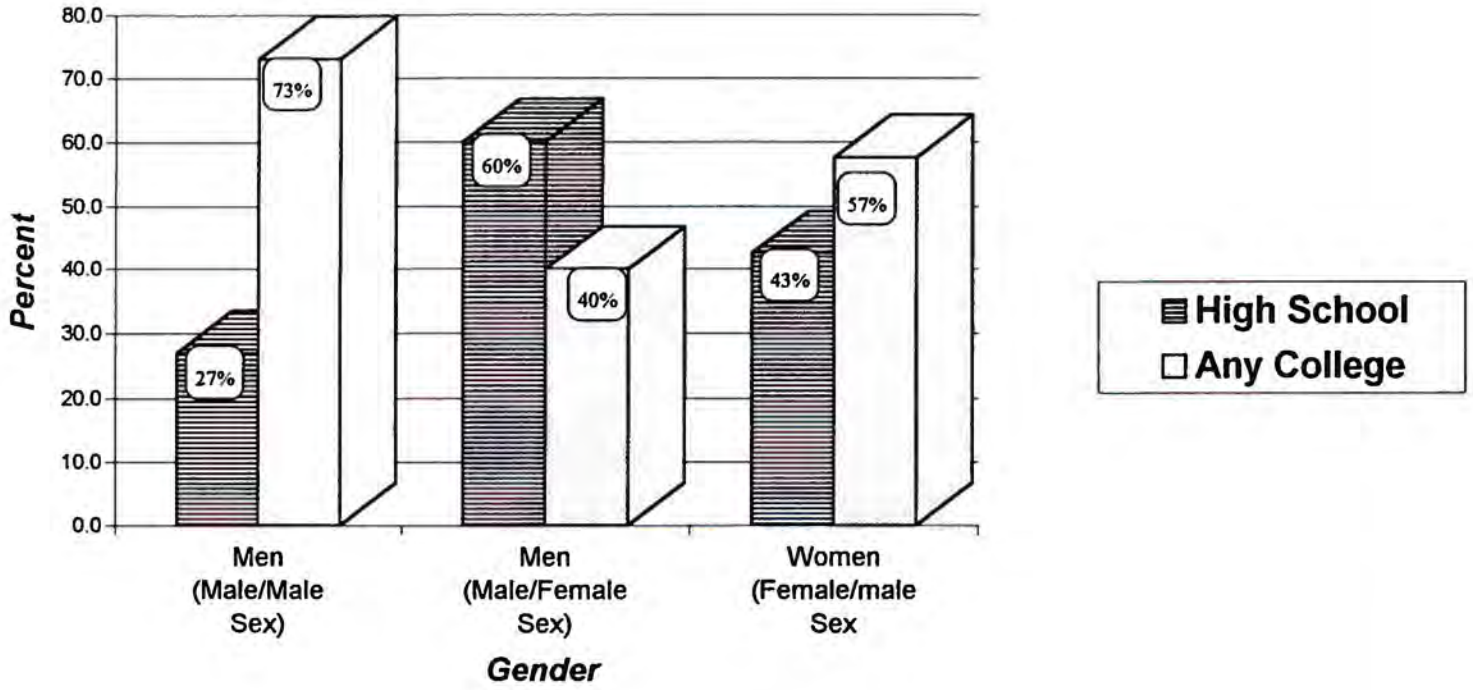
Shown in Figure 10, the study's risk group of IV drug users was predominately composed of men (77 percent). The women in this risk group who were interviewed tended to be young females who were often labeled with the derogatory street name of "panty-down girls," for the fact that they often trade sex for drugs.

Figure 6: Sexual Preference Risk Groups By Age



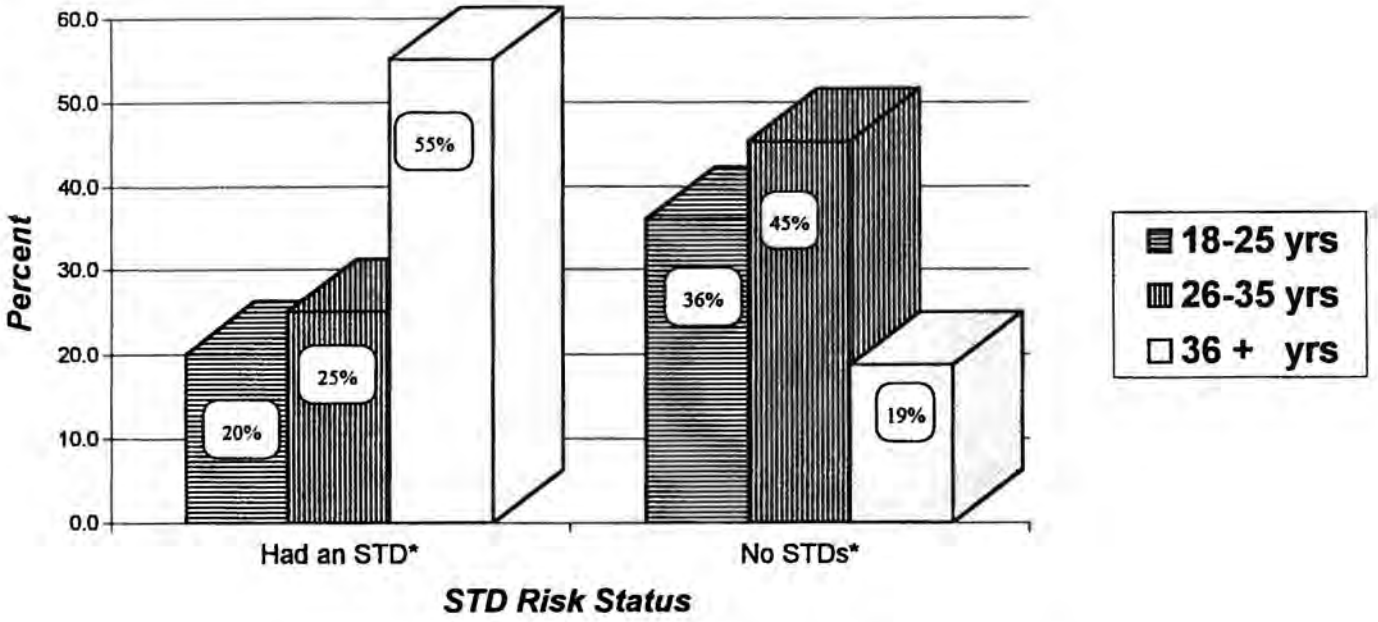
SOURCE: *1996 HIV/AIDS Needs Assessment Study.*
The Survey Sample consisted of 120 persons, 26 men (male/male sex), 50 men (male/female sex) and 40 female respondents (and 4 gender unknown).

Figure 7: Sexual Preference Risk Groups By Education



SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study.*
The Survey Sample consisted of 120 persons, 26 men (male/male sex), 50 men (male/female sex) and 40 female respondents (and 4 gender unknown).

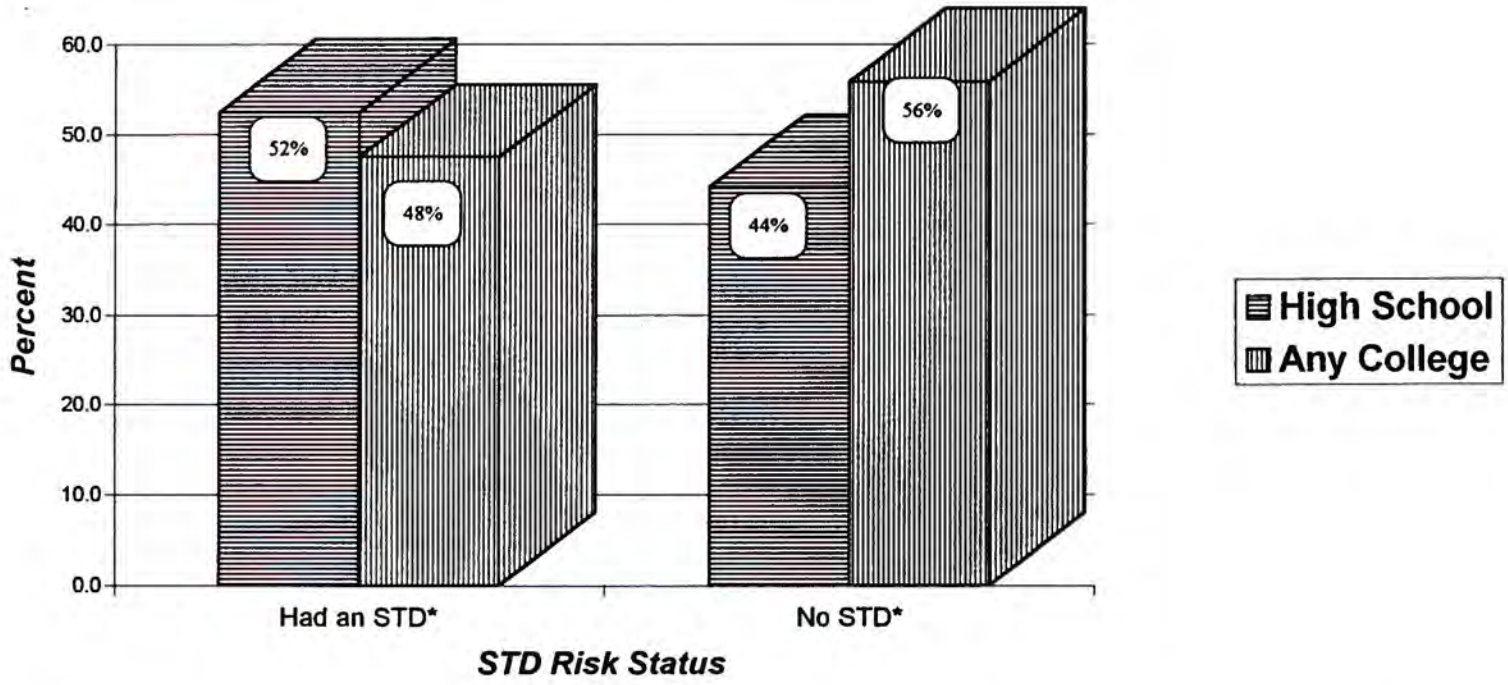
Figure 8: Sexually Transmitted Disease (STD) Risk Group By Age



* This High Risk Group labeled as having ever had an STD (Sexually Transmitted Disease) is also composed of persons who responded that they had hepatitis (A, B, or C)

SOURCE: *1996 HIV/AIDS Needs Assessment Study.*
The Survey Sample consisted of 120 persons, 40 who reported ever having had either an STD or Hepatitis.

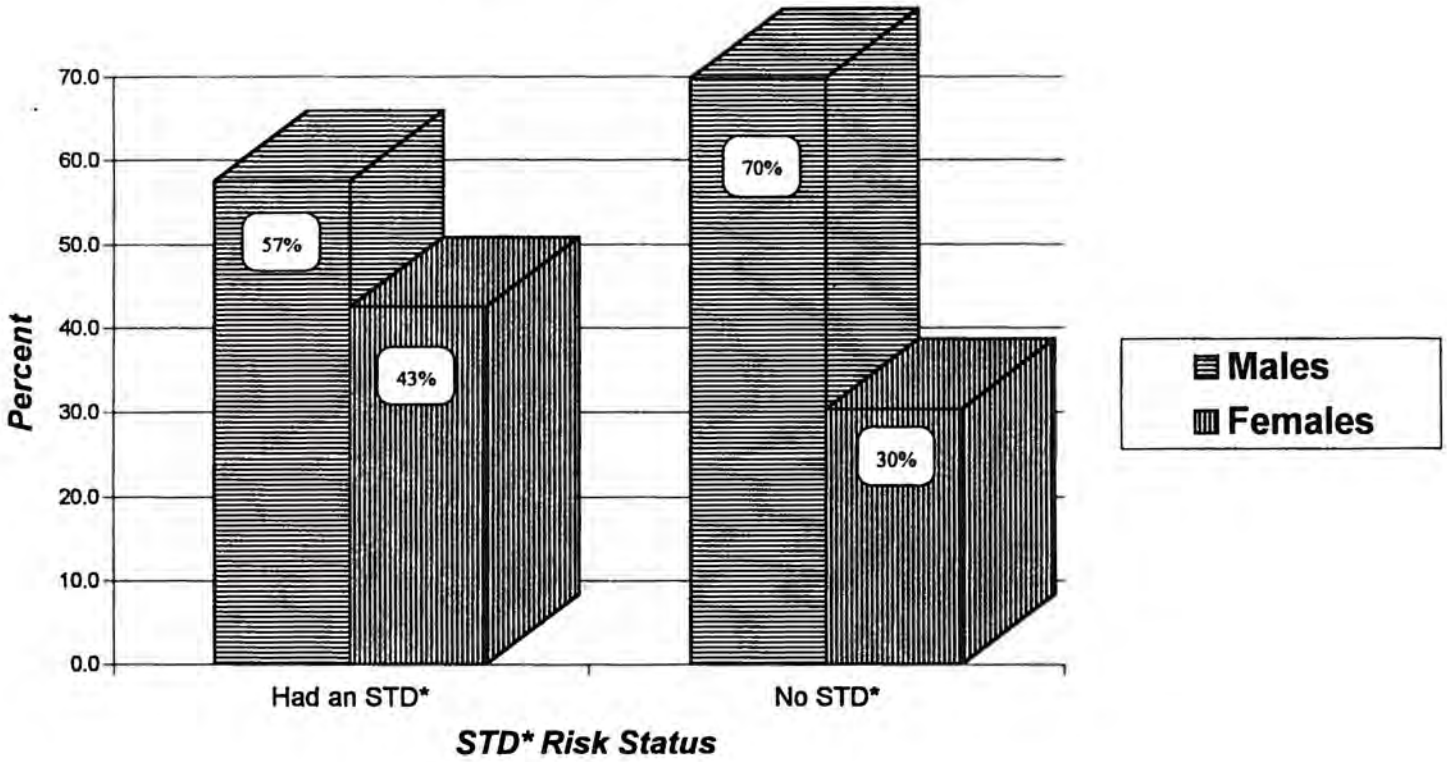
Figure 9: Sexually Transmitted Disease (STD) Risk Group By Education



* This High Risk Group labeled as having ever had an STD (Sexually Transmitted Disease) is also composed of persons who responded that they had hepatitis (A, B, or C)

SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study.*
The Survey Sample consisted of 120 persons, 40 who reported ever having had either an STD or Hepatitis.

Figure 10: Sexually Transmitted Disease (STD) Risk Group By Gender



* This High Risk Group labeled as having ever had an STD (Sexually Transmitted Disease) is also composed of persons who responded that they had hepatitis (A, B, or C)

SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study.*
The Survey Sample consisted of 120 persons, 40 who reported ever having had either an STD or Hepatitis.

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THEMES FROM THE FOCUS GROUP INTERVIEWS

Major Themes Across The Focus Group Sessions

Three general themes or collective insights emerged from a content analysis of the specific ideas identified in all of the focus groups. These are presented below and then followed by a listing of specific ideas and illustrative comments made by people supporting each general theme.

1. There are intense value conflicts, misunderstandings, and controversies over issues related to HIV/AIDS. These become obstacles to the implementation of HIV/AIDS prevention activities, and reduce the impacts or outcomes that could result from prevention activities.

2. There is a need for HIV/AIDS education targeted at specific professional groups and segments of the population that increases people's understanding and sensitivity to persons with HIV/AIDS, and reduces the social stigma associated with the disease.

3. The major institutional sectors of the community -- Medical Health Care, Public Health Services, Religion, and Education -- must strengthen their collaboration and increase communication to mount several coordinated HIV/AIDS educational activities.

Theme 1. There are intense value conflicts, misunderstandings, and controversies over issues related to HIV/AIDS. These become obstacles to the implementation of HIV/AIDS prevention activities, and reduce the impacts or outcomes from prevention activities.

Group 2. The community is struggling with the stigma associated with AIDS.

- (Referring to a poster picture of down cast facial image and words "Dying In Silence") "She's holding the disease inside, she doesn't want any one to know she's shamed."
- It was a hush thing but now we have friends who have it and I even have relatives who died from it. Here on Guam its been in the closet but now with the deaths it's coming in the open, and I'm pretty much aware of it now.
- The people I know say: "it can't happen to me". I think now that more people are dying from it, that this idea is changing, but back before people said "I'm not the type."

Group 4. The community is struggling with the stigma associated with AIDS.

- A stigma is involved and it is very difficult for them to say how the family member died. the parents tell every one it was a brain tumor; - because of this stigma these people go back into their shell. But as an opportunity, I think the church can make a big difference on how their friends, and the family will accept them.
- Because of the sensitivity and the influence of our Church, many of us in medical practice certainty don't want to look like we are endorsing the lifestyles associated with this type of disease. This is something that we must deal with as medical professionals, and the church must come out to accept that The church takes the position on the issue. Because of the strong Catholic background in the community, the words homosexual, abortion, and AIDS really bring out people's suspicions and this puts some of us in very difficult situations . As a doctor, working in the operating rooms where abortions take place, you sense a pressure from friends in church and the community. The doctors feel like they carry some baggage which they have to explain.
- There needs to be more involvement between the church and the medical community. The medical community has the credibility to deal with the disease but there must be dialog and educational cooperation among school professionals, medical people and the church community.

Group 3. There are suspicions between the moralities of the community of churches, and many people with life styles placing themselves at risk for HIV/AIDS, or those who have HIV/AIDS.

- Many people with AIDS feel very alienated from the church - they need to have a sense of redemption.
- There is no major institutional involvement in the care or concern of the people who have HIV/AIDS - The church does not have a message for treating the people specifically - The

Catholic church does not have a specific objective in any role for reaching out to these people with AIDS.

- We live in isolation from AIDS infected people. There is ignorance on both sides - they don't know us and we don't know them.

Group 1. There is a concern and feeling among some that public and private schools are not promoting HIV/AIDS education, and imposing restrictions when presentations are made by others.

- Education comes from the school but they do not educate on this issue.
- I used to teach at Catholic school, where I circulated a survey asking questions like " what are your concern about your health?". 90% of the students wanted to know more about STD or HIV/AIDS. The reaction of other teachers was resistance to sex education.
- I used to attend Catholic school: the health class had no topic discussions about sex . The youth have no information, their only source of information is from friends or peers.

Group 3. The well known controversy over condom education, distribution and use as a prevention strategy for reducing HIV/AIDS divides Guam's community of churches, and the positions are held as strongly as anywhere in the world.

- PRO: I'm unsure about the moral position of the idea that "sex is only appropriate for marriage". People need to make their choice about safe sex techniques. The church needs to talk about sexuality and responsible sex behavior, but the church needs to prepare to deal with people who have made their choices. The church should follow people through their difficulties as they try to make their choices.
- CON: AIDS is transmitted through sex; there is right and there is wrong. They have a choice - the cause of all this is being disobedient of what is right and wrong. We have a choice to destroy ourselves or to help yourself. You either do it and get sick and die; or don't do it and live longer and happy. The church defines what is right or wrong.
- PRO: What message do we give when Christian clergy go about saying on the one hand we have compassion for you, but you can't use condoms, and if you catch HIV, you've sinned but we will comfort you in your dying.
- CON: We do protest the use of condoms or giving out of condoms. Our church does not promote that. Condom education is a means of promoting sex.

