Dallas National HIV Behavioral Surveillance System 2012 Annual Data Report Injection Drug Use

August 2015

HIV Information and Projects Group
TB/HIV/STD Epidemiology and Surveillance Branch
Texas Department of State Health Services

Acknowledgements

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National HIV Behavioral Surveillance System
Injection Drug Users in Dallas, Texas, 2012

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This report was supported by Cooperative Agreement Number 5U1BPS003257 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

EXECUTIVE SUMMARY

The National HIV Behavioral Surveillance System (NHBS) is an ongoing effort to collect cross-sectional data among populations at high risk for acquiring HIV. This report focuses on activities from the third data collection cycle among people who inject drugs (PWID) within the past 12 months. Participants were recruited from the Dallas Metropolitan Division using respondent driven sampling from September-December 2012. The following are key findings presented in the report. Statistics are based on 500 eligible participants unless otherwise stated.

Demographics

Survey participants were:

- Predominantly Black (84%) and male (68%)
- 71% are ages 50 and older
- Older than the general population and the HIV positive population in the Dallas Metropolitan Division
- 39% had less than high school education, 54% (n=499) earned <$10,000 per year, and only 11% were employed
- Only 4% of PWID annual wages approached the national median household income of $51,371 annually or surpassed this amount (Noss, 2013)

Drug Use

- Heroin was the most commonly injected drug reported by participants
- Over half of PWID reported using non-injection drugs such as crack cocaine, marijuana, crystal meth, powdered cocaine, downers, heroin that is smoked or snorted, painkillers, non-injectable crystal meth, ecstasy or hallucinogens
- 68% shared some type of injecting equipment in the past 12 months

Drug or Alcohol Treatment Program

- A majority of the participants (69%) reported ever participating in a drug or alcohol treatment program
- 34% of those individuals who reported ever participating in a drug or alcohol treatment program did so in the past 12 months

Sexual Behaviors

- Of males that had female partners, 86% (n=319) had 1 or more sex partners in the past 12 months
- Of females that had male partners, 77% (n=151) 1 or more sex partners in the past 12 months
- 90% of men had condomless sex with female main partners and 91% of women had condomless sex with male main partners; 75% of men had condomless sex with female casual partners

Access to Healthcare

- Approximately half (53%) of participants had no health insurance
- 72% had seen a healthcare provider in the past 12 months. Among participants who reported seeing a healthcare provider, 49% were offered HIV testing.

Health Conditions

- 52% reported ever having hepatitis
- Gonorrhea, chlamydia and herpes were the most commonly reported STIs

HIV Testing and Prevention (N=506)

- 87% reported ever being tested for HIV and of those individuals 61% tested in the past 1-2 years
- Of individuals who have not been tested in the past 12 months, the main barriers to testing were fear of the test result, not having enough time and low perceived risk of infection (n=329)

HIV Infection (N=506)

- 3% of PWID tested positive for HIV and 43% of those were unaware of their status

Incarceration (N=506)

- 29% of PWID were incarcerated in the past 12 months
- Of the PWID incarcerated in the past 12 months, only 41% reported being tested for HIV, and 9% of those tested did not receive test results

INTRODUCTION

The National HIV Behavioral Surveillance System

In 2000, the Centers for Disease Control and Prevention (CDC), in collaboration with representatives from state and local health departments, academic institutions, and clinical and prevention entities initiated a strategic planning process that culminated in the development of the CDC's HIV Prevention Strategic Plan Through 2005 (CDC, 2001). As part of this plan, four national goals were identified to reduce by half the annual number of new HIV infections in the United States. One of the four identified goals is to strengthen the national capacity to monitor the HIV epidemic to better direct and evaluate prevention efforts.

As a first step to meet this goal, the CDC awarded funds to state and local health departments to develop and implement a surveillance system that would monitor behaviors that put people at risk for HIV infection. This system is called the National HIV Behavioral Surveillance (NHBS) System. In 2012, the Dallas Metropolitan Division was one of 20 to conduct NHBS (Figure 1) due to the location's high AIDS prevalence in 2000. The Dallas Metropolitan Division is defined by the area within the geographical boundaries of Collin, Dallas, Delta, Denton, Ellis, Hunt, Kaufman and Rockwall counties.

Figure 1. National HIV Behavioral Surveillance System Sites, 2012.

Source: The Centers for Disease Control and Prevention (CDC), 2011.

NHBS is an ongoing behavioral surveillance system that collects cross-sectional data among populations at high risk for acquiring HIV, including men who have sex with men (MSM), injection drug users (IDU), and heterosexuals at high risk for HIV infection

(HET). NHBS activities are implemented in one-year cycles so that data are collected from each risk group every three years; these study cycles are referred to as NHBS-MSM, NHBS-IDU, and NHBS-HET. NHBS started collecting data for the first MSM cycle in 2003-2004. During some cycles, anonymous voluntary HIV testing and hepatitis C testing was also conducted. This report focuses on activities from the third IDU cycle in which data were collected among people who inject drugs from September - December 2012.