Group 4. The community holds conflicting views on what is acceptable or proper sex education. This is part of the need for more dialogue between the medical community, the community of churches, and the education community.

- Now for some odd reason we cannot easily join with DOE to educate because they are very particular about what we say in the classroom- to educate about HIV/AIDS how much can you not say that a vagina is involved or a penis is involved. I gave a presentation at St.' Anthony's and they were very stringent I was not to mention certain words and that makes it very very difficult.

- DOE & private schools have limitations on what can be taught in school. Many 6th- 8th grade students lack the sex education classes, and at the same time many principals and counselors are afraid of promoting the idea of sex education. They fear what parents may say about this sex education.

Theme 2. There is a need for HIV/AIDS education targeted at specific professional groups and segments of the population that increases understanding and sensitivity to persons with HIV/AIDS, and reduces the stigma associated with the disease.

Group 1. Education efforts need to reduce the stigmas and myths that affect people's understanding of HIV/AIDS and persons who have been infected.

- vast variety of misconception of AIDS, unreasonable fears and anxiety of AIDS

- Biggest misconception is that AIDS is a homosexual disease, that perceptions needs to be changed.

- We need to reach the older population- their concept of AIDS is that it is only a gay thing.

Group 1. There is a need for educating family members and parents of high risk persons.

- I would like to set a group of parents just to let them know how it feels.

- Educate parents about the disease. Increase public awareness through education.

Group 4. There is a need for educating family members and relatives of HIV patients, as well as the general public to reduce the social stigma that hinders support and care.

- (MD) How do GMH social workers deal with the home care for these patients? If I was to refer a patient to the hospital with HIV/AIDS, do you have a special activity program to deal with the family members. A mother will ask me what can she do to care for an infected son:- She will ask what shouldn't she do. I feel very short handed and cannot deliver such service. It would be nice if I could write a referral for counseling of family; who do I refer them to? How do I reference that information? This may be the first confirmation of HIV/AIDS in the Family unit, and I think family members as much as health care professionals have preset ideas.

They're confronted with not being able to run away from it- this is my brother; he uses my bathroom, sits at my table, eats my food.

- I'm not really clear as to who is the best referral for a mother or family relative in that situation- What kind of education could they have prior to that - and what do we need to do to make our education programs effective for that kind of information. Your example highlights that something is missing and our community needs to ask where we are failing. because people are still getting infected.

- (Medical Social Worker)- I'm not sure just how much the community is prepared to help or cope with the people who have AIDS. There is a need for good information and services. I don't think we have services sensitive to AIDS patients on Guam. - AIDS on Guam is still a taboo situation. I 'm not sure patients or their families are having their psycho-social need met.

Group 1. Social Service paraprofessionals and volunteers need training to increase their understanding of HIV/AIDS.

- We want to educate house parents and our volunteers-our service providers-with correct information and with awareness on how to relate the information to the youth.

- We need to train instructors to make the issue more sensitive volunteer youth groups and parish counsel members

Group 3. Staff in church sponsored service programs, members of congregations, lay leaders, and the religious ministry, all need educational programs to increase their awareness, understanding, and sensitivity to HIV/AIDS.

- When I started work at the hospital, I was very scared of this disease at first and looking back I had a very poor understanding and knew so little or nothing. I prayed with them. Nobody taught me how to deal with it. I've seen three die in 3 years, and 1 is dying now. I get very personally involved with patients and try to help them to get through the difficult period..

- Ministers should also be able to help gay people, and probably do with or without the Bishop's consent. But they do not have enough information about AIDS; as the others said it includes those people who work in the hospital as well as those who run the church. There is not enough awareness about AIDS

- As a Catholic Priest in the Philippines I associated AIDS with prostitution, but since working with sick and ill people I've changed my attitude from being very judgmental to sympathy. Initially I didn't know the people who were infected with AIDS. I was unaware until after I had the chance to meet and see the people.

Group 4. Health Care Professionals and medical practitioners need training opportunities to increase their understanding of HIV/AIDS and care skills.

- Patient Health- Education: I'm concerned as to how well the island community can respond to the HIV crisis -I'm also concerned about how well the staff at GMH are prepared to handle HIV patients; they need to be trained or educated, so they are able to handle the taboos - that still surrounds them and the care of these patients.

- The fact is that health care professionals are terrified in this situation. They know HIV/AIDS is not just a homosexual disease but has spread across the board to infect many lifestyles and both sexes.

- Nursing and support staff wonder how safe are they with the patients. They are still very worried. How can the hospital grasp this need to make these people more comfortable. We can provide all the training, but support staff say they still feel uncomfortable with AIDS patients.

Group 4. There is a need to encourage more nurses and doctors, especially family practitioners to deliver a standard HIV-AIDS message as part of routine health care procedure.

- Doctor- I talk about HIV risk with my patients. I'm not sure if this is a standard way (not sure what other doctors are doing) of education - there should be a standard procedure just like immunization. HIV issues should be part of that. When we talk to adolescents about drugs, alcohol, tobacco, and sex. So part of my talk involves specific questions on HIV and perhaps that particular segment of the medical profession should have a standard way to communicate the message -

- There are a lot of opportunities and need for education at the hospital. Many physicians are very sensitive to the need and are contributing educational experiences to staff.

- We always talk about educating children, but the people who also need educating are the married middle age people (30 - 50) they are also considered a high risk. But those people don't consider themselves as being a high risk group, but they are because there's a lot of extra-marital sex, and occasional affairs.

Group 4. Awareness of HIV/AIDS media coverage is currently very low.

- There's not much in media coverage out to the general public. I also don't see many posters or flyers except an occasional few. Media coverage will be a tremendous help.

- My concerns about HIV/AIDS education is whether or not we are reaching each and every segment of the population with accurate information and are our education materials adequate. Are we really reaching the people we need to reach?

- I have worked with HIV patients both at a private clinic and as a volunteer with a health service organization- I have not seen any feedback on the effectiveness of our teaching method for AIDS education.

Group 2. Awareness of HIV/AIDS media coverage is currently very low.

- Last time I heard HIV was a long time ago because there was- they' re mostly concentrating on drugs. Haven't heard anything on the radio.
- My work was offering those AIDS awareness class down at DOA, but I didn't go- they were just passing around a flyer.
- Here on island I can't recall seeing anything for some time.

Group 1. Education materials and other media need to be designed and produced in ways that are appealing to specific targeted audiences, and written at their reading level.

- Some clients don't really know how to read, and there are other disabling factors. Make sure that the person who is going read the information must be able to understand it.
- Drug culture - youths go out and exchange sex for drug use. How do we teach them that what they are doing is dangerous. work with the youths "survival sex", just to get by day-to-day dangerous activity.
- Educators or outreach workers need to be able to relate to the audience. You must see them regularly and be in their presence for building trust; you have to know what it's like to be them. You are not there to be judgmental.

Group 2. Among men with some moderate to high level of risk, awareness of HIV/AIDS is largely through media news events associated with celebrities.

- I think I first heard about it 7-8 years ago. What drew my attention was the young boy in Florida who got AIDS by blood transfusion (another comments: was the boy's name "Brian White"). So many people thought it was a homosexual disease, initially, then it broadened to drug trafficking and taking drugs intravenously with needles.
- I guess I learned through the TV and News, mostly the TV from the mainland about those famous people in sports, like that guy Arthur Ashe. It really didn't affect me until Arthur Ashe and that story about him.
- When Magic Johnson was in the papers

Group 2. Similar to a known celebrity, is awareness gained by personally knowing or seeing or listening to an HIV/AIDS patient.

- Well, uh, when I first heard about AIDS was I had a cousin who died from it. I knew he was gay, and um, no one wanted to visit him, but I worked in the Bay area so I knew about gays. I felt sorry for him because no one wanted to touch him or anything like that. I didn't know

much about the disease or why he had it but I wasn't scared to touch him and he needed the support. After the disease progressed he passed away.

- Well, I have a friend I knew since we were 6-7 years old and he came back to the island- he came back with full blown AIDS. Basically, we talked about what kind of medication he does, ahumm, and this guy used to be a real big healthy dude, I mean he had- he was a joker way back but now he's real serious. I knew he had AIDS because he was real skinny- but he doesn't have black or blue marks or anything., ahh, he used to have real pretty hair- now his hair is straight. He was telling me he has to take IV's every morning and every night which takes an hour to hour an a half.
- What made me really think is when I actually saw a person, you know, he's got AIDS; it was real and I was looking at this guy who has AIDS. And I feel for this. It's the visual that catches you. That's what really got me.

3. The major institutional sectors of the community -- Medical Health Care, Public Health Services, Religion, and Education -- must strengthen their collaboration and increase communications to mount several coordinated educational activities.

Group 1. The island's Church Community needs to be invited in and made part of the HIV/AIDS prevention program network.

- One big controversy is the issue of the adolescent and teenage pregnancy rate caused by unprotected sex.
- this is a touchy subject, the church doesn't like people using condoms.
- how about the Church, they are not very supportive, there must be a way of approaching the church.
- the Church is very influential but they are reluctant to hear or talk about the subject.
- It is different now, I think the churches are responding in their own ways.
- If they knew the percentage, they will probably assist in trying to inform the community of what is going on.

Group 3. The group felt that some of the distance between the church community and HIV/AIDS services is engendered by judgmental assumptions among people within the network of social services working with the HIV/AIDS issue on Guam.

- I used to be part of a prison ministry and saw many spouses separated because of drugs or sexual affairs. "I've felt that it would be only a matter of time before the church was confronted and had to face this problem. I've wanted to offer help to those who are dying of AIDS - to help people in that process, but I find it is hard to penetrate into the community of service workers. The drug users and people with AIDS are protected/isolated by service workers - there is no easy way to approach them."

- I have not found a way or an opportunity to penetrate into serving this problem - I feel shut out from those leading the public health and medical efforts to deal with this issue.

- A barrier is there for some who want to hear the message. The Public Health and Medical service workers have their own group or their own fellowship and they don't want to let church people to participate in their fellowship. They have their own bias.

Group 4. There is a need for more dialogue and networking between the medical community, the community of social services, the community of churches, and the education community.

- Another need is for networking - there are a lot of organizations out there doing duplicate things but there is no networking. All of them need to communicate to get the doctors to be aware of resources - at one point there was a Grace House, but most of the doctors were not aware that a home actually existed for HIV patients -

- Services in general are very fragmented across the board. There is duplication of effort and competitive separation obstructing communication among the island's agencies throughout public health and non profit organizations.

- I agree there is no or little communication in agencies and a real need for more coalition building. But also the stigma is there because they relate AIDS as the homosexual disease, and most people never think it could happen to someone in their family until it hits home.

Group 3. Active caring and coping with the stress of HIV/AIDS upon the person and familial relations is a very important role performed by the community of churches.

- One barrier is the unwillingness of people to admit that they are HIV positive. The church has a fine line to walk along, to define- sexuality so it goes with more responsibility and at the same time we need to reach people where they are.- we can't put out a judgmental attitude

- It is the mission of our church that programs like "True Love Waits" must be supported by our priests, actively. A basic opportunity is education. The church tends to be very judgmental and there is no reason to judge people who are sick . They need support and comfort, and it doesn't matter where they got AIDS. To teach children correct attitudes and correct information is important.

- I agree with that - the church is a large community - we can't provide the answer for all society but we do provide comfort and compassion when people suffer

Major Themes Found In The Focus Group Session: Human Service Providers Interested In HIV/AIDS Education, March 14, 1996

Summary: This group consisted of 13 persons associated with human service programs both public and private. Some were employed professional staff, but several were working volunteers, including one volunteer activist who had a family member afflicted with AIDS.

I. **Education materials and other media need to be designed and produced in ways that are appealing to specific targeted audiences, and written at their reading level.**

Using peer educators and outreach workers is viewed as a good method

II. **There is a need for educating family members and parents of high risk persons.**

III. **There is a concern and feeling among some that public and private schools are not promoting HIV/AIDS education, and imposing restrictions when presentations are made by others.**

IV. **Social Service paraprofessionals and volunteers need training to increase their understanding of HIV/AIDS.**

V. **Education efforts need to reduce the stigmas and myths that affect people's understanding of HIV/AIDS and persons who have been infected.**

VI. **The island's Community of Churches needs to be invited in and made part of the HIV/AIDS prevention program network.**

Major Themes Found In the Focus Group Session:
The Multi-denominational Church Community, April 1, 1996

Summary: This group consisted of eight people from Guam's multi-denominational community of churches, including lay leaders, clergy, and members active in social service programs organized by their churches. The Catholic, Episcopalian, Methodist, Presbyterian, and Baptist churches were represented.

I. **There are suspicions between the moralities of the community of churches, and many people with life styles placing themselves at risk for HIV/AIDS, or those who have HIV/AIDS.**

II. **The group felt that some of this distance is engendered by judgmental assumptions among people within the network of social services working with the HIV/AIDS issue on Guam.**

III. **Staff in church sponsored service programs, members of congregations, lay leaders, and the religious ministry, all need educational programs to increase their awareness, understanding, and sensitivity to HIV/AIDS.**

IV. **Active caring and coping with the stress and impact of HIV/AIDS upon the person and familial relations is a very important role performed by the community of churches.**

V. **The well known controversy over condom education, distribution and use as a prevention strategy for reducing HIV/AIDS divides Guam's community of churches, and the positions are held as strongly as anywhere in the world.**

Major Themes Found In The Focus Group Session: The Medical Community, April 9, 1996

Summary: The following themes emerged from a focus group which consisted of seven medical and health professionals employed at Guam Memorial Hospital, Naval Hospital, and private health care clinics.

I. **Awareness of any HIV/AIDS public education media coverage is very low.**

II. **The community is struggling with the stigma associated with AIDS.**

III. **There is a need for more dialogue and networking between the medical community, the community of social services, the community of churches, and the education community.**

IV. **The community holds conflicting views on what is acceptable or proper sex education. This is part of the need for more dialogue between the medical community, the community of churches, and the education community.**

V. **There is a need for educating family members and relatives of HIV patients, as well as the general public to reduce the social stigma that hinders support and care.**

VI. **Health Care Professionals and medical practitioners need training opportunities to increase their understanding of HIV/AIDS and care skills.**

VII. **There is a need to encourage more nurses and doctors, especially family practitioners to deliver a standard HIV-AIDS message as part of routine health care procedure.**

Major Themes Found in the Focus Group Session:

Men's Outpatient Therapy Group, March 27, 1996

Summary: The following themes emerged from a focus group composed of 17 men in an outpatient therapy group operated by the Department of Mental Health and Substance Abuse. They ranged in age from 17 to 50, and were comprised of a full range of ethnic backgrounds representative of Guam's multi-cultural population.

I-A. Among men with some moderate to high level of risk, awareness of HIV/AIDS is largely through media news events associated with celebrities.

B. Similar to a known celebrity, is awareness gained by personally knowing or seeing or listening to an HIV/AIDS patient.

C. Work site education programs are another important method that reaches men who may be at high risk.

II-A. Awareness of HIV/AIDS messages and media coverage is currently very low.

B. Men in *at-risk* groups have trouble with written condom packet materials, and prefer seeing and hearing the HIV/AIDS message via broadcast media.

III. The community is struggling with the stigma associated with AIDS.

IV. Some men at risk are getting tested, but their numbers are few. The attitude for many is denial of risk and a lack of caring or concern about being at risk.

V. Condoms are used more often with extra-marital and casual sex partners, and less often with steady partners. This group's perception was that few women insist on the use of condoms, and then primarily as a means to avoid pregnancy rather than as a prevention of STD or HIV. Moreover, these men felt that their spouses would be suspicious if they possessed condoms because to have or use condoms may imply they are having extra-marital relations.

PERSONAL CASE STUDY NARRATIVES FROM PERSONS WHO ARE HIV POSITIVE

CASE 1 : 37 YEAR OLD CHAMORRO MALE, DIAGNOSED HIV + IN 1996

"Jim" (not his real name) is a 37 year old Chamorro male raised on Guam and educated through 12th grade. He was diagnosed with HIV in January 1996. He has never injected drugs. He lived off-island but has been back on Guam for 7 years. He states that he is gay.

Jim has seen AIDS awareness posters in local bars and elsewhere on island, and believes it's up to the individual to apply the message. He says the printed word is not enough - people need auditory and visual messages, such as continued showing of health education videos on TV, mounted in clinics and in waiting rooms. The AIDS prevention message should be repeated continuously, including in the work place, for people to become familiar with it. Also, education begins in the home and parents should be informed so they can help their kids.

In Jim's youth, 20 years ago, sex was not discussed in the home, and sex education in school was limited (for example, learning about VD). Safe sex was not an issue at the time, because sex education was so limited, there was nothing going on to make people aware. On Guam, where family is a source of stability, family members need to be able to talk about sexual issues, but they are scared to discuss it, and poorly informed, says Jim.

Jim began to question his sexual identity after he began to feel attracted to men after graduation. As a child, he experienced sexual molestation from a relative but it was not cruel treatment and he does not blame his homosexuality on this. Jim is comfortable with himself and his sexual I.D.

Jim's first homosexual experience at age 19 was "definitely not safe". At that time he had no concept of safe sex. The new experience helped him "know who I was" and take a direction with his sexual identity. His first sexual experience had been heterosexual at age 15 in high school. But after he discovered that homosexual sex was more satisfying for him, Jim took the view that it would be cheating himself, and unfair to female partners, for him to return to heterosexual relationships. Jim has strong respect for himself.

Since being diagnosed HIV+, Jim finds sex is not as important to him as it was formerly. He does not want potentially interested partners to become emotionally involved with him. He treasures friendship more. He likes to socialize and used to go out every night, but he has learned he needs to avoid alcohol.

Jim's negative view of alcohol derives from his feeling that it contributed to his HIV infection. Jim had been practicing safe sex in Hawaii and got tested regularly. He became involved with a new partner, whom he later learned was a heavy drug user. Under the influence of alcohol Jim forgot to practice safe sex. He felt concerned and got tested. The test was positive. Jim does not blame anyone for his situation.

Jim tested positive in January 1996 on Guam. There was a time when he was afraid of being tested, and he thinks many people are afraid to be tested. For a long while he had tested negative, going to the clinic yearly and then twice-yearly because he wanted testing to be a routine part of his life. His first test was at a private clinic. He practiced safe sex, was selective with partners, and seldom had one night stands (He has had three long term partners). Jim does not think he

infected anyone with HIV. Since testing positive, there has been a 180 degree turn around in his life - he is now sexually abstinent.

Jim says he has accepted his condition but does not yet know enough about HIV. He has not told his parents. He has told his brother, sister, boss and work colleagues. He has received a lot of emotional support from the family members he lives with. One of his biggest worries was financial because his job is a low paying one in the private sector. MIP is very helpful with the cost of medication. Without MIP he would not be able to deal positively with his life now. He wants other HIV+ people to know about MIP.