People Who Inject Drugs

NHBS surveillance activities target PWID because this population is known to have elevated risk of HIV infection. Acquisition of data relating to HIV infection within this population is limited due to difficulties eliciting information from PWID concerning risk behaviors and other risk factors. Although it may be difficult to study HIV among PWID, NHBS activities are designed to minimize some of the known difficulties and gather useful information. NHBS generates a snapshot of the HIV epidemic among PWID in a particular metropolitan area every 3 years. Data are collected focusing primarily on the following risk factors/behaviors: sexual risk, substance use risk, access to healthcare, existing health conditions, HIV testing practices, prevention activities, and history of incarceration. Recent trends in risk behaviors can be analyzed and used to inform decisions for evaluating and tailoring HIV prevention and care services to PWID in specific geographic areas.

Formative Assessment

Formative research is conducted prior to implementation of each NHBS cycle in order to enhance data collection activities. NHBS project sites gather information about the public health-related attributes of the study population, determine how that population should be defined, and determine the best ways to access it through the use of a formative assessment (Higgins et al., 1996; Ulin et al., 2005).

Activities in the formative assessment for NHBS IDU3 were conducted from March 28, 2012 to May 4, 2012 and included:

- Secondary data review where information was gathered from Texas HIV Core Surveillance published and unpublished data from a variety of sources about IDU networks in Dallas.
- Analysis of the general characteristics of the population, along with the status of the HIV epidemic and where HIV prevention services were being utilized.
- Interviews in a semi-structured format of key informants in the Dallas IDU community that included individuals of various races, ages, and gender who provided services to the IDU community and IDU themselves.

Major findings from the formative assessment were as follows:

- Dallas PWID tend to commute from all parts of Dallas to southern areas of Dallas to do most of their buying and injecting of drugs, so recruitment operations should be concentrated in this area.
- Drug commuters typically live in predominately white, middle- and upper-class neighborhoods in North Dallas.
- While there are no distinct subgroups of PWID on demographic characteristics or drug choice, homelessness represent a shared characteristic among some social network with shared behavioral traits surrounding drug use.
- Hispanics tend to be an insular group with a tendency to take care of issues within the family as opposed to seeking outside help. This reluctance to seek outside help may be tied to a strong distrust of authority. Undocumented immigrant Latinos are often especially fearful of authority, but this distrust extends to US-born and documented immigrant Latinos as well. Hispanics, therefore, may be challenging to recruit to NHBS unless through someone they know and trust.
- Young PWID, who are 30 years of age and younger, will be difficult to target since they have not experienced the consequences of their behavior. One possible way to recruit younger PWID is to seek assistance of a service provider when identifying seeds who are 30 years of age and younger.
- Injecting drug use tends to occur in inner-city neighborhoods where residents are primarily African American and Hispanic, whereas White IDU are likely to reside in suburbs and spend limited time in the city and thus may be more difficult to recruit.
- Injection drug use occurs at all times of the day and most times of the night.
- Injecting is often regarded as a social activity and people of all ethnicities other than Hispanics seem to use drugs together.

Methods

Respondent Driven Sampling

Data were collected using respondent-driven sampling (RDS) in accordance with the national protocol (Centers for Disease Control and Prevention, 2011). RDS builds on the concept of "snowball sampling" whereby initial participants refer people they know to a study and those people refer others they know to the study (Heckathorn, 1997). RDS in NHBS continues through successive recruitment cycles until a predetermined sample size. The RDS theory asserts unbiased population estimates can be calculated and adjusted for cross group recruitment patterns and network size (Heckathorn, 2002).

- RDS studies begin with assessment of the population of interest, typically conducted by an ethnographer, to determine behavioral trends in the population and locate initial recruits for the study called "seeds."
- The CDC recommends using 5-10 seeds for each NHBS cycle.
- In order to limit recruitment opportunities, seeds are each given 3-5 coupons to distribute to other potential recruits for the study.

- Those who return to study sites with their coupons will in turn receive 3-5 coupons to distribute to other potential recruits until the desired sample size is met.
- A modest incentive is provided to participants for completing the interview, recruitment of peers and for taking an HIV test.
- Data collected from an RDS study can be analyzed using RDSAT software.
- Population estimates and frequencies presented in this report were generated by RDSAT (unless otherwise noted) and are weighted to adjust for recruitment bias (some participants may recruit 5 other people to the study while some may recruit none), homophily (tendency for people to recruit others with demographic traits similar to themselves, e.g. Hispanic females tend to recruit other Hispanic females rather than black or white males), and differential personal network size among study participants (Heckathorn, 2007).

Targeted Population

- People who inject drugs throughout the Dallas Metropolitan Division were recruited using RDS from September 7, 2012 to December 15, 2012.
- Eleven seeds were purposefully recruited and efforts were made to ensure diversity among the seeds. One of those seeds was ineligible and was therefore unable to recruit subsequent participants. Among the ten seeds, 4 were Whites, 3 were Hispanics, 2 African-Americans, and 1 was multiracial. These seeds were excluded from analysis.
- To participate in the study, subjects were required to have injected drugs in the preceding 12 months, have physical signs (e.g. track marks) or knowledge of local injection practices, be either male or female (not transgender), be able to complete an anonymous interview in English or Spanish, and have not previously participated in the IDU3 cycle.
- The 10 seeds yielded 500 eligible participants when analyzing risk behaviors related to HIV, and 506 eligible participants when analyzing HIV testing.
- Participants were asked to give their informed consent to an interview and for a voluntary anonymous HIV test prior to eligibility screening.
- Some participants reported being HIV positive during the interview.
- Consent to the HIV test was not necessary for participation in the IDU3 interview.