Being HIV+ has changed Jim a lot. He is aware of foods and environmental agents that are not good for his health. He wants to take care of himself and keep a positive outlook.

CASE 2 : 36 YEAR OLD CHAMORRO MALE, DIAGNOSED HIV + IN 1985

Simon (not his real name) is a 36 year old chamorro male who was diagnosed with HIV in 1985. Simon was born on the mainland but came to Guam at age 12, grew up here and graduated from UOG. Simon then left the island, but returned in 1993. Simon identifies as gay. He has been living with HIV for 11 years.

Simon found out about his HIV status through testing required for a duty transfer in the Army Reserves. He was employed in a mainland medical lab at the time, and had the lab do the test. He had not been consciously putting off the test, had just never bothered with it. He knew the difference between HIV and AIDS at that time. He was informed of the positive result by his commanding officer.

Following his diagnosis, Simon went in to a 2 year period of "denial," followed by a lonely five years when he did not seek a partner. Then he entered in a 1 1/2 year relationship, followed by his present relationship of 3 years standing. In both of these relationships, Simon informed the partners of his HIV status. They got tested regularly, always with negative results. His present partner carefully watches over Simon's health.

Simon is not sure if he infected anyone with HIV. Possibly a couple of partners, he says...but they might have been HIV positive before they met Simon. These partners showed no signs of infection. They have since died, and Simon never had the opportunity to discuss the matter with them. It is possible a partner would keep quiet about an HIV positive test, Simon says, because "at that time you were socially ostracized if you were HIV positive - it was like when cancer first came out."

Simon has no clue how he became infected. Following the positive test result (this was his first HIV test), a medical evaluation showed Simon's T-cell count to be about 1200, suggesting his infection had occurred within the previous year. Prior to the test result he had not been using safe sex practices.

Simon is against drugs and has never been a drug user. He has smoked "to see how it feels," and he tried cocaine once, but finds he is more "turned on" by a good book. Simon's first gay relationship broke up over the partners' drug use (needles were not involved). He believes that not using drugs has helped him to be a long-time survivor with the HIV virus.

Simon had little sex education when he was young. Sex education dealt mostly with reproduction. He was taught that sex was something you weren't supposed to do until you married, but not about its possible consequences (such as disease). Safe sex was not talked about. In the "crazy sixties" teens experimented and shared stories. The big thing when dating was "Did you get it?"

Simon's first sexual experience was at age 15 in the US mainland. This was an experimental encounter in which "safe sex" was not practiced. This was a "gay" relationship. Simon did have one heterosexual relationship when he was young, but says both partners had alcohol problems and "she broke my heart." He appears comfortable with his gay identity.

Simon does not consider himself promiscuous, and says he has "always been a monogamous type of person." Since testing positive he feels turned off by sex, thinking "Is this the way I got it?" His present involvement "is more like a platonic relationship." The partners utilize non-intercourse means of sexual communication (such as masturbation) and focus on the emotional side of the relationship rather than the physical.

A behavior that Simon feels puts him more at risk is drinking alcohol. He found that every time he drank, he would drink heavily, and his inhibitions would disappear. He says he has ceased such risky behavior and now drinks only in the company of select friends he can trust to take care of him. Simon notes that alcohol is probably the most common drug among people who are HIV+.

Simon is now acutely aware of what safe sex practice should be, and preaches to his nephews and nieces about being careful. He describes himself to them as a living example of the worst that can happen. Speaking of his niece attending UOG, he says "The knowledge is there but there needs to be that extra kick to get people to start doing it." Since he has begun thinking a lot about safe sex, STD's and teen pregnancy, Simon feels concerned about the teenagers he sees together at, for example, Micronesia Mall. However, he says "There's nothing [we] can do except inform them. It's up to them to use the information."

Simon has given a presentation on his experiences to a group of older teens (16 - 18 years old) at a churchyouth program. Through a personal connection, he plans to to younger students (9 - 11 years old) also.

Simon did not inform his family when he tested positive with HIV. He did not want them to worry over his every illness. The family found out about his health status in 1995 when Simon was in GMH with pneumonia. The family has accepted the situation, although individual members tend to over compensate with Simon when health issues come up. Simon's mother turned out to be well informed about HIV while his father was not, and it was interesting for Simon to have to deal with the dual attitudes.

Simon says he has been though the psychological stages of anger, denial, (etc.) and is now at acceptance of his condition. He looks at the other people with a different perspective, and feels he himself is a better person. He wishes he had come to this outlook by a different route.

When Simon returned to Guam in 1993, he saw billboards addressing HIV/AIDS (at the Paseo, for example), and thought they were effective. He has not seen much recently. His present source of information is the Communicable Diseases Social Worker, and the ARROW Archer newsletter.

Simon commented on his experience with medical personnel on Guam. "Some doctors tend to lose the color in their face when they look at my chart, and some don't have a problem with it." For medical care he is attending a private clinic and reports that he has been treated by the physicians there"with the utmost respect." Simon prefers to tell medical staff face-to-face about his HIV status, rather than to write it on a patient information form.

Initially Simon was hesitant about going to a dentist, but he has resolved this concern. When he had dental work done at a private clinic recently, he observed that the doctors and their hygienists use a lot of protective gear in dental work.

Simon speaks very positively of the care provided him by the Public Health doctor. He says of his present mdeical care on-island, "I think that's what shaped my attitude: I've been fortunate in getting these positive physicians who are treating an HIV/AIDS case as another kind of terminal illness, without the social and political implications."

Simon is working with the doctor at Public Health to bring an additional protease inhibitor on island. He is trying to arrange for GMHP to cover the cost of the new medication. He communicates via E-Mail with a Doctor at U.C.L.A. Simon says there is a lot of information and programs available to help people get medication, but people don't know about it.

CASE 3 : 37 YEAR OLD CAUCASIAN FEMALE, DIAGNOSED HIV + IN 1988

Jessica (not her real name) is a 37 years old Caucasian female who tested positive for HIV in 1987. She moved to Guam from Boston, MA 7 years ago when a friend of hers invited her here to live. Currently, she is unemployed and raising her 4 year old step-daughter. She never graduated from high school and currently lives in public housing. She also does not own a car. She sees herself alone with few friends, yet seems to be accepting and satisfied with how she has chosen to live her life. Jessica is very open about her virus and, thus, feels this is why people have chosen to stay away from her.

Jessica was born and raised in Boston , MA. the youngest of five children with 2 sisters and 2 brothers. Her first sexual experience was at the age of 4 when she was molested by a baby-sitter. She was also sexually abused by her father and older brother for several years. Sex was never openly talked about in her house and she viewed it as something that just happened, not an act that was suppose to be enjoyed. She describes herself as being horrified and disgusted with sex before she even knew what it was. She had no knowledge of a what a sexual relationship was

because her father slept in his room and her mother slept on the couch. She lost her virginity when she was 13 or 14 after having run-a-way from home. She doesn't remember it happening due to the fact that she was intoxicated and on drugs. She never remembers being worried about sexually transmitted diseases or getting pregnant, and at that time AIDS was not even heard of. Because she describes herself as being on a suicide trip much of her life, safe sex was never an issue until recently. At the age of 16 she met a man and fell in love. They were married when she was 22 and less than 5 months later he was brutally murdered. This was the time when she was first introduced to heroin.

After Jessica's husband died, she became extremely suicidal. She had been left some money from his death and her friends introduced her to heroin as a way to bring her out of her depression. This is when she began an 8 year addiction to heroin. As her addiction became more severe, she turned to prostitution as a means to support her habit. She suffered from hepatitis and a severe case of PID from which she was hospitalized. She also became involved with other drug related crimes such as drug dealing and writing stolen checks. Because of this, she ended up serving time in prison. It was during a six month prison sentence between 1987 and 1988 when she became ill with pneumonia and was hospitalized for 2 or 3 months. A month after she was released from the hospital and back to the main facility of the prison, she was called back to the hospital where she was informed that she had tested positive for HIV.

Jessica remembers feeling truly happy and a great sense of relief when the doctor told her she was HIV positive. From what she knew about AIDS at that time, she thought she would die in the very near future, and her relief was that she would soon be out of the "drug addicted disgusting life" that she was living. She had never worried about being tested before, although she had heard about AIDS, because she figured she would die on the streets anyway. After she was released from prison she continued to support her heroin addiction through prostitution. The fact that she was HIV positive did not change her behavior. She describes her behavior as self destructive and not concerned that she may be passing HIV on to other people. She saw her clients as supporting her habit and keeping her sick therefore, they deserved what they got. When she had condoms, she would sometimes offer them but usually they were not preferred by her clients and therefore, not used. Nearly all of her clients were men. She estimates having sex with thousands of men and less than 10 women. She only had sex with women for money to support her heroin addiction and has always considered herself to be heterosexual. Jessica also continued to share needles with other heroin users. She got her needles from diabetics who would sell them, free needle programs on the streets and from other users. She never worried about using clean needles, needles that others had used or having others use the needles she had used even after she was aware that she was HIV positive. She believes that she was infected through IV drug use rather than sexual contact since most of the people who she shot dope with are now dead from AIDS. This continued until she came to Guam in 1989.

Jessica was invited to Guam by a married business man who was a client of hers. Since she was running from the law, Guam seemed to be a good place to go. She also felt that part of her wanted to come to Guam to get clean, while the other part came because there wasn't enough heroin in Boston to get her high anymore. She would be closer to Asia, and therefore, heroin.

On the plane to Guam she began going through withdrawals and was taken to the hospital from the airport. Less than a week after arriving on Guam she was approached by a police lieutenant and asked to answer some questions. Both the police and the governor had heard about her and sent for her file from the Mainland. She was questioned and released. Later that day she came home to find an article written in the Guam Tribune about her which stated her name, the fact that she was HIV positive and also wrongly accused her of working in a massage parlor. Jessica countered the attack with an interview for the Pacific Daily News.

After this she became friends with the Police Lieutenant and he and his girlfriend put Jessica up in a motel. She got a job, stayed clean and gradually was able to support herself on her own. Two years later she met her current husband and was married. She feels sex was ruined for her in her younger years and therefore not anything that was enjoyed with her husband. He was aware that Jessica was infected with the virus before they had intercourse and he was counseled twice at Public Health before they became intimate. However, this did not effect his decision to practice safe sex. Both he and Jessica consciously made the choice to have unprotected sex.

Both Jessica and her husband had affairs during their marriage. The few times that Jessica did have affairs her partners knew that she was infected with HIV. More often than not she used condoms. She and her husband are now separated because he is consumed with "ice". He has decided not to be tested for HIV, but Jessica thinks there is a very strong chance that he is infected also. She warns others by stating, "that cute guy in the nice looking car with all the ice is probably infected" - just a message of warning to those young girls who can get caught up in it because she did.. People really need to know that healthy looking people that look like they have it all could be infected and young girls are attracted to the material things and glitter of drug money.

Jessica's suggestions for using advertising as a way to prevent the spread of HIV would be messages that conveyed the idea that anyone can get infected. That it's not just drug users and stupid or "obnoxious" people that are at risk, but an open and honest "everyday type of person". She also sees a need for the advertising to be more centrally located because she feels there may be people on Guam who believe that AIDS is not effecting their island.

Her criticisms of the current advertising for AIDS are that there aren't enough of them, the ones that are shown aren't informative and that scare tactics should not be used because they don't work. One commercial she found offensive stated "get high, get stupid, get AIDS". She was offended by this because it insulted the people that are HIV positive and as a mother, she felt it gave her daughter a negative impression of her.

CASE 4 : 28 YEAR OLD "CHAMAOLE" MALE, DIAGNOSED HIV + IN 1993

Mark (not his real name) has lived all of his life on Guam. His mother is a Statesider and his father is Chamorro. He is the youngest of three boys. Currently, Mark is working on his Bachelors Degree at the University of Guam and is an employee of the Government of Guam.

Mark was diagnosed with HIV 3 years ago when his current partner suggested that he be tested. His partner, however, has not been tested. Mark says that his partner has not refused to get tested, he just had not had time to do so. He has been in this monogamous relationship for three years and they have a commitment that his partner will take care of him when he should become ill. Their relationship is a sexual and condoms are sometimes used.

Before this relationship, Mark has had sexual relations with 7 men in what he describes as short term relationships - from 6-12 months. He has never had a sexual relationship with a woman.

Before Mark was tested for HIV, he felt he was at a higher risk than other people because he rarely used condoms. Since finding out that he is HIV +, his sexual behavior has not changed much. He is still with the same person that he was involved with before he was tested and they use condoms sometimes. He has no idea who he was infected by or if he has infected anyone else.

Mark' s first sexual experience was at the age of 12 when he and his older brothers began having intercourse in the shower. This continued for approximately three years. He describes this as being a reason for his homosexuality although both of his brothers are married and have families now. Sex was never discussed in his family when he was growing up and he was not concerned about AIDS or STD's.

When asked who he had told that he was HIV positive, he noted that none of his family members had known, yet a couple of co-workers and friends of his and his partner, along with his doctor. He notes thats his T-Cell count has been slowly rising, but his doctor says he has another 20 years to live. When he informed his doctor (at SDA), he was very supportive and invited Mark to a prayer session. Mark has been to the dentist but has not told them of his status. He does not feel any mistreatment by his co-workers.

Mark has seen little advertising stressing safe sex or AIDS prevention. The only time he has seen some is during AIDS Awareness week. He notes advertising that is out there, is effective to some extent but "people have their own differences and don't to take it vitally." He is somewhat aware of the different support groups on island, but is not an active member in them. He recieves the Arrow newsletter, but does not have time to attend any of the meetings. When asked what he thought would be a way to help promote AIDS prevention and awareness, he stated that it should be a part of the curriculum in schools.

Mark feels that being HIV positive has not changed his life much. He feels that he is living his life not much differently than he would of if hadn't been infected. His advice to others is to do the same but be to use precautions (condoms) and be honest with your partner about your infection.

CASE 5 : 35 YEAR OLD CHAMORRO MALE, DIAGNOSED HIV+ IN 1992 -1 993

Ben (not his real name) is a 35 year old Chamorro man who was diagnosed HIV + 3 -4 years ago. Ben has spent 24 of his 35 years on the island, having left at age 16 (he completed high school on the Mainland), lived in various cities, then returned to Guam 9 years ago to see his family. Ben identifies his sexual orientation as gay and says he is comfortable with this.

Ben is concerned that in the culture in which he was raised (i.e., Chamorro), feelings are expressed through anger rather than through love. Based on his own experience, Ben feels that educating the youth of the community in how to have an initimate relationship - one-on-one dating -should be part of the HIV/AIDS management program. Feeling unneeded in relationships as a youth, Ben had turned to sexual activity as a way of finding acceptance, and sex became an obsession. He also became involved with drugs and alcohol.

Ben's family was dysfunctional. Ben was sexually abused by one individual from the early age of 6 or 7. His first sexual relationship (beyond the abuse) was heterosexual and not "safe" (AIDS was not heard of then). At age 18, feelings he had for a man surfaced at a gay function and thereafter he did not go with women. Ben has given a lot of thought to why he turned out gay - wondering whether it was because of the molestation - but found no answer to this question, and decided to accept himself as he is. He does not make his gay identity publicly known because "there is still prejudice". He used to feel angry towards his abuser until he got outside help (therapy) for his feelings.

Ben thought having sex "was great" when he was growing up. He refers to a culture of promiscuity in the gay community has was part of. Safe sex was not practiced and he did not understand what it was. Ben's involvement with drugs and alcohol increased sexual stimulation and blocked perception of reality. He sometimes used condoms, but Ben says many men do not want to use condoms because they say they don't feel anything; and this safe sex practice leaves some partners frustrated.

Ben states that he did not shoot drugs, but used cocaine, marijuana, speed, and Quaaludes. He is sure some of his partners were needle users. Ben always remained with the group at high risk for HIV infection, and his partners were high risk also.

Ben recalls that when the AIDS epidemic broke there was a lot of stigma, anger and fear. An example is those posters which imply that contracting AIDS will end your life. Negative ads like this encourage at-risk people not to face the issue because of what they will have to go through. Once diagnosed, they will feel condemned, so the issue is ignored. Ben was "in *denial*" about the possibility that he was infected until he became concerned about his health.

Ben's first HIV/AIDS test, 3-4 years ago at Guam Public Health, was positive. He had always been in the high-risk group. He did not know who infected him and whether he infected others. He told his HIV status to some partners, but does not know if they have been tested. Ben's last relationship was 3-4 years ago. Since becoming sick, he has been sexually abstinent.

Ben was afraid of being tested, and although he subconsciously realized he was infected, did not want to face it. His main fear was what his family would think, and his fear was justified - they have not taken it well. As for the wider community, because AIDS has become publicly known Ben did not experience the worst kind of community reaction; nevertheless, he felt from some people that it is " a yucky thing to have." His family prefers not to mention it. Family members said they will not support Ben with any special effort but they will "be there" for him. When hospitalized, he had many visitors.

Having AIDS has provided a turning point in Ben's life. He sees that he was a person with obsessions. He recognizes that he is intelligent and wanted to achieve. Now he observes and reflects on what is going on around him. AIDS for Ben is not about death. Coping is his goal, and the goal of other infected people he knows. However, dealing with the physical side effects of AIDS illnesses and the mental consequences of being "whacked out" from medication, requires emotional support. Ben is a member of a support group where he can express his feelings, and he feels strongly that there should also be a support group specifically for HIV positive people on Guam. He is concerned that Grace House is no longer operating. Dealing with HIV/AIDS involves more than managing illness; it requires helping people with their feelings.

The media was Ben's source of information about HIV and AIDS. Prior to testing positive, he did not know the difference between the two. He had seen posters at the library, but did not see their message as something he should apply for himself. He sees as more effective than posters, going to the public to talk about the issues, especially to youth. He would advise young people today to seek one-on-one relationships, get tested before starting a relationship, and to use condoms when "one night stands" are involved.

Ben feels he has been very well taken care of by the medical community on Guam. When seriously ill in GMH, he felt he wanted to die. But the GMH staff gave him great support, and he felt glad that he came out alive. He has not yet been to a dentist.

CASE 6: 36 YEAR OLD CAUCASIAN FEMALE, DIAGNOSED HIV+ IN 1995

According to Jody (not her real name), she has seen some pamphlets about HIV/AIDS infection at the Doctors Clinic, Public Health and the New Beginnings Program, and that is it. She has not seen posters or other prevention information on display at other clinics or places where people gather. Because she watches very little TV, this form of media coverage was never effective for her.

The pamphlet entitled ***Common Sexually Transmitted Diseases*** was effective for me. The first time I picked one up it really made me think. It was effective for me because it was a reality check. I was pregnant, I was on drugs, and it made me realize I needed to be tested. I could just feel it. Having a clear head, being in treatment at New Beginnings and having Bernie come in and speak had a profound effect on me. Bernie's public education was very effective for me. She has very graphic visual aids and she is not intimidated at what she does. People look at it (HIV/AIDS) as a gay disease or a disease of drug addicts. We need to change that belief.