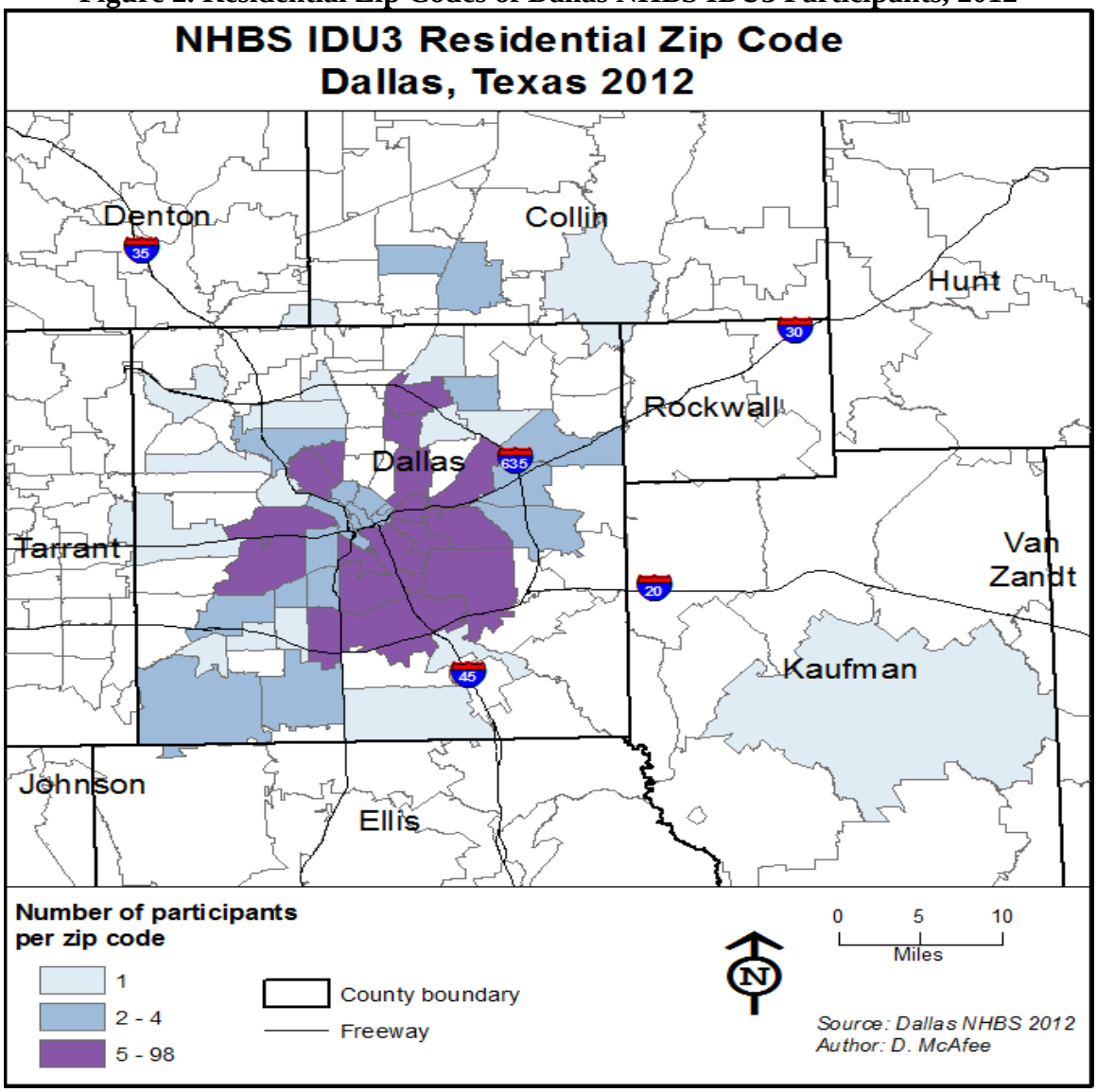
There is evidence that high-risk sexual behavior is reduced after people become aware they are HIV positive (Marks et al, 2005). We have chosen to analyze our data making an assumption that PWID that are aware of their HIV positive status may also behave in a manner that would result in a reduction of high-risk injection and sexual behaviors. The sample size for this purpose is 500 participants. When we are quantifying anything related to HIV testing (HIV prevalence, awareness, or unawareness), we include those who self-report HIV in order to get a true sense of the picture of who are aware and unaware of their status. The sample size for this purpose is 506 participants. All charts, graphs and tables in this document are based on the 500 eligible participants or the sample size will be stated otherwise.

Study participants were free to decline to answer any question in the survey and therefore some questions received few responses.

Residential Zip Code of IDU3 Participants

The residential zip codes of NHBS IDU3 participants were predominately within Dallas County (98%), but the survey included a few individuals from other counties in the Dallas Metropolitan Division. The majority of PWID reported residing in south eastern Dallas. The formative assessment revealed that IDU commuted from all parts of Dallas to central locations in South Dallas to purchase and use injection drugs. These locations were mainly in predominantly Black and Hispanic neighborhoods (Figure 2).

Figure 2. Residential Zip Codes of Dallas NHBS IDU3 Participants, 2012



Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

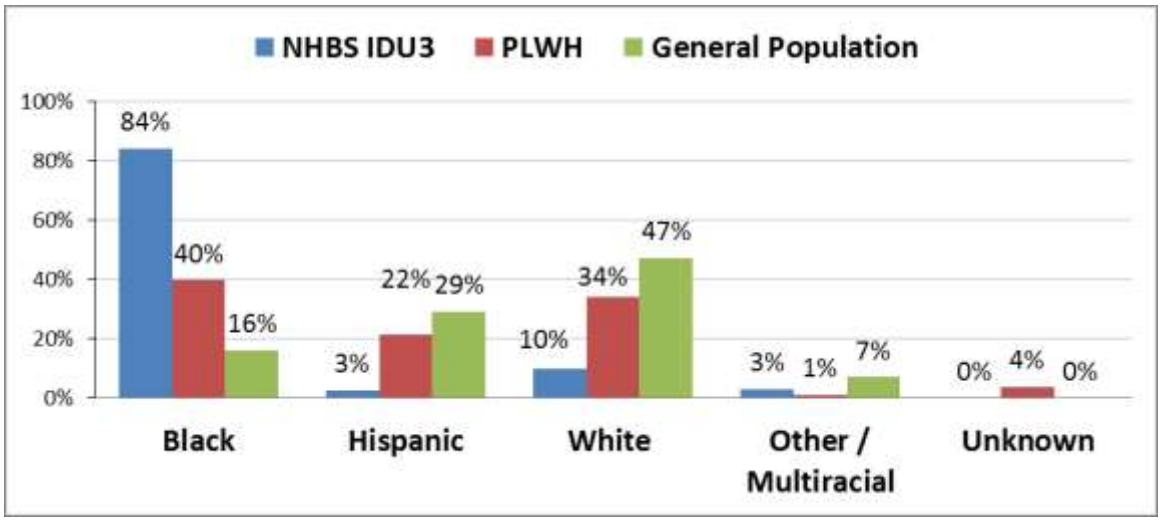
DEMOGRAPHIC CHARACTERISTICS

Race and Ethnicity

The rate of People Living with HIV (PLWH) in the Dallas Metropolitan Division in 2012 shows an uneven burden of disease. Black persons had the highest rate (962 per 100,000) for PLWH. This rate was more than 3 times higher than the rate in White persons (288 per 100,000) and Hispanic persons (295 per 100,000). In 2012, 7 percent of the PLWH in the Dallas Metropolitan Division were people who inject drugs (Texas Department of State Health Services, 2015).

Within the Dallas Metropolitan Division in 2012 nearly half of the estimated general population 18 years of age and older was White, followed by Hispanic and Black. PLWH in the Dallas Metropolitan Division were predominantly Black, despite having a lesser proportion of Black persons than White and Hispanic persons in the general population. Participants in the Dallas NHBS IDU3 study had a different composition, with 84% of them being Black, 10% White and only 3% Hispanic (Figure 3).

Figure 3. Comparison by Race and Ethnicity in the Dallas Metropolitan Division among the Estimated General Population in 2012, the PLWH in the Dallas Metropolitan Division in 2012, and the Dallas NHBS IDU3 Sample in 2012



Sources: Texas Department of State Health Services, NHBS IDU3, Dallas-Plano-Irving Metropolitan Division (MD), 2012. Enhanced HIV/AIDS Reporting System (eHARS) 2012, US Census National Center for Health Statistics, 2012

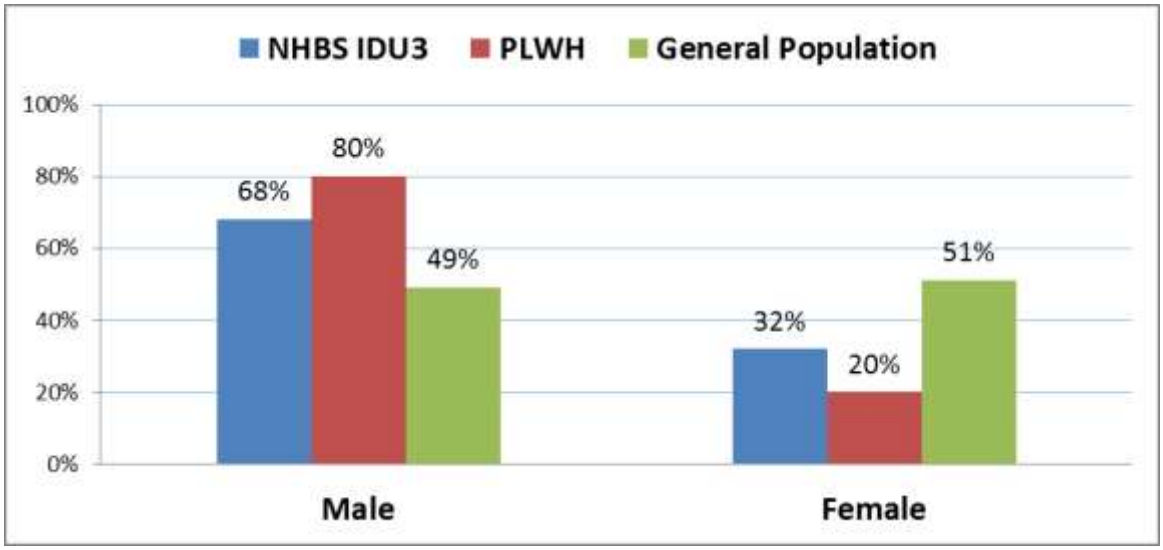
Sex

In 2012, the estimated number of diagnoses of HIV infection among adult and adolescent males in the United States was approximately 4 times the number for females. Among males, an estimated 8% of diagnosed HIV infections were attributed to injection drug

use, and 5% were attributed to male-to-male sexual contact and injection drug use. Among females, 17% of diagnosed HIV infections were attributed to injection drug use (Centers for Disease Control and Prevention, 2014).