In the late seventies I was more interested in the opposite sex and interested in sex. Safe sex did concern me because one of the first persons I had sex with gave me the clap (Gonorrhea). I did not know I had it until a year later when I had sex again and my partner got it from me. Safe sex was prevention from getting pregnant. But even then the late seventies was a time when the pill was popular. Condoms were not really used to much.

When Jody was about thirteen, she had her first sexual experience with a boy a year younger. She describes herself as being very naive. Worried about pregnancy, Jody and her partner used a sandwich bag to cover his penis as a means of contraceptive. Jose stated that looking back she does not even think that she was menstruating and that she was worried that he was going to urine on her. Jody did not enjoy the experience although she thinks he did.

Jody stated that when she was diagnosed she realized that "shit happens to me too." She describes her sex life as being over. With little sex drive, Jody said after the birth of her daughter, having an HIV diagnosis, and having no drugs in your system, she has little sex drive.

Jody states that she has had sex with both men and women at the same time because she was curious and she wanted the experience. She also stated that she enjoyed the experience but that she is not a lesbian. Nor does she see herself as having a relationship with a women.

Sexually Jody describes herself as "a straight but kinky girl." She really has never questioned her sexuality. She feels that she has always been attracted to men but that she has had sex with women and that she did enjoy it.

Yes, She's an IV drug user. She sat in silence before answering this question. A question which transformed her back to a youthful world of twenty years ago, 1976. Back to a time when Wireless Rock could be heard on most of Guam's radio stations and typhoon Pamela was yet a memory. Jody was sixteen, and arrived on Guam when there was "plenty of China White Heroin."

Jody's first experience with drugs was with the help of a young neighbor boy who taught her how to snort Heroin. This went on for about a year. While attending a party at a boys house whose parents were off island, Jody talked a young man into mainlining it for her. "Unable to do it myself, he must have known what he was doing because he injected just the right amount so that it was an instantaneous high, instant gratification. I was already an addict at this point so shooting-up just made it worse.

I continued to shoot-up once or twice a week or sometimes as much as I could. At times, I would stop and do other drugs but it seems that I would always go back to Heroin. From about 1981 to 1984 there was a heavy run. [Heavy Run is when there is plenty of dope available and you use it daily] I was dealing it at that time. My husband was my dope partner. We finally married in 1986. We read about HIV even back then but I thought that if we only shared needles with each other everything would be ok. I really did not think about extra marital sex/risk.

We use to use used needles from a friend whose aunt was a diabetic. I have shared needles with others. Once we learned more about HIV, we did clean our needles with water and bleach. However, if you were sick [Jones: body goes through withdrawal when it does not get fix] and someone offers you some heroin with a used needle, there is not a junky that would turn it down, clean or not. Only thing you want is to get the dope into your system so that you can get well. I would not use the needle exchange program because I am in recovery however, if Guam had a needle exchange program I would back it. I think everyone should be able to go to a pharmacy with out a prescription. I think by having a needle exchange program Guam would be trying to prevent the spread of AIDS. Addicts are sexually active just as well.

Jody states that the father of her child had sex with other people while he was with her and that he shared needles with other people as well. The disease is sexually transmitted and I think about the numbers of people who do not think that they are going to get it and the next thing you know is they have it. I think about the innocent girls that my ex-boyfriend took to bed and I know that even if he had HIV, it would not stop him from being with these girls that are about eighteen years old. When he is with them they smoke ice. There is a high sex drive amongst people who smoke ice together and they are not real picky about who they have sex with. Now-a-days if the guy has the drug and the girl wants it, she will go to bed for it, there is no two ways about it.

I learned that I was HIV positive through the wonderful people at Public Health. I was worried about HIV for about a year before I tested. I had developed a rash on my back, stomach, and abdomen that would not go away. This was about the time I got pregnant. I guess my pregnancy must have triggered the disease. I was not recovering from my delivery. My energy level did not come back. I was scared so I called a friend at Mental Health who encouraged me to come in and take a test. If it was not for her, I do not think I would have had the courage to take the test. She came to Public health with me and was with me though the whole process.

I don't know and I don't want to waste a lot of time trying to figure it out. At this point, it is not relevant... It could have been from the sharing of needles, or was it the neighbor who also tested positive last year. It could have been my boyfriend or did it happen in 1993 when I took a trip to Bali and had sex with a man who was vacationing from San Francisco. My Tcell count is low so it must have been longer than a year. I don't want to blame anyone. I think I was infected by my ex-boyfriend. His life style included sex with women who danced at strip clubs. I never had a negative test result. I have only taken one test and I am sure I was infected on Guam.

I was faithful to my boyfriend for some three years. However, he slept with everyone. There was a time when I did sleep with a guy and we used a condom. It was his idea because he had caught a disease from someone else and he did not want to bring anything home to his girlfriend again.

I have had sex with guys who have shared needles. That describes my last boyfriend. I don't think he was bisexual however, I did wonder if he was HIV because he was not careful with the woman he had sex with. I knew I was at risk having sex with him but I pushed those thoughts to the back of my head because my main concern was to get my fix for the day. There are a lot of drug abusers who have the same mentality and will not change. Many do not want to change their lifestyle. They just want to go on with their lifestyle.

Being an IVD user puts me at high risk. My behavior had changed before I tested positive for HIV because I was in recovery. Now I do not have a sex life and have not had sex for about eight months. It does not look like I am going to have a sex life in the near future and it really is not a priority for me. It would be nice to have someone to have a relationship with. I have some really good friends and that is important to me and they are all in recovery. I am trying to stay healthy and focused.

People need to know that even if you are faithful to one person you can still become infected. I knew I put myself at risk being with a man that was with everyone else. I think of that as being my fault because I knew the risk and yet I wanted the drugs that he gave me.

I don't think that I infected anyone. .. I may have shared my needles with someone and infected them that way. But I did not go out and intentionally infected anyone. They wanted to use my needles. After I tested positive for HIV, I know I never infected anyone. I am practicing abstinence. I know that people who were HIV positive generally were not sick yet and people with AIDS were developing Ois. I did not know the clinical differences.

Before I tested positive for HIV, I got my information from my girlfriend, who works in the area of HIV/AIDS prevention - the Health Educator for CDC, DPH&SS and from pamphlets.

Being HIV positive has changed my outlook on life. It has changed who I live from day to day. It has changed everything. I have different values. I want to spend as much quality time with my children from now till whenever. I am not as concern about meeting Mr. Right. I have learned from this program to make the best of each day and to be thankful because I am not really sick yet and the baby is not either. My other children are doing well. My mom is very supportive. I am thankful to have really good friends like my girlfriend who also has three children and is not scared to hang out with me. When I was on drugs, good sex was a real priority. Now I feel that I have been there, done that, and had that and it was great and fun while it lasted. I am living a more spiritual life now and I like that.

I have not gone to a dentist since I tested positive but I have gone to a Dermatologist at a private clinic. I told him about my HIV status because I figured that it may make a difference in his treatment for my skin condition. After he treated me once, I got the feeling that he did not want to see me again. I think the doctor at Public Health is my best bet.

When I was using drugs, I did not want to test for HIV. It was not until I was in recovery that I was willing to take an HIV test. When you are on drugs, you do not want to face reality.

CASE 7: 37 YEAR OLD CHAMORRO FEMALE, DIAGNOSED AIDS + 1996

Before I knew about my HIV status, I associated HIV with things that were "not right." I believed that bisexuality, homosexuality, and intravenous drug use (IVD) were wrong. Once I even asked my second husband Larry what he thought about the people who were testing positive for HIV. He replied that "it was God's way of punishing these people."

We both have learned a lot since then...and at a very high price. I think about those who are very innocent, trusting people who are contracting this disease through their husbands and wives. Patients who were infected during transplants and blood transfusions. Babies contracting this disease from their mothers. Neither one of us now feel that "you get what you deserve." But that's now. Back In 1984, I was married to an alcoholic, I was eight months pregnant, and my first husband Joe was sick. He had what we thought was the flu. Joe caught it twice in a row. The second time he was really sick and he was not getting better. His high fevers and constant sweating would not stop. My husband was also being treated for cirrhosis of the liver. Worried, I called his doctor and told him that I could not lower his fever and that he had already missed work for a week. Joe was admitted and treated for dehydration.

I remember going to the hospital to see my husband and thinking how good he looked. Feeling relieved with his progress, I left the hospital and returned about three hours later. When I saw Joe, he looked like hell. He honestly looked like he was going to die. I was told by the doctor that he was going to transfer the case to Dr. C-- and that this new doctor specialized in this disease. I asked the doctor "what disease?" and the doctor told me AIDS. He also stated that Joe had about four days to live.

I was not present when the doctor told my husband that he had AIDS. I had left the hospital to contact his family members. Looking back...I was in shock. Not for myself. I never thought it would happen to me. I was in shock because of what was happening to my family.

After my husband's diagnosis, we never had sex. I think my husband knew he was infected. He was at risk. He was an IV drug user and had just quit about one to two years before I met him. His drug use started while he was in the Marines stationed in Okinawa and then in Germany. My husband used to share needles with his best friend, Mike. I remember Mike's wife Carol had died, but no one told us that she had AIDS until after Joe was diagnosed, and only when we tried to contact Mike (so he could be tested).

I guess you could say I was very sheltered in regards to sex. My mother never dared discuss that word with me. I was about fifteen when I started dating. Even then my parents never gave me advice about sex. I learned about sex from what I read in magazines, saw on TV and heard from friends. When I first started to date, my boyfriend and I held hands and kissed, and gave each other hickies. It meant that you were "taken."

My first sexual experience was when I was seventeen years old. It was not my boyfriend. It was actually a one nighter and it was not safe. You meet a guy...you think he is cute...he takes you to bed, and you want to please him and maybe hold on to him. My first experience was not romantic. It was not pleasurable and afterwards you ask "what did I do?" It had no meaning. I did it to please him. I felt he thought I was cheap and that anyone could pick me up. It made me really think and I knew that I wanted to get to know the person a little bit more the next time.

Prior to my first marriage, I was approached by my roommate and her boyfriend. I could never get into it. It was not appealing to me. Sex should be personal. I am heterosexual. I have never desired a woman. I am the type to have a relationship with a man and even then it is one man at a time. Even if I could get away with having two sex partners, I would rather have one person in my life and stick to them. It would not feel right, and morally I know that I would be cheating.

When I was told that I needed to be tested for HIV (in 1984-85), we held off until my child was born. Actually, I waited until my son was eleven months old before we were both tested. I remember taking my eleven month old son, Manny to the hospital for our HIV test and feeling very sad.

Joe actually lived about a year longer than what was predicted. During this time, I would educate myself about HIV and AIDS from what the doctors told me, what I read, and what AIDS specials

were on TV. I was scared. My family was back on Guam, I was pregnant, my husband was sick, and after hearing about Joe's health, my friends started to disappear. I knew I had to be strong. I worried that if I was not, who would be there to love my child and give him support.

It was a hard time sitting back and watching my husband die. I followed him through the different steps of death and I did not even know it. He went through depression, anger, bargaining, denial and more.

Finally when he did die, I was sad...but relieved. I had seen him suffer so much with pneumonia. There were times when he could not get out of bed because he was so sick. There were times when he could not even talk. I did not want to see him suffer anymore. The last time he bargained with God was to have him live long enough to see Manny walk. Shortly after Manny took his first steps, my husband died.

During this time my son was monitored by a Kaiser Pediatrics specialist and I as being monitored by Dr. Smith. Manny and I returned to the hospital for the test results. His were negative and I had tested positive for the ELISA test. My blood sample then underwent the Western Blot Test and it came out negative. All these years later and I still have the copies of our test results in my desk that I keep in my bedroom.

Looking back, I know I should have taken another test a couple of years after my initial test...but I did not. I was scared. I thought about it...but then, I was negative. That is what the doctor told me and that is what I wanted. I honestly believed the doctor, when he told me that I had nothing to worry about. I took the news and I ran with it. Any doubt I had about my test results I pushed aside. All these years later...I still have the copies of my test.
I remember the doctor asking me why I thought my results were negative. I told him that about a year before my husband's diagnosis. I stopped using the pill and my husband and I started using condoms. I had been on the pill for a while and felt my body needed a change. The one time we did not use a condom, I got pregnant.

When my son turned ten years old, he is eleven now, you don't know how happy I was. It confirmed to me that we were "home free." We had made it to the ten year mark and neither of us had gotten any major illnesses. My doubts about having HIV did not have to be pushed aside. Our good health was now proof. I have learned a lot since my son's tenth birthday.

According to the doctor at Public Health, the Western Blot Test now tests for more bands than what the confirmation test did back in 1986. The two bands that were tested back then that were non-reactive are now reactive. It's like wow, now I have it!

After Joe's death, I was not interested in having any type of relationship. I concentrated on raising my son and making a good home for him.Larry and I met about three years after Joe died at a birthday party. I was not interested in him when we first met. He was married at the time and I had never dated a married man.

My relationship with my current husband is very special. It has to be in order to overcome my diagnosis. Our lives have changed since my HIV test. It has not been easy, but it has given us a chance to take a closer look at our love and commitment to each other. I do not know at this time if I have infected Larry. I think about that often. I love him and I would never want to hurt him in this way. I am eager and scared to know what his test results will be. I guess for now, we will have to wait and see...I pray that I did not infect him.

I do get sick, but very rarely, and I do consider myself to be very healthy. However, last year, I had flu like symptoms and I went to my private clinic for treatment. While I was there the doctor and I discussed the thrush that I was experiencing. I know what it was because Joe had it as well. But I did not know why I had it. I was negative for HIV, and should not have thrush in my mouth.

My clinic doctor did not offer any test that would have explained the thrush in my throat. I even asked her why I would have thrush. All she said was "there are fungus everywhere" and she left it at that. She gave me medication for the treatment of fungus, but did not ask any questions about why I might have thrush nor did she ask me to come back for follow up.

A few weeks later our family attended a party and I ate shrimp. I love shrimp kelaguen; it is my favorite food. I never had any problems or bad reactions from eating shrimp before, but about a day later I broke out in hives. I went back to the clinic where I spoke to a nurse practitioner about the hives and about the thrush. She too stated "there are fungus everywhere."
About two weeks later, we went to another party and again I filled my plate with shrimp kelaguen. Again, I broke out, but this time in little dots, almost like a rash and my eyes turned super blood shot. I went back to my clinic for the third time and I received treatment. This was on a Friday. During the weekend I was not getting better, but worse. I was starting to itch more and I had developed a fever. On Monday, I went back to my clinic. It was at that time that an HIV test was recommended.

Part of me was very scared and part of me was very confident. I was negative before so I thought should still be negative now. Yet I had thrush and I did not know why it was there. My first husband had had Pneumonia and thrush. Those were his symptoms so I was trying to relate his situation and mine.

When the day came for me to get my test results, I received a call from my private clinic. I could not understand why I was unable to get my results over the phone. When the nurse told me that I needed to go to my clinic to discuss my results, I knew then that I was infected. Larry and I went down to the clinic together. He actually took the news really well considering he did not know how my first husband had died.

Before my diagnosis, I knew the difference between HIV and AIDS. I also knew that a T-Cell count of 200 or below is considered AIDS. However, when I tested positive for HIV and I took a T-Cell test, for some reason even after I was told that I had a count of 13, it still did not register that I had AIDS. I kept thinking that I was HIV positive. Even Larry knew that I had AIDS because he was present with me during my first doctor's visit.

My health is an issue and then it is not. Despite my low T-Cell count, I do not suffer from any opportunistic infections. I try and take care of myself and stay away from people who are sick with flu, etc. I take my medication as prescribed to me. I want my health to get so well that I will not have to take any more medications.

I feel that I must have been infected by Joe even though I only tested positive recently. But I continue to ask myself, why didn't it show synptoms in my body before all this. I don't know.

Since I tested HIV positive, I refused to have sex with my husband. I don't want to take a chance of infecting him (if he is not already infected). Even with a condom, I will not have sex.
I feel that he loves me, for me and if I can spare him from this disease, I want to do so. There are other ways to express love.

I do not think about the physical aspect of our relationship. I am human and I am sure he thinks about it too. On those nights...he sleeps on the couch and I sleep in the bedroom. On other occasions our baby will come into the room. We use to take him back to his room but now we leave him in the bed with us. I think that by leaving him in the bed, it is our way that we protect ourselves knowing that we will not do anything sexually with a child in the room.

Actually, we don't talk about the physical part of our relationship. We still kiss and hug each other. We still love each other. However, we now have alternative expressions of love such as pulling weeds together, seeing to the children together and just spending time together.

I see pamphlets and literature sitting around when I go into clinics. I also watch TV specials and commercials which are effective ways of reminding the public about HIV and AIDS. But I feel that, locally, more needs to be done. I see Stateside messages on pamphlets and Stateside TV commercials. I would like to see more local educational stuff. I also feel that Government of Guam needs to make it mandatory for each agency to undergo work site HIV/AIDS education classes, the same way that the military requires it.

I want to see more local advertisement and more local educational materials. I want to see more women educated about this disease. So many of them are unaware that their husband/boyfriend may be at risk doing things... and as a result, are putting themselves at risk.

As for me, I want to be around a long time for my children and my husband. Larry tells me that I am going to live at least ten years and that I am going to be hassling him the entire time.

SURVEY FINDINGS AMONG PERSONS WHO SELF-IDENTIFY AS EXHIBITING HIGH RISK BEHAVIORS

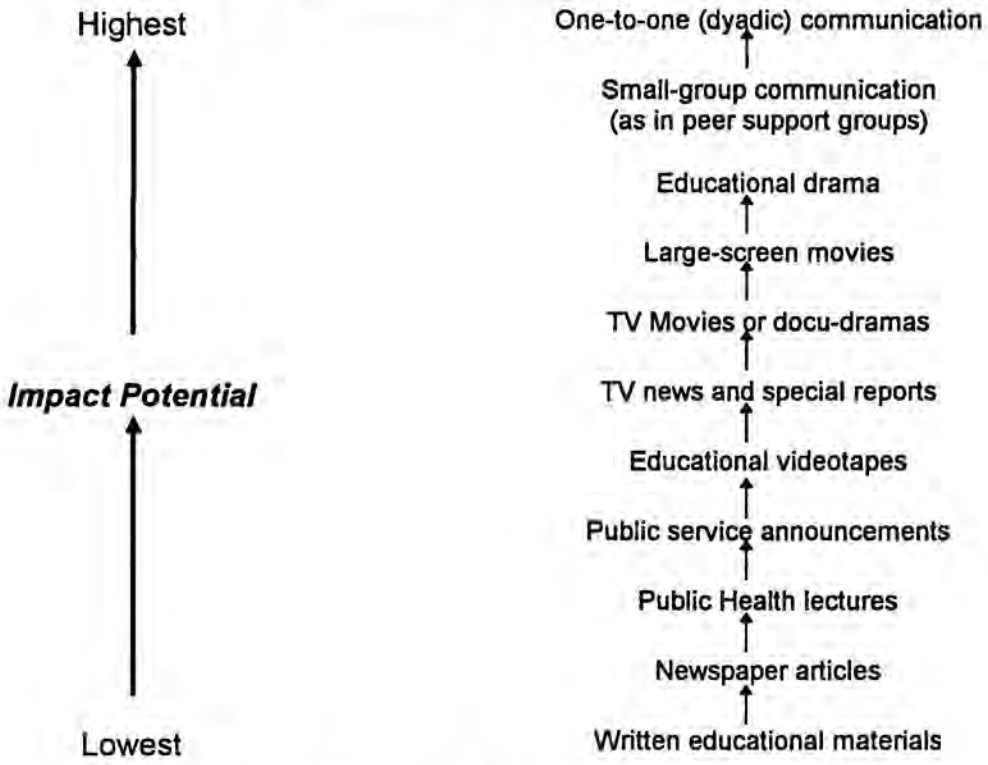
If you haven't done so, when you read the themes from the focus group interviews (see pages 21, 30 to 33) and compare these to the narrative stories of persons infected with HIV/AIDS, (see pages 35 to 50) you will begin to comprehend the different program needs of the general population from the needs of persons infected with HIV. There are only three modes of HIV tranmission: sexual contact with with an infected person, exposure to infected blood or blood products (mainly through needle sharing among injection drug users), and perinatal transmission from an infected woman to her fetus or infant. Involvement in such behaviors place people in high risk categories where they stand between the general population and those already infected. Diagnosed cases of HIV/AIDS are the clinical end point of a funneling or channeling of people into life situations involving ever increasing risk of HIV infection At the end of the funnel, testing services document those victims where HIV infection is no longer a question of risk but a fact.