PLWH in 2012 in the Dallas Metropolitan Division were predominantly male. In the Dallas NHBS IDU3 study, females made up less than one-third of the participants; approximately two-thirds of the female participants reported an IDU male as their last sex partner. In contrast, the percentage of males and females in the general population in the Dallas Metropolitan Division was more evenly distributed (Figure 4).

Figure 4. Comparison by Sex in the Dallas Metropolitan Division among the Estimated General Population in 2012, the PLWH in the Dallas Metropolitan Division in 2012, and the Dallas NHBS IDU3 Sample in 2012

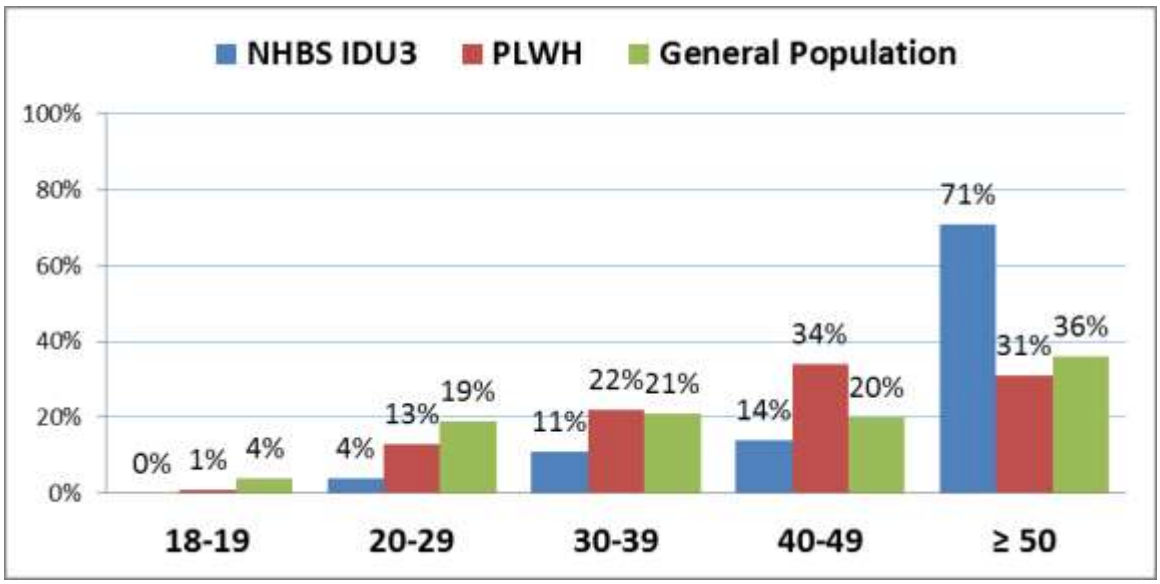


Sources: Texas Department of State Health Services, NHBS IDU3, Dallas-Plano-Irving Metropolitan Division (MD), 2012. Enhanced HIV/AIDS Reporting System (eHARS) 2012, US Census National Center for Health Statistics, 2012

Age

In the Dallas Metropolitan Division, the age distribution of the population of PLWH from 2005 to 2012 continued to shift to older ages, reflecting the aging of the population infected with HIV. Participants in the Dallas NHBS IDU3 study had a different age composition than the composition in the estimated general population in the Dallas Metropolitan Division and the PLWH in the Dallas Metropolitan Division in 2012. While 71% of the NHBS IDU3 sample was 50 years of age and older, 31% and 36% of the PLWH and the general population, respectively, were within that age group (Figure 5).

Figure 5. Comparison by Age Groups in the Dallas Metropolitan Division among the Estimated General Population in 2012, the PLWH in 2012, and the Dallas NHBS IDU3 Sample in 2012



Sources: Texas Department of State Health Services, NHBS IDU3, Dallas-Plano-Irving Metropolitan Division (MD), 2012. Enhanced HIV/AIDS Reporting System (eHARS) 2012, US Census National Center for Health Statistics, 2012

Other Socioeconomic Characteristics

The levels of education, household income, employment status and homelessness of the Dallas NHBS IDU3 sample are shown in Table 1. Among IDU3 participants who answered socioeconomic questions, a majority of participants had a high school education or less, a low household income, or were unemployed. Forty-one percent of IDU3 participants answered "Yes" to ever being homeless, 45% of those individuals resported that they were currently homeless.