Understanding the different needs between these three groups is important for planning HIV/AIDS prevention. Program activities for each group will have to differ to meet their particular needs, yet the program actions should be designed to mutually contribute to the singular goal of reducing the suffering brought about by HIV/AIDS. To illustrate, the focus groups revealed that Guam's general population needs to increase their understanding of how HIV is transmitted so that unwarranted fear and discrimination is reduced. The case studies revealed that HIV/AIDS positive people need medical, emotional, personal, and institutional support, but also that they want - and need program opportunities where they can relate their human story to combat the social stigma they experience.

In the following series of figures and data tables it is evident that high risk persons need to increase their understanding of how HIV is transmitted so they can initiate real behavioral change to avoid infection. But getting people to change behavior patterns is no easy task. If programs are to be successful they will need to involve the full spectrum of the community in actions that lead high risk individuals to initiate and sustain health behavior change. This is how programs for the general population and for HIV/AIDS positive persons can contribute to prevention programming targeted at high risk individuals. High Risk persons need experiences helping them to over come their denial of being at risk, to see themselves in the human story of HIV infection, and to make decisions to engage in behavior practices that reduce their risk of infection.

It is important to recognize that different methods of HIV/AIDS education will not be equally effective, nor equally appropriate for all audiences and target groups. In fact the effectiveness of a method may increase or become more appropriate in combination with other strategies. This idea that educational methods differ in their direct impact on behavior change is suggested in Chart A. As Deborah Rugg explains, "printed messages alone are seen as having limited impact potential for preventing AIDS. However, when repeated frequently and in concert with a variety of other targeted strategies, they may play an important reinforcing role (1990: 12)."

CHART A: Hypothetical Continuum of Psychological Involvement and Impact Potential for AIDS Education *



Note: **Impact potential increases with repetition of the intervention.**

* **Source**: Page 13 in Rugg, D.L. 1990 "AIDS Prevention: A Public Health Psychology Perspective," (L.C.Leviton, A.M. Hegedus and A. Kubrin, Eds.) *Evaluating AIDS Prevention: Contributions of Multiple Disciplines*, New Directions For Program Evaluation, No. 46 (Summer), Jossey-Bass.

Public health lectures, newspaper articles and other methods at the bottom of the continuum in Chart A can become more effective if they support or become part of strategies that get the general population and/or HIV/AIDS positive persons helping high risk individuals personally attend to the prevention messages and actively relate the ideas into their life situations. In short, a key factor increasing the success of program strategies may well be the extent to which activities can directly engage the targeted high risk individuals for making AIDS personally relevant and thereby facilitating behavioral changes.

Where can such events be held? Chart B presents this study's finding that beyond news papers and media, Guam's high risk populations can be reached via work site education events,

CHART B: Sources of HIV/AIDS Information Among High Risk Persons On Guam

Overall, Primary Source among all respondents
NEWS MEDIA / NEWS PAPERS

Secondary Sources among Men who have sex with men
PUBLIC HEALTH / OTHER

Secondary Sources among Men who have sex with women
MEDICAL CLINICS / WORK SITE EDUCATION

Secondary Sources among Women who have sex with men
SCHOOL / MEDICAL CLINICS

(B) programming delivered at medical clinics, and through (C) activities conducted at local high schools. The particular location and educational method would depend on the specific high risk group (e.g., men who have sex with men, women at risk, I.V. drug users, or promiscuous men), and the particular message to be delivered. It is also vital to recall the findings about education messages found from the focus goup with men at high risk (see page 33). The discussions among these men revealed the importance of connecting HIV/AIDS messages with recognizable celebrities and the primacy of "broadcast media" (radio and TV) in their lives.

Insights to the content or topics that should be emphasized in Guam prevention efforts were revealed in the behaavior of high risk groups. Figures 11 through 25 display behavior patterns placing our survey respondents at risk of HIV infection.

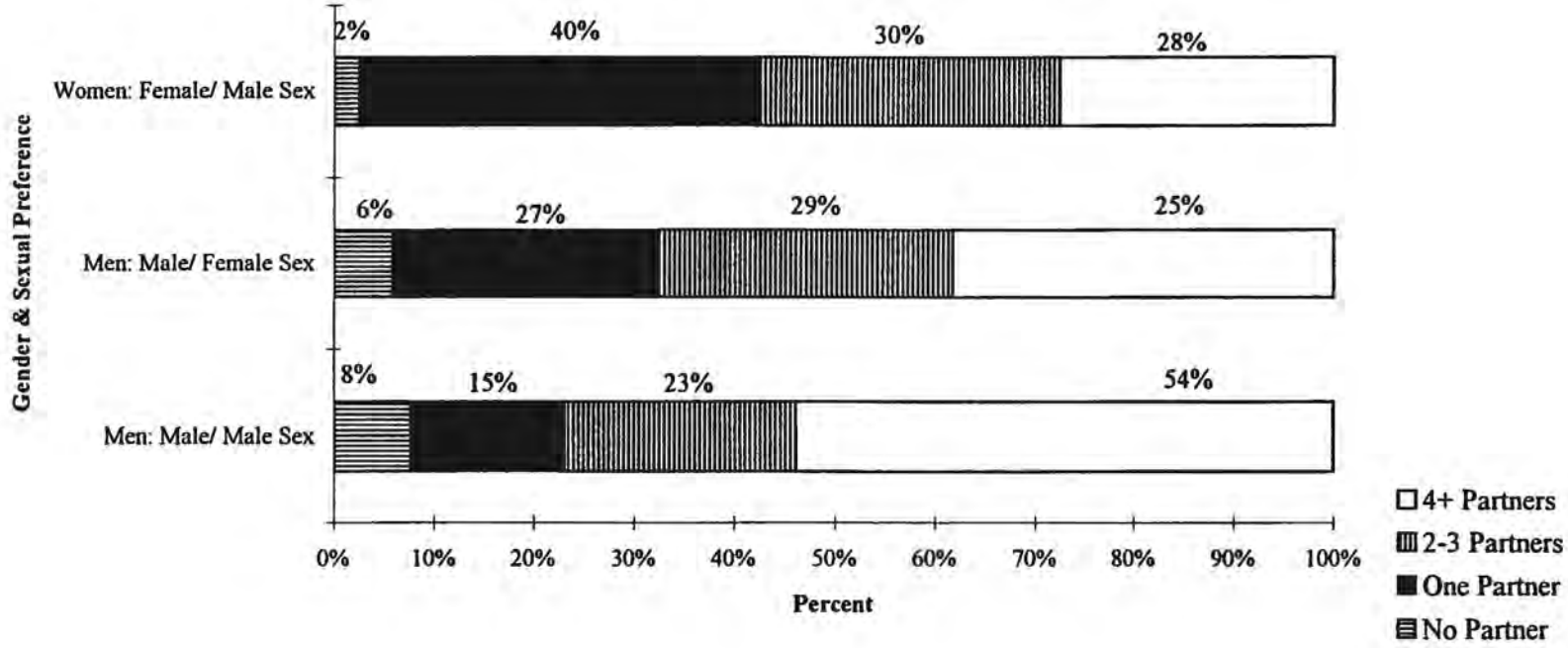
Major characteristics of sexual behavior putting people at a higher risk of infection are the number of sexual partners, and familiarity with the sexual networks of these partners (see Figures 11 and 12). As described in several of the case studies (see Case nos. 1, 6 and 7), the transmission source can be one's own spouse (who has extramarital affairs), a new love relationship, or anonymous (one-night-stand) sexual encounters.

The focus group with members of Guam's religious communities documented the need to combine values for abstinence as a prevention method along with messages aimed at increasing the use of condoms (see page 31). Figures 13 to 16 display the disparagingly low use of condoms by all of the different risk groups.

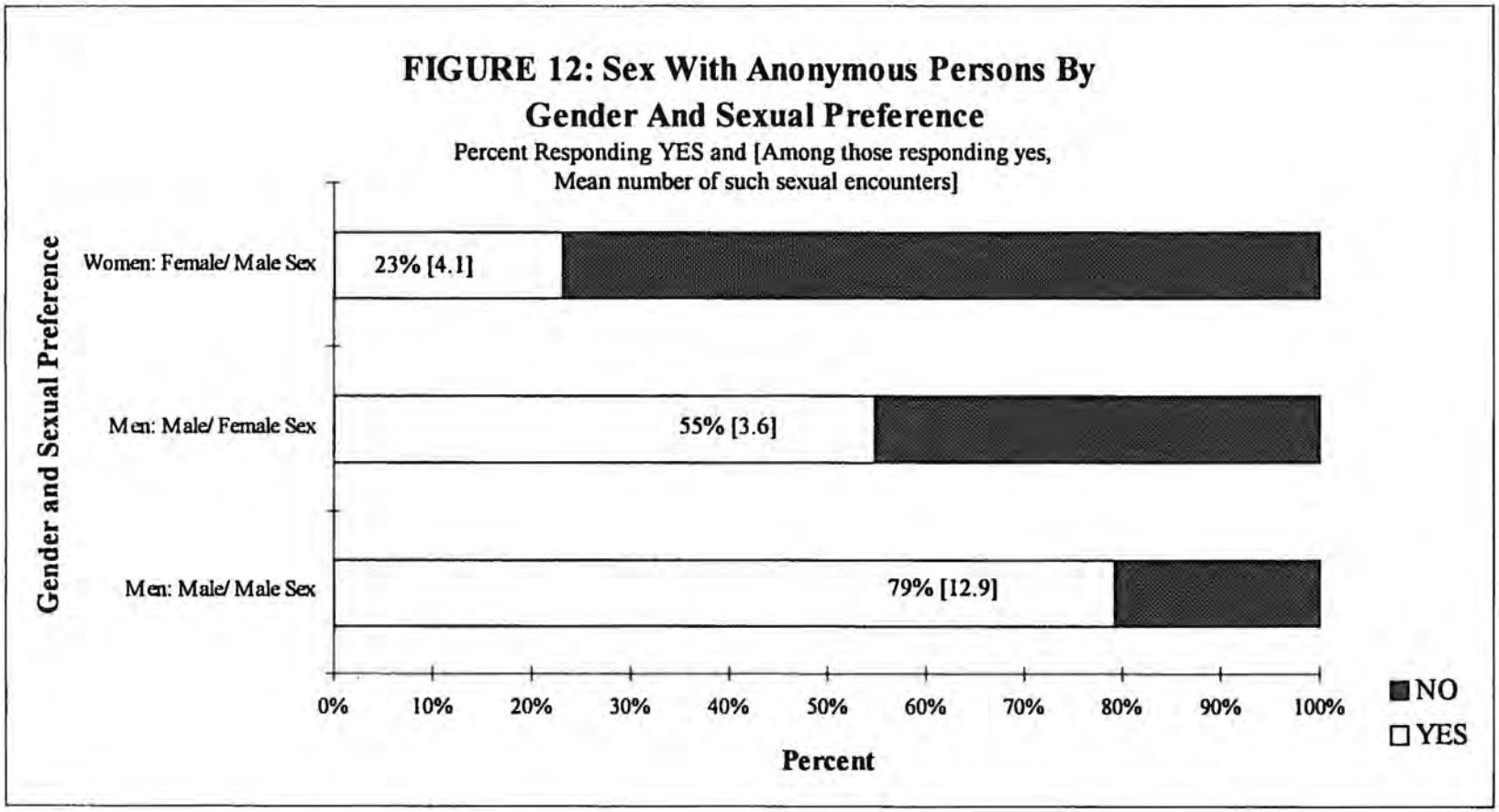
Figures 17 through 21 present behavioral practices among intravenous (IV) drug users. One important finding appears in Figure 18, where it is revealed that diabetic relatives and friends are a major source of needles. This segment of the population should be included in education about HIV and the dangers of re-using other people's needles. As pictured in Figure 21, Guam's IV drug users were found to lack knowldge about how to safely clean needles.

Finally, Figures 22 through 25 reveal that there continues to be a need to educate people ;about what puts a person at risk, and a need to help individuals over come personal denial that they are not at-risk, only "other" people.

FIGURE 11: Number of Sexual Partners By Sexual Preference

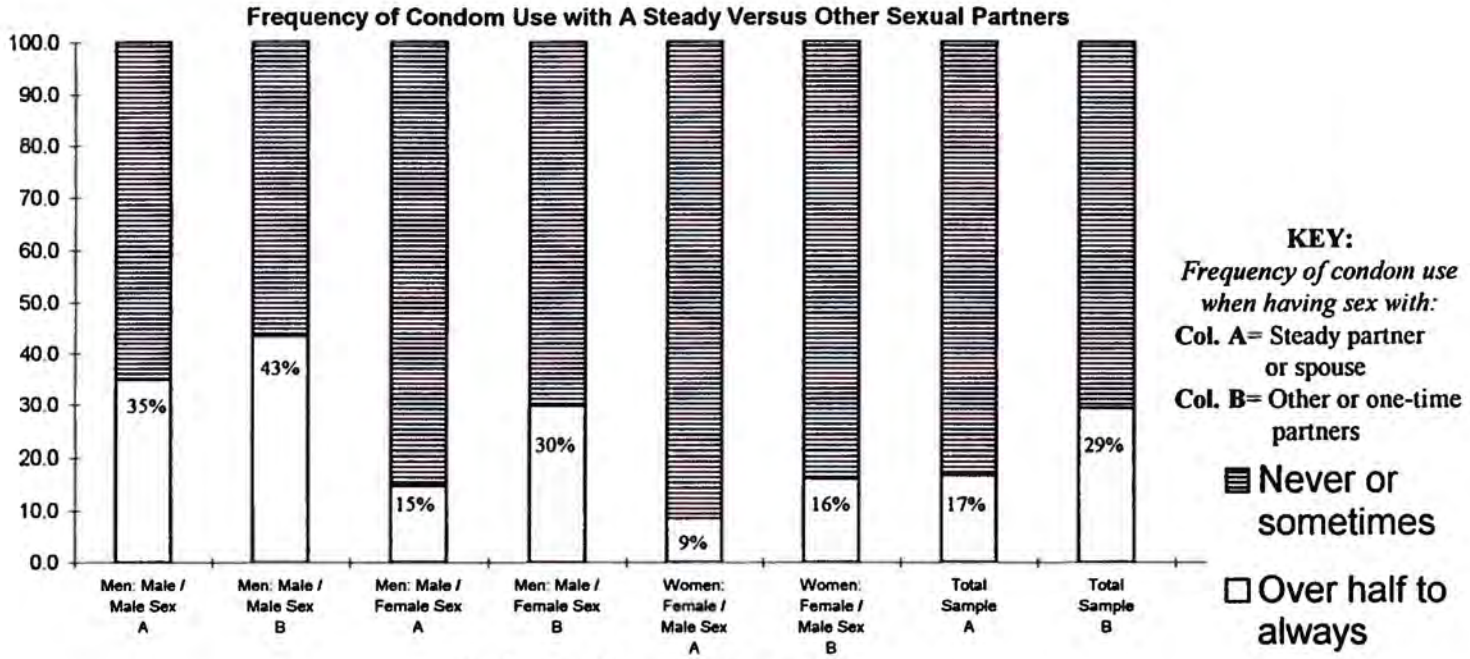


SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
The Sample consisted of 26 men who have sex with men, 54 high risk men, and 40 high risk women.



SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
The Sample consisted of 26 men who have sex with men, 54 high risk men, and 40 high risk women.

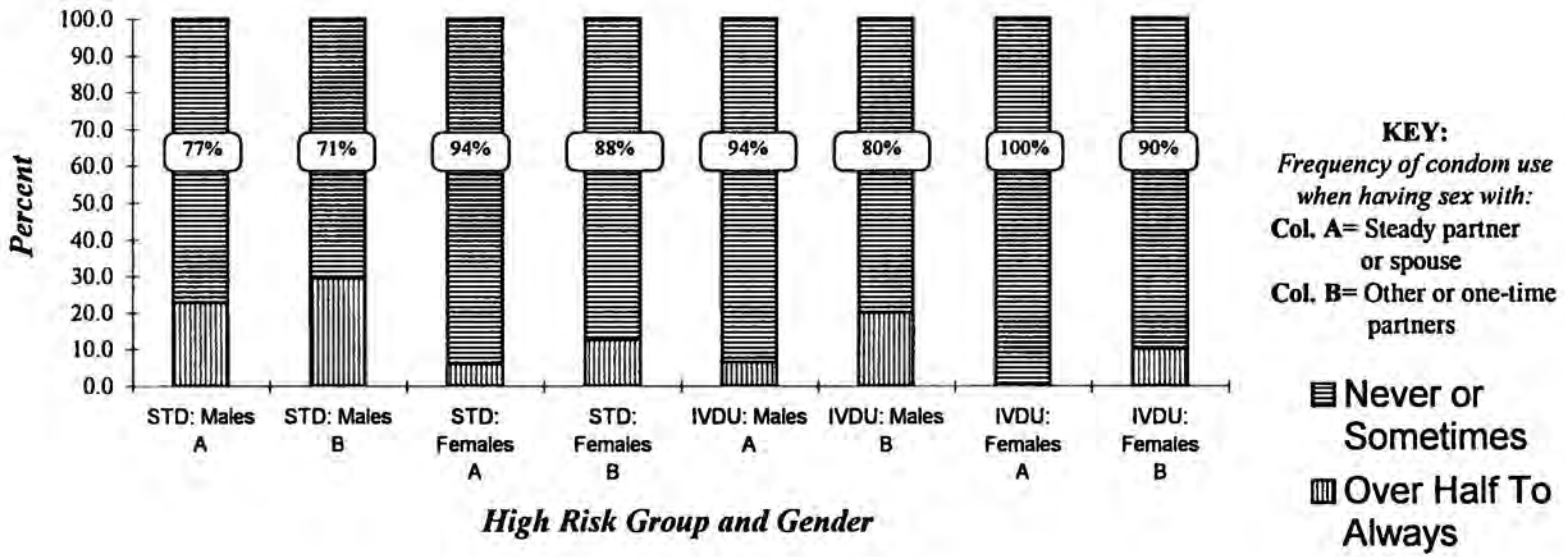
Figure 13: Condom Use By Gender and Sexual Preference



SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
The Sample consisted of 26 men who have sex with men, 54 high risk men, and 40 high risk women.

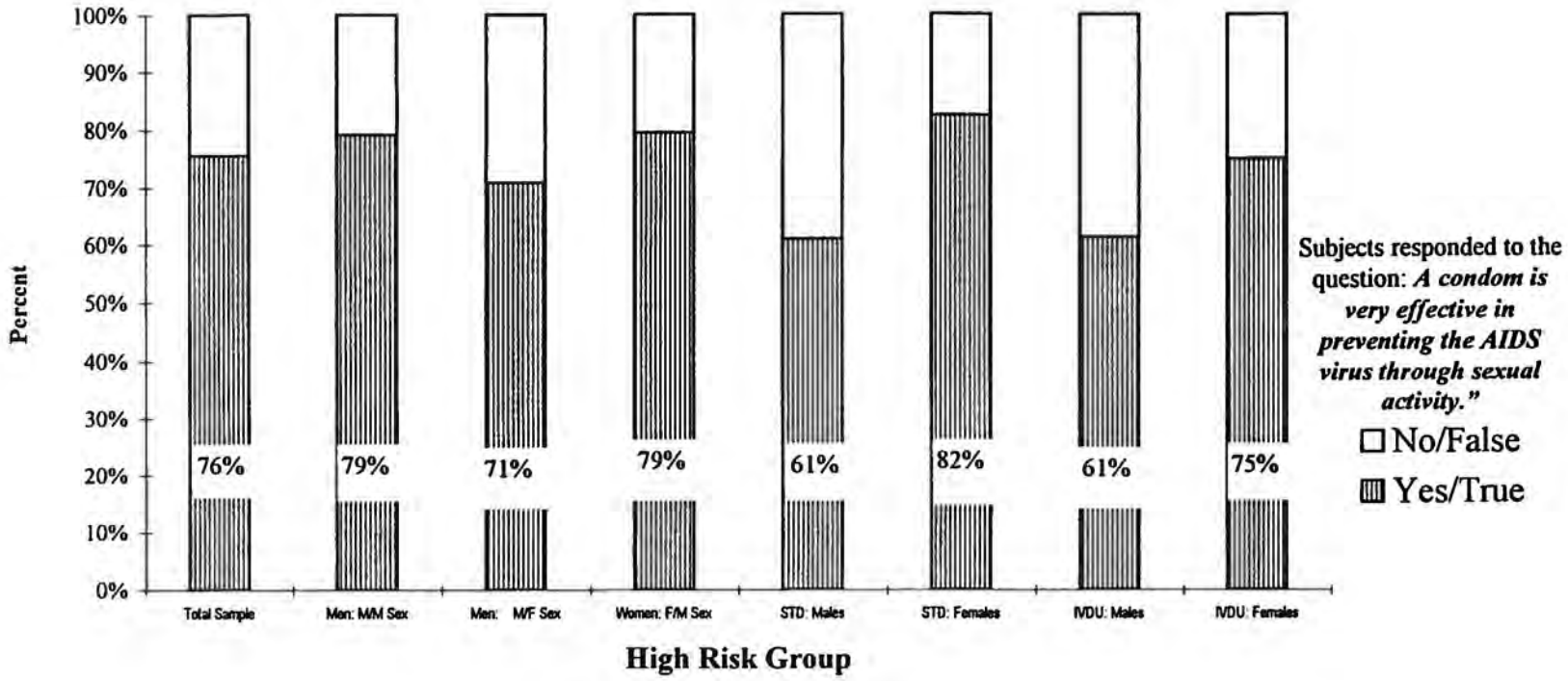
Figure 14: Condom Use Among Persons Who Have Had An STD and Intravenous Drug Users

Frequency of Condom Use with A Steady Versus Other Sexual Partners



SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
Of the 72 men responding to the question, 16 (22%) solicited a woman for sex; half (8) of these men never used a condom.

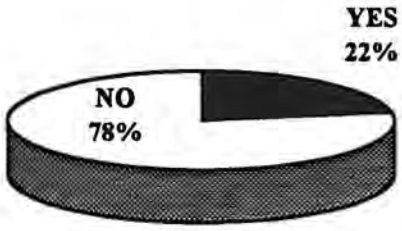
FIGURE 15: Perceived Effectiveness of Condoms By High Risk Groups



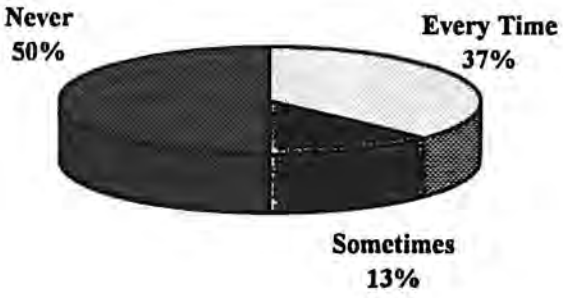
SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
The Sample consisted of 26 men who have sex with men, 54 high risk men, and 40 high risk women.

Figure 16: Men's Solicitation of A Woman for Sex, and Condom Use With These Partners

Did you give money or drugs to have sex with a girl or woman?

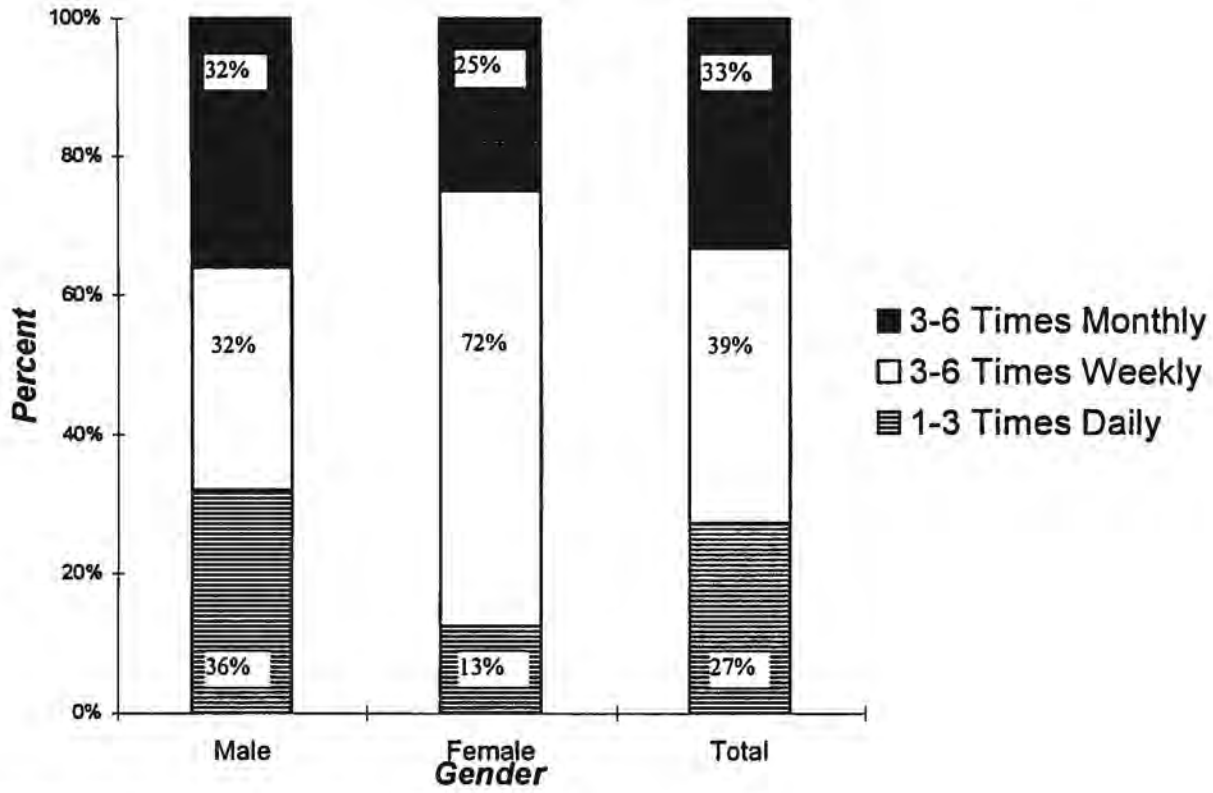


How often was a condom (rubber) used with these partners?



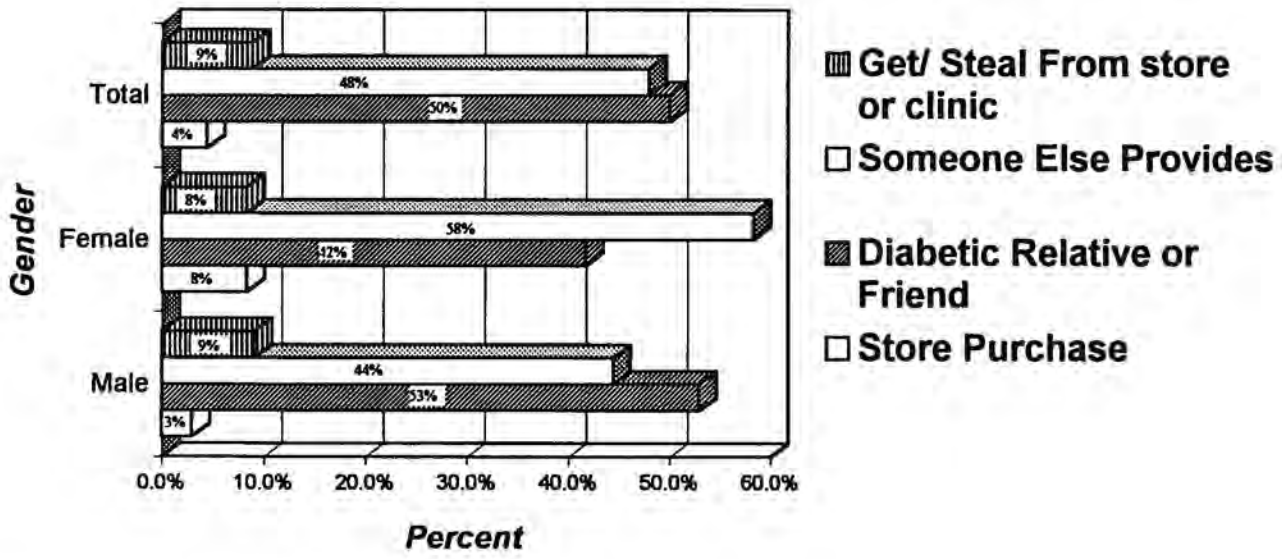
SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
Of the 72 men responding to the question, 16 (22%) solicited a woman for sex; half (8) of these men never used a condom.

Figure 17: Frequency of Drug Use Among Intravenous Drug Users By Gender



SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
Of 52 respondents identified themselves as Intravenous Drug Users, only 33 answered this question (25 Males and 8 females).

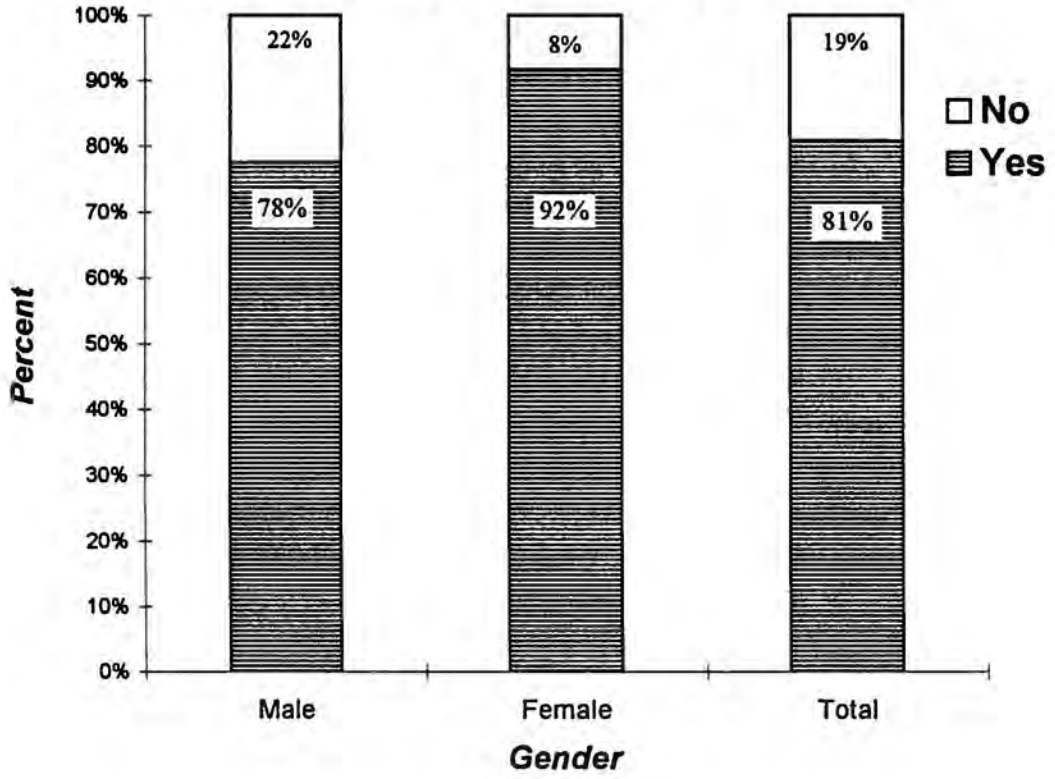
Figure 18: Source of Needles Among Intravenous Drug Users By Gender



SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
Of 52 respondents identified themselves as Intravenous Drug Users, 45 answered this question (33 Males and 12 females).

Figure 19: Needle Sharing Among Intravenous Drug Users By Gender

Have you ever used a needle or syringe (works) AFTER someone else used it?



SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
A total of 52 respondents identified themselves as Intravenous Drug Users (40 Males and 12 females).

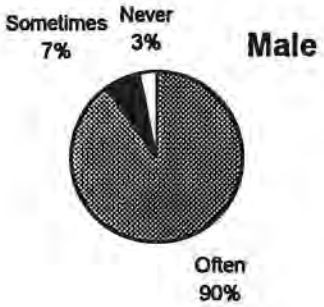


FIGURE 20: Needle Cleaning Among Intravenous Drug Users By Gender

SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study* Of 52 respondents identifing themselves as Intravenous Drug Users, 41 answered this question (30 Males and 11 females).

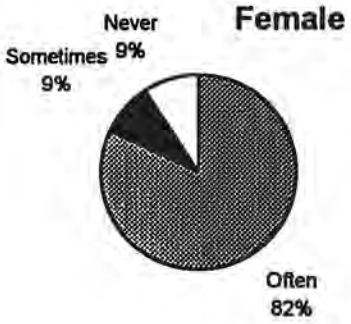
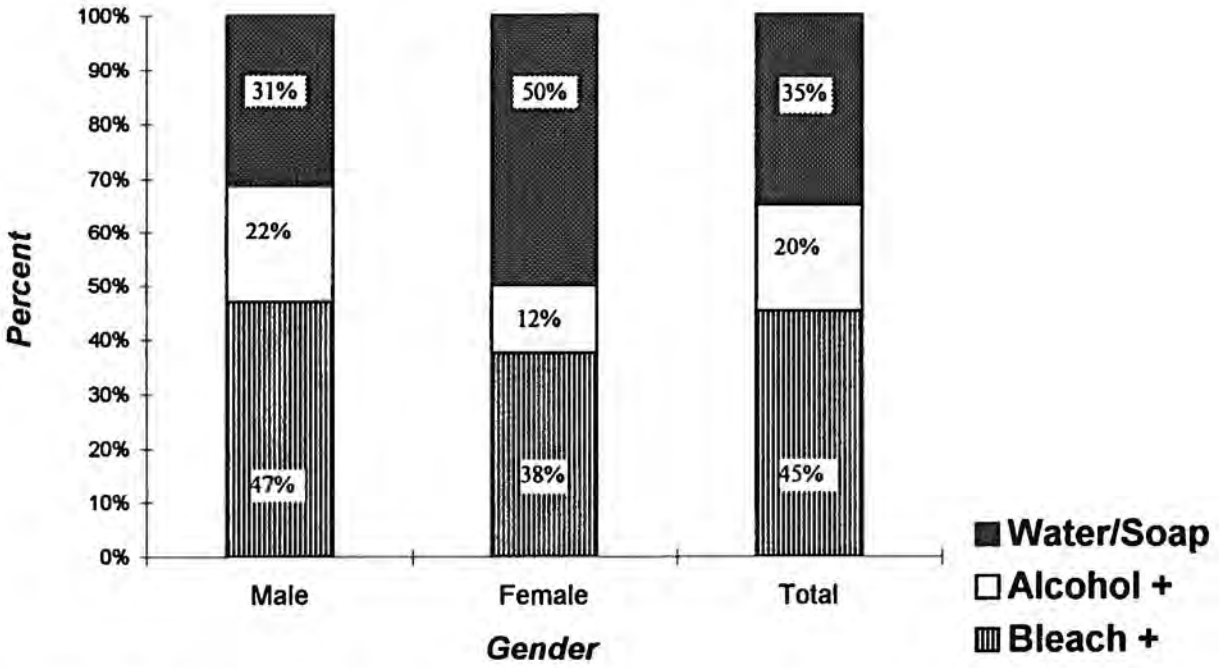


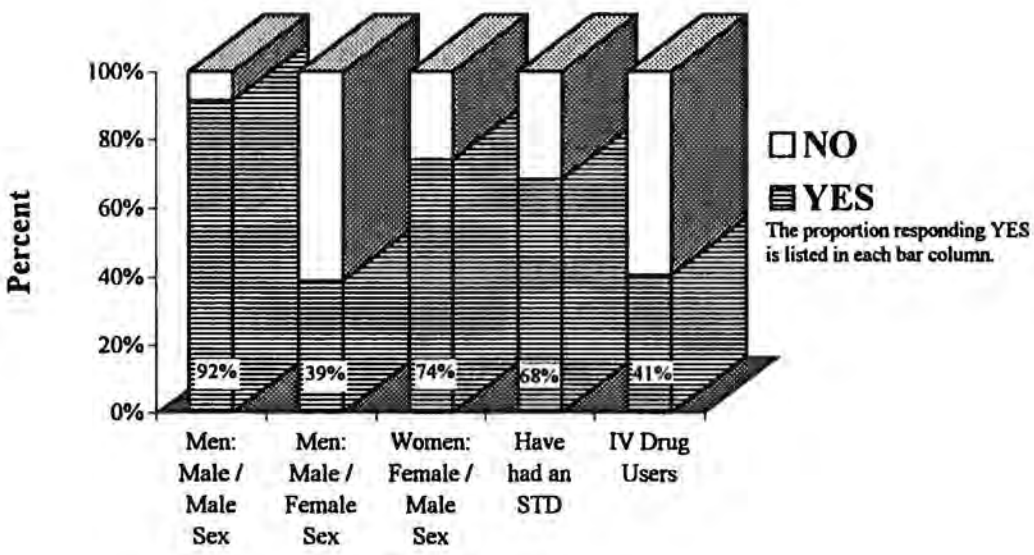
Figure 21: Cleaning Methods Used Among Intravenous Drug Users By Gender



SOURCE: *1996 Guam HIV/AIDS Prevention Needs Assessment Study*
Of 52 respondents identified themselves as Intravenous Drug Users, 40 answered this question (32 Males and 8 females).