Table 1. Education, Income, Employment Status and Homelessness among Dallas NHBS IDU3 Participants, 2012:
Weighted Frequencies and Population Estimates

Characteristic	Frequency	Estimate
Education Level		
Less than high school	193	38.6%
High School/GED	187	37.4%
Some college	112	22.5%
College grad/post grad	8	1.6%
Annual Household Income		
$0-$9999	271	54.3%
$10,000-$19,999	132	26.4%
$20,000-$39,999	60	12.0%
$40,000 +	25	5.0%
Unknown	11	2.2%
Employment Status*		
Unemployed	174	34.8%
Employed full or part time	54	10.8%
Other	272	54.4%
Homelessness		
Ever Been Homeless	203	40.6%
Currently Homeless (of those who have ever been homeless)	91	44.8%

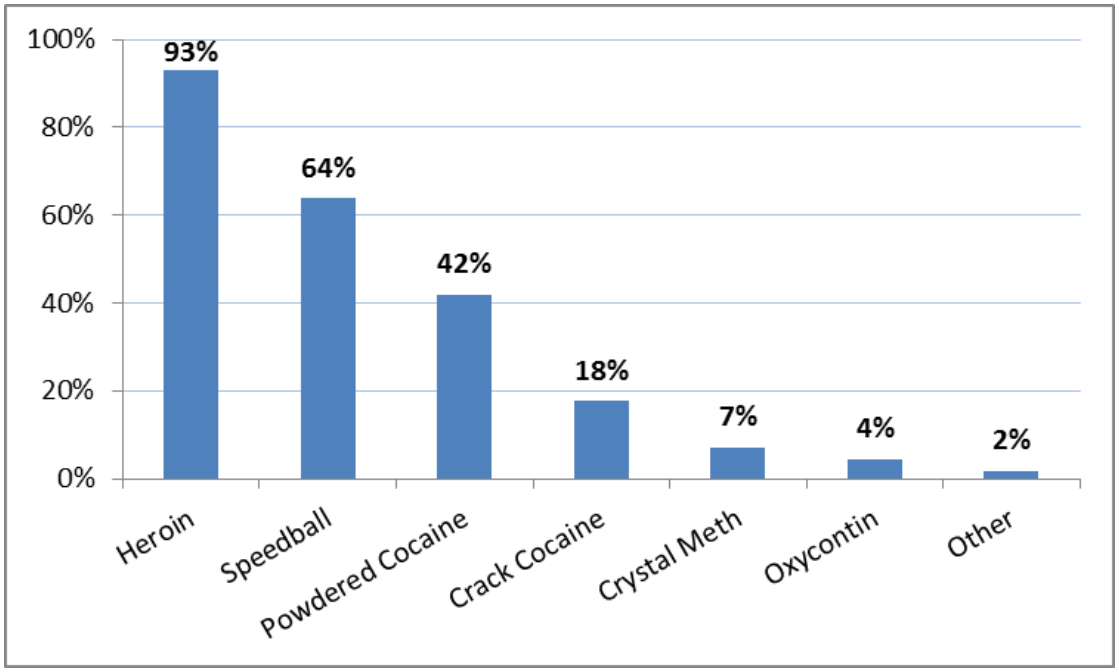
*Other includes home maker, full time student, retired, and disabled.
Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

INJECTION AND NON-INJECTION DRUG USE

In 2012, 12% of Texans living with HIV were infected via injection drug use (Texas Department of State Health Services, 2015). Sharing needles and paraphernalia is a high-risk behavior for contracting HIV. In addition to the direct relationship between injection drug use and HIV infection, drug abuse plays other, less recognized, roles in HIV transmission. Drug use may affect the users' judgment which may increase the likelihood of engaging in high-risk sexual behavior, in addition to reducing the effectiveness of HIV treatment drugs (National Institute on Drug Abuse, 2005). Thus, it is important to determine which drugs (both injection and non-injection) IDU use frequently so that education and prevention efforts can be properly focused to mitigate the effects and consequences of drug use.

Heroin was the most frequently reported injection drug among Dallas IDU3 participants, with a weighted frequency of 465 IDU (93% weighted) reporting use (Figure 6). The second most reported injection drug was speedball (combination of heroin and cocaine), with a weighted frequency of 319 IDU (64% weighted) reporting use and powdered cocaine with a weighted frequency of 209 (42% weighted) over the past 12 months.