FIGURE 22: Knowledge of People At-Risk of HIV Infection

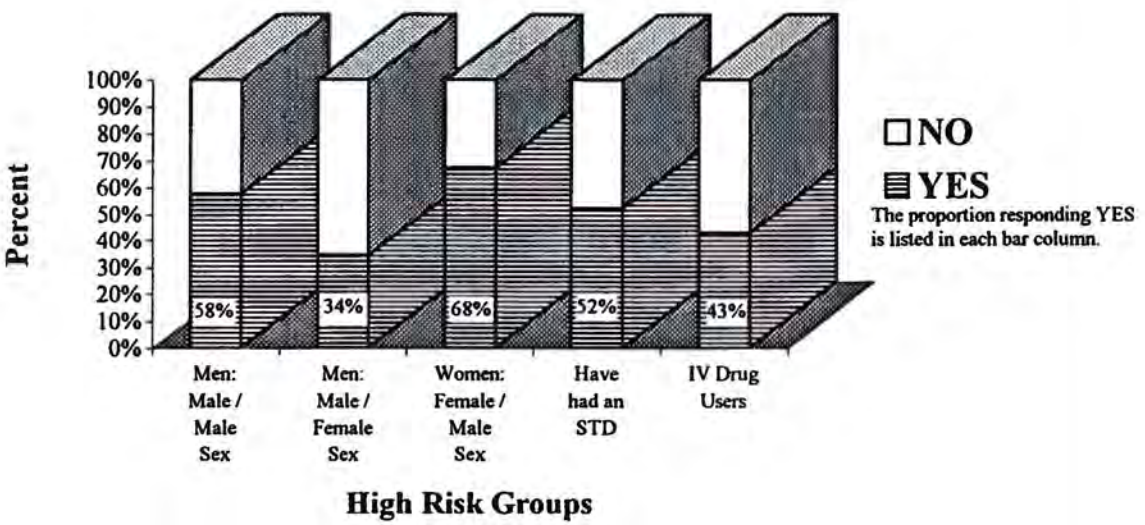
Do you know someone At-Risk of HIV?



Source: ***1996 Guam HIV/AIDS Prevention Needs Assessment***
The sample consisted of 26 men who have sex with men, 54 high risk men, and 40 high risk women (120 respondents total). These persons were also grouped as 40 persons who ever had an STD (sexually transmitted disease), and 52 persons who were or had been Intravenous(IV) Drug Users.

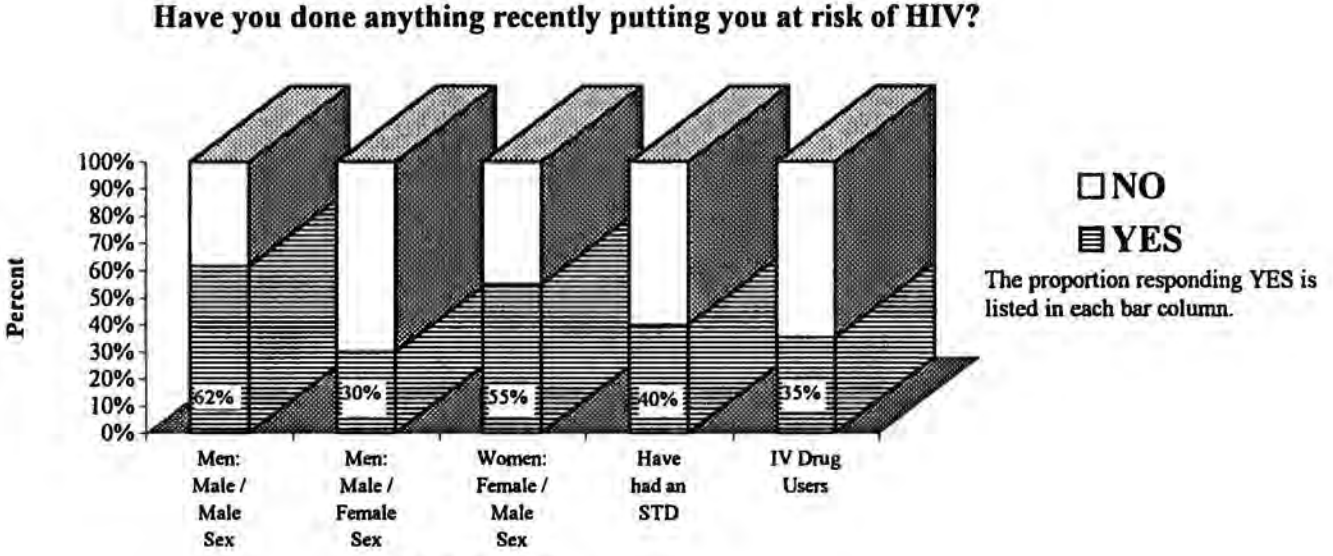
FIGURE 23: Perception of Being At-Risk of HIV Infection

Are you At-Risk of HIV/AIDS?



Source: ***1996 Guam HIV/AIDS Prevention Needs Assessment***
The sample consisted of 26 men who have sex with men, 54 high risk men, and 40 high risk women (120 respondents total). These persons were also grouped as 40 persons who ever had an STD (sexually transmitted disease), and 52 persons who were or had been Intravenous(IV) Drug Users.

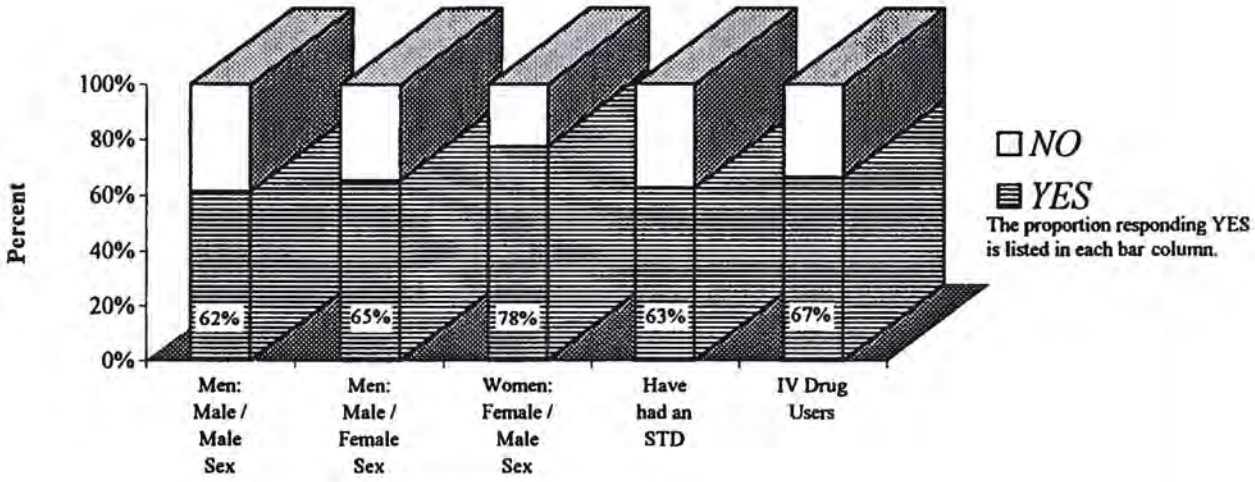
FIGURE 24: Behavior In the Past Month Putting Respondents At-Risk of HIV Infection



Source: ***1996 Guam HIV/AIDS Prevention Needs Assessment***
The sample consisted of 26 men who have sex with men, 54 high risk men, and 40 high risk women (120 respondents total). These persons were also grouped as 40 persons who ever had an STD (sexually transmitted disease), and 52 persons who were or had been Intravenous(IV) Drug Users.

FIGURE 25: Perceived Need To Change One's Own Behavior To Reduce Risk of HIV Infection

Do you need to change your behavior to reduce your risk of HIV?



Source: ***1996 Guam HIV/AIDS Prevention Needs Assessment***
The sample consisted of 26 men who have sex with men, 54 high risk men, and 40 high risk women (120 respondents total). These persons were also grouped as 40 persons who ever had an STD (sexually transmitted disease), and 52 persons who were or had been Intravenous(IV) Drug Users.

Table 1. Demographic Profile of High Risk Respondents

	Male	Female
Age:		
25 years and younger	15 (19.7%)	21 (52.5%)
26 - 35 years	33 (43.4%)	11 (27.5%)
35 and older	28 (36.8%)	8 (20.0%)
Total	76 100%	40 100%
Education:		
Less than high school	13 (17.1%)	3 (7.5%)
High school graduate	24 (31.6%)	14 (35.0%)
Some college	28 (36.8%)	21 (52.5%)
College graduate	11 (14.5%)	2 (5.0%)
Total	76 100%	40 100%
Ethnicity:		
Chamorro	47 (65.3%)	29 (74.4%)
Filipino	5 (6.9%)	4 (10.3%)
Caucasian	13 (18.1%)	3 (7.7%)
Other	7 (9.7%)	3 (7.7%)
Total	72 100%	39 100%
Place of birth:		
Guam	50 (64.9%)	20 (50.0%)
Other	27 (35.1%)	20 (50.0%)
Total	77 100%	40 100%
Status:		
Civilian	68 (89.5%)	37 (92.5%)
Active military	8 (10.5%)	2 (5.0%)
Military dependent	0 (0.0%)	1 (2.5%)
Total	76 100%	40 100%

Table 2. Sexual Preference and Gender by Age, Education, and Inclusion in Other HIV High Risk Target Groups

	Men (Male/Male sex)	Men (Male/Female sex)	Women (Female/Male sex)
Age:			
25 years and younger	3 (11.5%)	12 (24.0%)	21 (52.5%)
26 - 35 years	18 (69.2%)	15 (30.0%)	11 (27.5%)
36 and older	5 (19.2%)	23 (46.0%)	8 (20.0%)
Total	26 100%	50 100%	40 100%
Education:			
Less than high school	1 (3.8%)	12 (24.0%)	3 (7.5%)
High school graduate	6 (23.1%	18 (36.0%)	14 (35.0%)
Some college	12 (46.2%)	16 (32.0%)	21 (52.5%)
College graduate	7 (26.9%)	4 (8.0%)	2 (5.0%)
Total	26 100%	50 100%	40 100%
Reported having a Sexually Transmitted Disease:			
YES	5 (19.2%)	18 (36.0%)	17 (42.5%)
NO	21 (80.8%)	32 (64.0%)	23 (57.5%)
Total	26 100%	50 100%	40 100%
Reported Intravenous Drug Use:			
YES	4 (16.0%)	34 (68.0%)	12 (30.8%)
NO	21 (84.0%)	16 (32.0%)	27 (69.2%)
Total	25 100%	50 100%	39 100%

Table 3. Respondents Reporting Having Had Sexually Transmitted Diseases (STDs) by Age, Education, Gender, and Intravenous Drug Use

	Had An STD	No STD
Age:		
25 and younger	8 (20.0%)	27 (36.0%)
26 - 35 years	10 (25.0%)	34 (45.3%)
36 and older	22 (55.0%)	14 (18.7%)
Total	40 100%	75 100%
Education:		
Less than high school	5 (12.5%)	11 (14.3%)
High school graduate	16 (40.0%)	23 (29.9%)
Some college	15 (37.5%)	34 (44.2%)
College graduate	4 (10.0%)	9 (11.7%)
Total	40 100%	77 100%
Gender:		
Male	23 (57.5%)	53 (69.7%)
Female	17 (42.5%)	23 (30.3%)
Total	40 100%	76 100%
Reported Intravenous Drug Use:		
YES	23 (57.5%)	30 (39.0%)
NO	17 (42.5%)	47 (61.0%)
Total	40 100%	77 100%

Table 4. Respondents Reporting Intravenous Drug Use (IVDU) by Age, Education, and Gender

	IV Drug User	Abstainer
Age:		
25 and younger	15 (30.6%)	20 (31.3%)
26 - 35 years	8 (16.3%)	35 (54.7%)
36 and older	26 (53.1%)	9 (14.1%)
Total	49 100%	64 100%
Education:		
Less than high school	13 (25.5%)	3 (4.7%)
High school graduate	25 (49.0%)	13 (20.3%)
Some college	12 (23.5%)	36 (56.3%)
College graduate	1 (2.0%)	12 (18.8%)
Total	51 100%	64 100%
Gender:		
Male	38 (76.0%)	37 (57.9%)
Female	12 (24.0%)	27 (42.2%)
Total	50 100%	64 100%

Table 5. Global networks of activities reported in this study among the HIV high risk respondents

Subjects responded to the statement: *"Where did the activities you reported in this questionnaire take place?"*

Panel A: Locations By Gender and Sexual Preference

	Men (Male/Male Sex)	Men (Male/Female Sex)	Women (Female/Male Sex)
On Guam Only	8 (30%)	36 (67%)	34 (85%)
Guam & the U.S.	16 (62%)	13 (25%)	6 (15%)
Guam & Asia	2 (8%)	4 (8%)	0 .
Total	26 100%	53 100%	40 100%

Panel B: Locations By "Ever had a sexually transmitted disease? (STD)"

	Had an STD	Did Not Have STD
On Guam Only	30 (75%)	47 (60%)
Guam & the U.S.	10 (25%)	25 (32%)
Guam & Asia	0	6 (8%)
Total	40 100%	79 100%

Panel C: Locations By Intravenous Drug Use

	Drug User	Abstainer
On Guam Only	40 (75%)	36 (56%)
Guam & the U.S.	11 (21%)	24 (38%)
Guam & Asia	2 (4%)	4 (6%)
Total	53 100%	64 100%

Table 6. High Risk Sexual Behaviors
By Gender and Sexual Preference

Panel A: Number of Sexual Partners Over the Past Year

	Men (Male/Male Sex)	Men (Male/Female Sex)	Women (Female/Male Sex)
Male Partners			
None	2 (7.7%)	51 100.0%	1 (2.5%)
Only One	4 (15.4%)		16 (40.0%)
2 - 3 partners	6 (23.1%)		12 (30.0%)
4 or more partners	14 (53.8%)		11 (27.5%)
Total	26 100%	51 100%	40 100%
Female Partners			
None	23 (88.5%)	19 (37.3%)	38 (95.0%)
Only One	0	9 (17.6%)	0
2 - 3 partners	1 (3.8%)	10 (19.6%)	0
4 or more partners	2 (7.7%)	13 (25.5%)	2 (5.0%)
Total	26 100%	51 100%	40 100%

Panel B: Persons Reporting Sex With Annonymous Persons and Average Number of Such Events Over The Past Year

	Men (Male/Male Sex)	Men (Male/Female Sex)	Women (Female/Male Sex)
Sex with anonymous persons			
Yes	19 (79.2%)	17 (54.8%)	9 (23.1%)
No	5 (20.8%)	14 (45.2%)	30 (76.9%)
Total	24 100%	31 100%	39 100%
Of Those Saying YES:			
Average for past year	12.9	3.6	4.1
Number responding	17	13	8

Table 6 *continued*. **High Risk Sexual Behaviors By Gender and Sexual Preference**

Panel C: Persons Reporting Sexual Intercourse with Intravenous Drug User (IVDU), And Condom Us

	Men (Male/Male Sex)	Men (Male/Female Sex)	Women (Female/Male Sex)
Sex with an IV Drug User			
YES	7 (26.9%)	18 (35.3%)	28 (70.0%)
Probably	5 (19.2%)	3 (5.9%)	3 (7.5%)
Don't Know	8 (30.8%)	7 (13.7%)	1 (2.5%)
NO	6 (23.1%)	23 (45.1%)	8 (20.0%)
Total	26 100%	51 100%	40 100%
Of Those Saying YES:			
Used condom	1 (14.3%)	4 (22.2%)	0 (0.0%)
Did not use condom	6 (85.7%)	14 (77.8%)	28 (100.0%)

Panel D: Persons Reporting Sexual Intercourse With Known Or Suspected HIV Positive Person and Condom Use

	Men (Male/Male Sex)	Men (Male/Female Sex)	Women (Female/Male Sex)
Sex with a person HIV+			
YES	4 (15.4%)	1 (2.0%)	2 (5.0%)
Probably	2 (7.7%)	1 (2.0%)	2 (5.0%)
Don't Know	9 (34.6%)	8 (17.7%)	9 (22.5%)
NO	11 (42.3%)	41 (80.4%)	27 (67.5%)
Total	26 100%	51 100%	40 100%
Of Those Saying YES:			
Used condom	1 (25.0%)	0 (0.0%)	0 (0.0%)
Did not use condom	3 (75.0%)	0 (0.0%)	1 (100.0%)

Table 7. Sexual Behaviors of Persons Who Have Had a Sexually Transmitted Disease (STD)

Panel A: Number of Sexual Partners Over The Past Year By Gender

	Had an STD		Did Not Have STD	
	Male	Female	Male	Female
Male Partners				
None	17 (74%)	1 (6%)	30 (57%)	0
Only One	2 (9%)	7 (41%)	2 (4%)	9 (39%)
2 - 3 partners	1 (4%)	6 (35%)	6 (11%)	6 (26%)
4 or more partners	3 (13%)	3 (18%)	15 (28%)	8 (35%)
Total	23 100%	17 100%	53 100%	23 100%
Female Partners				
None	9 (39%)	16 (94%)	32 (60%)	22 (96%)
Only One	5 (22%)	0	4 (8%)	0
2 - 3 partners	3 (13%)	0	8 (15%)	0
4 or more partners	6 (26%)	1 (6%)	9 (17%)	1 (4%)
Total	23 100%	17 100%	53 100%	23 100%

Panel B: Mean Number of Times Had Sex With Anonymous Persons and Average Number of Such Events Over The Past Year

	Had STD	Did Not Have STD
Sex With anonymous person		
YES	11 (27.5%)	34 (43.0%)
NO	29 (72.5%)	45 (57.0%)
Total	40 100%	79 100%
Of Those Saying YES:		
Average Over Past Year	1.67	9.79
Number responding	9	29

Table 7 *continued*. Sexual Behaviors of Persons Who Have Had a Sexually Transmitted Disease (STD)

Panel C: Persons Reporting Sex With IV Drug User and Condom Use

	Had an STD	Did Not Have STD
Sex with IV drug user		
YES	24 (60.0%)	29 (36.7%)
Probably	5 (12.5%)	6 (7.6%)
Don't Know	3 (7.5%)	14 (17.7%)
NO	8 (20.0%)	30 (38.0%)
Total	40 100%	79 100%
Of Those Saying YES:		
Used condom	2 (8.3%)	3 (10.3%)
Did not use condom	22 (91.7%)	26 (89.7%)
	24 100%	29 100%

Panel D: Persons Reporting Sex With Suspected HIV/AIDS Positive Person and Condom Use

	Had STD	Did Not Have STD
Sex with a person HIV+		
YES	2 (5.0%)	5 (6.3%)
Probably	2 (5.0%)	3 (3.8%)
Don't Know	7 (17.5%)	18 (22.8%)
NO	29 (72.5%)	53 (67.1%)
Total	40 100%	79 100%
Of Those Saying YES:		
Used condom	1 (50.0%)	0 (0.0%)
Did not use condom	1 (50.0%)	3 (100.0%)
	2 100%	3 100%

Table 8. Sexual Behavior of Intravenous Drug Users

Panel A: Number of Sexual Partners Over The Past Year By Gender

	Drug User		Abstainer	
	Male	Female	Male	Female
Male Partners				
None	32 (84%)	0	15 (41%)	1 (4%)
Only One	1 (3%)	2 (16%)	2 (5%)	14 (52%)
2 - 3 partners	2 (5%)	5 (42%)	5 (13%)	6 (22%)
4 or more partners	3 (8%)	5 (42%)	15 (41%)	6 (22%)
Total	38 100%	12 100%	37 100%	27 100%
Female Partners				
None	14 (37%)	11 (92%)	26 (70%)	26 (96%)
Only One	7 (18%)	0	2 (5%)	0
2 - 3 partners	7 (18%)	0	4 (11%)	0
4 or more partners	10 (27%)	1 (8%)	5 (14%)	1 (4%)
Total	38 100%	12 100%	37 100%	27 100%

Panel B: Persons Reporting Sex With An Anonymous Person

	Drug User	Abstainer
Sex with anonymous person		
YES	15 (28.3%)	30 (46.9%)
NO	38 (71.7%)	34 (53.1%)
Total	53 100%	64 100%
Of Those Saying YES:		
Average Over Past Year	7.42	8.23
Number Responding	10	25

Table 8 *continued.* **Sexual Behavior of Intravenous Drug Users**

Panel C: Persons Reporting Sex With Intravenous Drug Users And Condom Use

	Drug User	Abstainer
Sex with IV drug user		
YES	32 (60.4%)	20 (31.3%)
Probably	2 (3.8%)	9 (14.1%)
Don't Know	3 (5.7%)	14 (21.9%)
NO	16 (30.2%)	21 (32.8%)
Total	53 100%	64 100%
Of Those Saying YES:		
Used condom	3 (9.4%)	2 (10.0%)
Did not use condom	29 (90.6%)	18 (90.0%)
	32 100%	20 100%

Panel D: Persons Reporting Sex With Suspected HIV/AIDS Positive Person And Condom Use

	Drug User	Abstainer
Sex with a person HIV+		
YES	2 (3.8%)	5 (7.8%)
Probably	1 (1.9%)	4 (6.3%)
Don't Know	7 (13.2%)	18 (28.1%)
NO	43 (81.1%)	37 (57.8%)
Total	53 100%	64 100%
Of Those Saying YES:		
Used condom	0 (0.0%)	1 (20.0%)
Did not use condom	2 (100.0%)	4 (80.0%)
	2 100%	5 100%

Table 9. High Risk Behaviors of Intravenous Drug Users By Gender

Panel A: Frequency of drug use (shooting dope)

	Males	Females	Total .
Several Times / Daily	8 (32.0%)	1 (12.5%)	9 (27.2%)
3-6 Times Weekly	8 (32.0%)	5 (72.5%)	13 (39.4%)
3-6 Times Monthly	9 (36.0%)	2 (25.0%)	11 (33.4%)
	25 100%	8 100%	32 100%

Panel B:Source of Needles (*More than one source could be checked*)

Percent Responding YES to each source

	Males	Females	Total .
Self-purchase in store	1 (2.8%)	1 (8.3%)	2 (4.2%)
From a diabetic	18 (50.0%)	5 (41.7%)	23 (47.9%)
Someone else gets them	16 (44.4%)	7 (58.3%)	23 (47.9%)
Get/steal from clinic	3 (8.3%)	1 (8.3%)	4 (8.3%)

Panel C: Needle Sharing (*use of syringe AFTER someone else*)

	Males	Females	Total .
YES	31 (77.5%)	11 (91.7%)	42 (80.8%)
NO	9 (22.5%)	1 (8.3%)	10 (19.2%)
	40 100%	12 100%	52 100%

Panel D Needle Cleaning (*How Frequently*)

	Males	Females	Total .
Often	27 (90.0%)	9 (81.8%)	36 (87.8%)
Sometimes	2 (6.7%)	1 (9.1%)	2 (7.3%)
Never	1 (3.3%)	1 (9.1%)	2 (4.9%)
	30 100%	11 100%	41 100%

Panel E: Cleaning Method Used

	Males	Females	Total .
Bleach +	15 (46.8%)	3 (37.5%)	18 (45.0%)
Alcohol +	7 (21.9%)	1 (12.5%)	8 (20.0%)
Water / soap	10 (31.3%)	4 (50.0%)	14 (35.0%)
	32 100%	8 100%	40 100%

Table 10. Perceived Effectiveness of Condoms For The Prevention of HIV/AIDS

Subjects responded to the statement: *"A condom is very effective in preventing the AIDS virus through sexual activity."*

Panel A: Perceptions By Gender and Sexual Preference

	Men (Male/Male Sex)	Men (Male/Female Sex)	Women (Female/Male Sex)
TRUE / YES	19 (79%)	34 (71%)	31 (79%)
FALSE / NO	5 (21%)	14 (29%)	8 (21%)
Total	24 100%	48 100%	39 100%

Panel B: Perceptions By "Ever had a sexually transmitted disease?" and Gender

	Had an STD		Did Not Have STD .	
	Male	Female	Male	Female
TRUE / YES	14 (61%)	14 (82%)	39 (81%)	17 (77%)
FALSE / NO	9 (39%)	3 (18%)	9 (19%)	5 (23%)
Total	23 100%	17 100%	48 100%	22 100%

Panel C: Perceptions By Intravenous Drug Use and Gender

	Drug User		Abstainer .	
	Male	Female	Male	Female
TRUE / YES	22 (61%)	9 (75%)	31 (89%)	22 (85%)
FALSE / NO	14 (39%)	3 (25%)	4 (11%)	4 (15%)
Total	36 100%	12 100%	35 100%	26 100%

Panel D: Perceptions By Education and Gender

	High School or less		Some College + .	
	Male	Female	Male	Female
TRUE / YES	23 (66%)	13 (76%)	30 (83%)	18 (82%)
FALSE / NO	12 (34%)	4 (24%)	6 (17%)	4 (18%)
Total	35 100%	17 100%	36 100%	22 100%

Table 11. Condom Use With A Steady Partner or Spouse Compared to Use With Other or Occassional Sexual Partners

Panel A:Condom Use By Gender and Sexual Preference

	Men (Male/Male Sex)	Men (Male/Female Sex)	Women (Female/Male Sex)
Use With A Steady Partner			
Over Half to Always	7 (35.0%)	6 (14.6%)	3 (8.6%)
Never or Sometimes	13 (65.0%)	35 (85.4%)	32 (91.4%)
Total	20 100%	41 100%	35 100%
Use With Occassional Partners			
Over Half to Always	10 (43.4%)	11 (29.7%)	4 (16.0%)
Never or Sometimes	13 (56.6%)	26 (70.3%)	21 (84.0%)
Total	23 100%	37 100%	25 100%

Panel B: Condom Use Among Persons Who Have Had a Sexually Transmitted Disease (STD) By Gender

	Had an STD		Did Not Have STD	
	Male	Female	Male	Female
Use With A Steady Partner				
Over Half to Always	5 (23%)	1 (6%)	8 (21%)	2 (11%)
Never or Sometimes	17 (77%)	16 (94%)	30 (79%)	16 (89%)
Total	22 100%	17 100%	38 100%	18 100%
Use With Occassional Partners				
Over Half to Always	5 (29%)	1 (12%)	16 (38%)	3 (18%)
Never or Sometimes	12 (71%)	7 (88%)	26 (62%)	14 (82%)
Total	17 800%	41 100%	35 100%	17 100%

Panel C: Condom Use Among Intravenous Drug Users By Gender

	Drug User		Abstainer	
	Male	Female	Male	Female
Use With A Steady Partner				
Over Half to Always	2 (6%)	0	11 (39%)	3 (13%)
Never or Sometimes	29 (94%)	11 (100%)	17 (61%)	20 (87%)
Total	20 100%	41 100%	28 100%	23 100%
Use With Occassional Partners				
Over Half to Always	5 (29%)	1 (12%)	16 (38%)	3 (18%)
Never or Sometimes	12 (71%)	7 (88%)	26 (62%)	14 (82%)
Total	17 100%	8 100%	42 100%	17 100%

Table 12. Profile of Men's Sexual behavior and Condom Use With Sex Industry Workers

In the past year, did you give money, drugs, or other services (e.g., a ride) to have sex with a girl or woman?:

YES	16 (22%)
NO	56 (78%)
Total	72 100%

Among those responding Yes:

Of these women, were they?:

	MOST	SOME	NONE
Female IV Drug Users	1 (7%)	8 (53%)	6 (40%)
Bar Girls	1 (7%)	5 (33%)	9 (60%)
Massage Parlor Girls	2 (13%)	3 (20%)	10 (67%)
Street Hookers	1 (7%)	3 (20%)	11 (73%)
Call Girls	2 (13%)	1 (7%)	12 (80%)

How often was a condom (rubber) used with these partners?:

Every time	6 (37%)
Sometimes	2 (13%)
Never	8 (50%)
Sub Total	16 100%

TABLE 13. Personal Knowledge of The Community of Persons At-Risk of Infection or Infected with HIV/AIDS By Membership In High Risk Target Groups

Panel A: Do you know someone AT-RISK of HIV Infection?

	Gender and Sexual Preference			Ever Had A Sexually Transmitted Disease		Intravenous Drug Use	
	Men: Male / Male Sex	Men: Male / Female Sex	Women: Male/ Female Sex	Had an STD	Never Had an STD	IV Drug User	Abstainer
YES	22 (92%)	18 (39%)	29 (74%)	26 (68%)	42 (56%)	20 (41%)	48 (80%)
NO	2 (8%)	28 (61%)	10 (26%)	12 (32%)	33 (44%)	29 (59%)	12 (20%)
Total	24 100%	46 100%	39 100%	38 100%	75 100%	49 100%	60 100%

Panel B: Do you know someone who is HIV Positive?

	Gender and Sexual Preference			Ever Had A Sexually Transmitted Disease		Intravenous Drug Use	
	Men: Male / Male Sex	Men: Male / Female Sex	Women: Male/ Female Sex	Had an STD	Never Had an STD	IV Drug User	Abstainer
YES	21 (87%)	14 (30%)	11 (28%)	14 (37%)	31 (41%)	14 (29%)	31 (52%)
NO	3 (13%)	32 (70%)	28 (72%)	24 (63%)	44 (59%)	35 (71%)	29 (48%)
Total	24 100%	46 100%	39 100%	38 100%	75 100%	49 100%	60 100%

Panel C: Do you know someone who has AIDS?

	Gender and Sexual Preference			Ever Had A Sexually Transmitted Disease		Intravenous Drug Use	
	Men: Male / Male Sex	Men: Male / Female Sex	Women: Male/ Female Sex	Had an STD	Never Had an STD	IV Drug User	Abstainer
YES	22 (92%)	14 (30%)	10 (26%)	15 (40%)	31 (41%)	17 (35%)	29 (48%)
NO	2 (8%)	32 (70%)	29 (74%)	23 (60%)	44 (59%)	32 (53%)	31 (52%)
Total	24 100%	46 100%	39 100%	38 100%	75 100%	49 100%	60 100%

TABLE 14. Perceptions of Being At-Risk of HIV/AIDS Infection By Membership In High Risk Target Groups

Panel A: Do you believe you are at-risk for HIV infection?

	Gender and Sexual Preference			Ever Had A Sexually Transmitted Disease		Intravenous Drug Use	
	Men: Male / Male Sex	Men: Male / Female Sex	Women: Male/ Female Sex	Had an STD	Never Had an STD	IV Drug User	Abstainer
YES	15 (58%)	17 (34%)	27 (68%)	21 (52%)	38 (49%)	22 (43%)	37 (58%)
NO	11 (42%)	32 (66%)	13 (32%)	19 (48%)	39 (51%)	29 (57%)	27 (42%)
Total	26 100%	49 100%	40 100%	40 100%	77 100%	51 100%	64 100%

Panel B: Did you do anything in the past month putting you at-risk of HIV infection?

	Gender and Sexual Preference			Ever Had A Sexually Transmitted Disease		Intravenous Drug Use	
	Men: Male / Male Sex	Men: Male / Female Sex	Women: Male/ Female Sex	Had an STD	Never Had an STD	IV Drug User	Abstainer
YES	16 (62%)	15 (30%)	22 (55%)	16 (40%)	37 (48%)	18 (35%)	35 (55%)
NO	10 (38%)	35 (70%)	18 (72%)	24 (60%)	40 (52%)	33 (65%)	29 (45%)
Total	26 100%	50 100%	40 100%	40 100%	77 100%	51 100%	64 100%

Panel C: Do you feel you need to change your behavior to reduce your risk of infection?

	Gender and Sexual Preference			Ever Had A Sexually Transmitted Disease		Intravenous Drug Use	
	Men: Male / Male Sex	Men: Male / Female Sex	Women: Male/ Female Sex	Had an STD	Never Had an STD	IV Drug User	Abstainer
YES	16 (62%)	32 (65%)	31 (78%)	25 (63%)	54 (70%)	34 (67%)	46 (72%)
NO	10 (38%)	17 (35%)	9 (22%)	15 (37%)	23 (30%)	17 (33%)	18 (28%)
Total	26 100%	49 100%	40 100%	40 100%	77 100%	51 100%	64 100%

Table 15. Sources of HIV/AIDS Information By High Risk Target Groups

Panel A: Information Sources By Gender and Sexual Preference

Information Sources	Men (Male/Male Sex) *(N=26)*	Men (Male/Female Sex) *(N=51)*	Women (Female/Male Sex) *(N=40)*
Newspapers/Media	81 %	55 %	80 %
Medical Clinic(s)	50 %	29 %	38 %%)
Public Health and Social Services	73 %	26 %	20 %
School	19 %	22 %	45 %
Work	31 %	26 %	28 %
Other Source	54 %	18 %	18 %

Panel B: Information Sources Among Persons Who Have Had a Sexually Transmitted Disease **(STD)**

Information Sources	Had an STD *(N=40)*
Newspapers/Media	80 %
Medical Clinic(s)	28 %
Public Health and Social Services	33 %
School	18 %
Work	25 %
Other Source	18 %

Panel C: Information Sources Among Intravenous Drug Users

Information Sources	IV Drug User *(N=53)*
Newspapers/Media	64 %
Medical Clinic(s)	17 %
Public Health and Social Services	23 %
School	21 %
Work	13 %
Other Source	19 %

Table 16. Changes in Sexual Behavior Since Learning About HIV/AIDS By High Risk Target Groups

Panel A: Behavior Change Among The Sample of High Risk Persons

Since learning about AIDS have you changed your behavior?	
YES	75 (66%)
NO	39 (34%)
Total	114 100%
Among those saying YES percent who now:	*(N=75)*
Have fewer partners	49 (65%)
Refrain from certain sex acts	47 (63%)
Use condoms more often	46 (61%)
Avoid "one-night stands"	28 (37%)
Practice monogamy	28 (37%)

Panel B: Behavior Change By Gender and Sexual Preference

Since learning about AIDS have you changed your behavior?	Men (Male/Male Sex)	Men (Male/Female Sex)	Women (Female/Male Sex)
YES	22 (92%)	29 (58%)	24 (60%)
NO	2 (8%)	21 (42%)	16 (40%)
Total	26 100%	50 100%	40 100%
Among those saying YES % who now:	*(N= 22)*	*(N=29)*	*(N=24)*
Have fewer partners	19 (86%)	19 (66%)	11 (46%)
Refrain from certain sex acts	21 (95%)	15 (52%)	11 (46%)
Use condoms more often	17 (77%)	18 (62%)	11 (46%)
Avoid "one-night stands"	3 (14%)	16 (55%)	9 (38%)
Practice monogamy	3 (14%)	16 (55%)	9 (38%)

Panel C: Behavior Change Among Intravenous Drug Users

Since learning about AIDS have you changed your behavior?	
YES	28 (55%)
NO	23 (45%)
Total	51 100%
Among those saying YES percent who now:	*(N=28)*
Have fewer partners	17 (61%)
Refrain from certain sex acts	14 (50%)
Use condoms more often	11 (39%)
Avoid "one-night stands"	15 (54%)
Practice monogamy	14 (50%)

Table 17. Persons Who Were Tested For HIV/AIDS By High Risk Target Groups

Panel A: Testing Among The Sample of High Risk Persons

Were you ever tested for HIV?	
YES	76 (67%)
NO	39 (33%)
Total	114 100%
Among those tested - where were you tested:	*(N=76)*
Guam Public Health	35 (46%)
Guam Private Clinic/GMH	6 (8%)
U.S./Hawaii	11 (14%)
Institutional (DOD,DepCor,etc.)	24 (32%)
Total	76 100%

Panel B: HIV/AIDS Testing By Gender and Sexual Preference

	Men (Male/Male Sex)	Men (Male/Female Sex)	Women (Female/Male Sex)
Were you ever tested for HIV?			
YES	20 (77%)	35 (69%)	21 (57%)
NO	6 (23%)	16 (31%)	16 (43%)
Total	26 100%	51 100%	37 100%
Among those tested - where?:	*(N= 20)*	*(N=35)*	*(N=21)*
Guam Public Health	11 (55%)	8 (23%)	16 (76%)
Guam Private Clinic/GMH	3 (15%)	3 (9%)	0 (--%)
U.S./Hawaii	5 (25%)	2 (6%)	4 (19%)
Institutional	1 (5%)	22 (63%)	1 (5%)
Total	20 100%	35 100%	21 100%

Panel C: HIV Testing Among Intravenous Drug Users

Were you ever tested for HIV?:	
YES	25 (50%)
NO	25 (50%)
Total	50 100%
Among those tested - where were you tested?:	*(N=25)*
Guam Public Health	8 (32%)
Guam Private Clinic/GMH	2 (8%)
U.S./Hawaii	3 (12%)
Institutional (DOD,DepCor,etc.)	12 (48%)
Total	25 100%