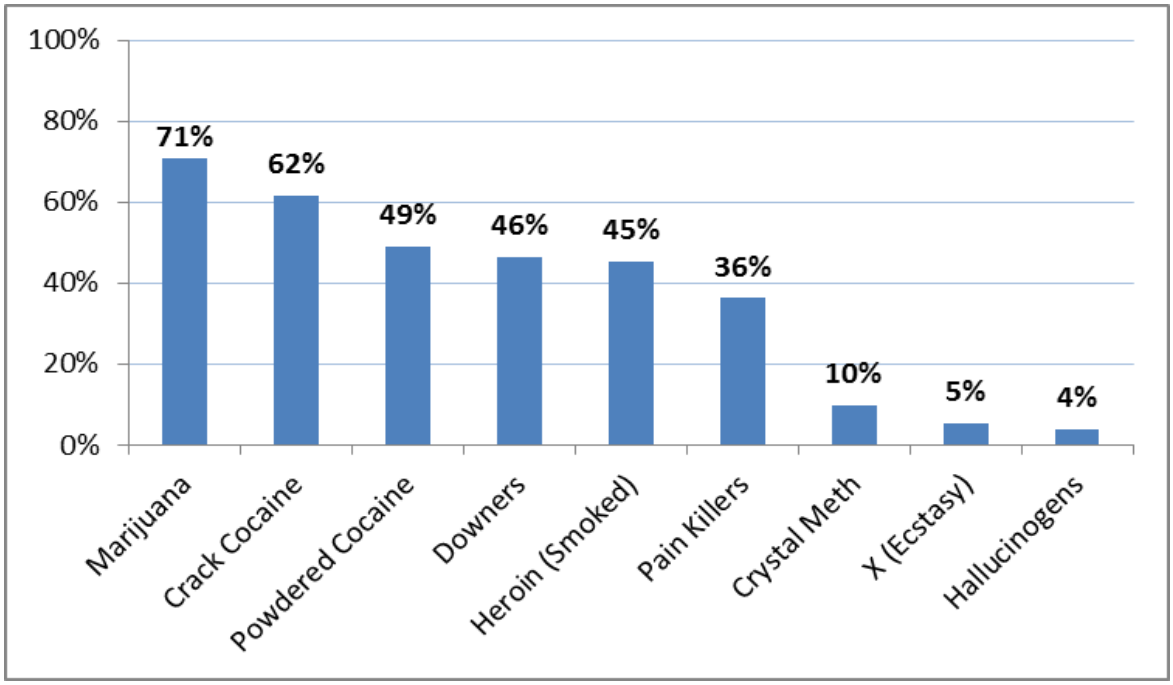
Figure 6. Types of Injection Drugs that Dallas NHBS IDU3 Participants Used in the Year Prior to 2012 Interview (N=500): Weighted Population Estimates, 2012*



*Participants could report use of more than one type of injection drug in the year prior to the interview.
Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

As illustrated in Figure 7, of the IDU3 participants acknowledging use of non-injection drugs, over half reported use of marijuana or crack cocaine. Also of note is that nearly half of reported use of powdered cocaine, downers (benzos such as Valium, Ativan or Xanax) or smoked heroin. Thirty-six percent of those using non-injection drugs used prescription painkillers.

Figure 7. Types of Non-Injection Drugs that Dallas NHBS IDU3 Participants Used in the Year Prior to 2012 Interview (N=298): Weighted Population Estimates, 2012*



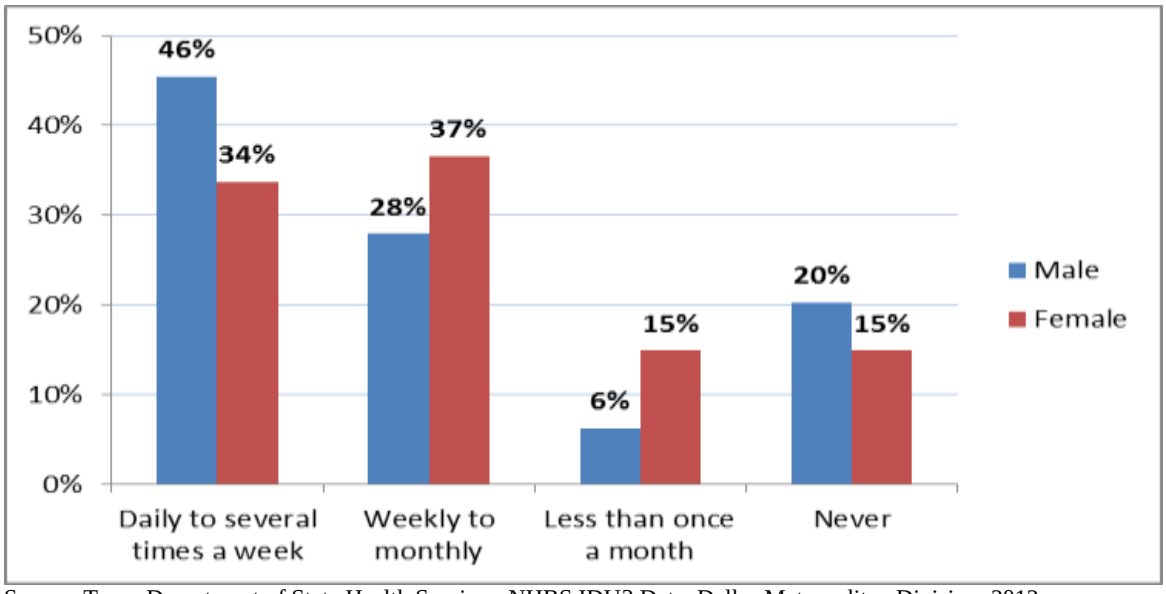
*Participants could report use of more than one type of non-injection drug in the year prior to the interview; less than 5% of participants reported use of hallucinogens, Ketamine, GHB, amyl nitrate (poppers) or other non injection drugs.
Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

DRUG USE RISK BEHAVIOR

Fifty percent of NHBS IDU3 participants were 19 years of age or younger when they began injecting drugs, 35% began using injection drugs between 20 and 29 years of age, 10% began using injection drugs between 30 and 39 years of age and 5% were over the age of 40 when they began injecting drugs.

Frequency of alcohol use varied among male and female PWID (Figure 8). Among those who reported alcohol use in the 12 months prior to the 2012 interview, 46% of males and 34% of female participants reported having 5 or more alcoholic drinks in one sitting daily to several times a week, 28% of males and 37% of females reported weekly to monthly, 6% of males and 15% of females reported less than once a month, and 20% of males and 15% of females never had more than 5 drinks in one sitting.

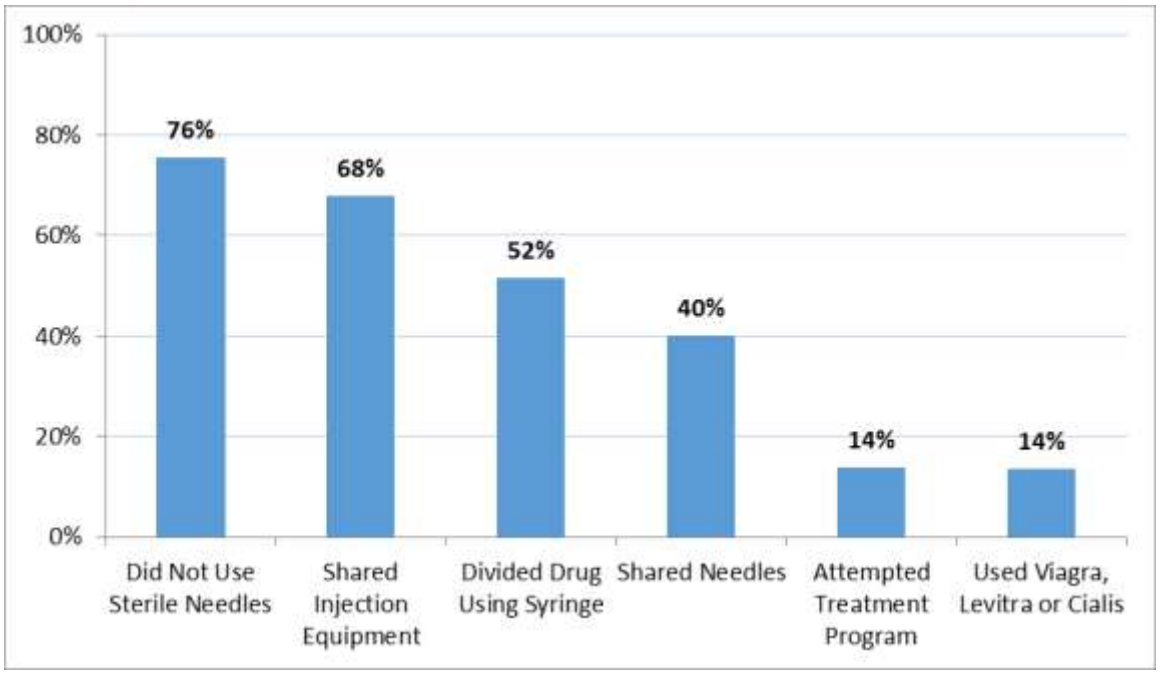
Figure 8. Frequency of Alcohol Use among Dallas NHBS IDU3 Participants Who Reported Alcohol Use in the Year Prior to the 2012 Interview (N=286 Male, N=115 Female): Weighted Population Estimates, 2012



Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

Injection drug-related risk behavior for contracting HIV was reported by a large percentage of NHBS IDU3 participants (Figure 9). Seventy-six percent of participants reported they had not always used a sterile needle to inject in the past year. Sixty-eight percent of PWID shared injection equipment (cooker, cotton or water), 52% divided drugs with a syringe that had already been used, and 40% shared a needle with someone else. Fourteen percent of participants reported attempting getting in to a drug treatment program. Fourteen percent of male PWID reported use of Viagra, Levitra or Cialis.

Figure 9. Drug Use Behaviors among Dallas NHBS IDU3 Participants in the Year Prior to 2012 Interview (N=500): Weighted Population Estimates, 2012



Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

SEXUAL BEHAVIORS

Study participants were asked questions about the number and type of sex partners and the sexual behaviors they had engaged in over the past 12 months. Of the male participants who answered these questions about their female partners, 40% reported having 2-5 partners, 8% reported having 6-10 partners and 5% reported having 11+ partners. Of the female participants who answered these questions about their male partners, 25% reported having 2-5 partners, 7% reported having 6-10 partners and 13% reported having 11+ partners (Table 2).

Table 2. Number of Sex Partners Dallas NHBS IDU3 Participants Reported in the Year Prior to 2012 Interview: Weighted Frequencies and Population Estimates, 2012

Characteristic	Frequency	Estimate
Male Participants: Female Partners		
None	46	14.5%
1 partner	104	32.6%
2-5 partners	127	39.7%
6-10 partners	25	7.9%
11+ partners	17	5.4%
Female Participants: Male Partners		
None	34	22.6%
1 partner	48	31.7%
2-5 partners	38	25.2%
6-10 partners	11	7.4%
11+ partners	20	13.0%
Male Participants: Male Partners		
None	11	77.3%
1 partner	3	23.0%

Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

Study participants were also asked about their main or casual sex partners. Ninety percent of male participants who answered sexual behavior questions engaged in condomless sex with their main female partner, and 75% of male participants engaged in condomless sex with their female casual partner (Table 3).

Table 3. Dallas Male NHBS IDU3 Participants with Female Partners who Engaged in Condomless Sex in the Year Prior to 2012 Interview: Weighted Frequencies and Population Estimates, 2012

Partner Type	Condomless Sex w/Female	Frequency	Estimate
Main	Yes	198	90.4%
	No	21	9.6%
Casual	Yes	123	75.3%
	No	40	24.7%

Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

Of female participants who answered sexual behavior questions, 91% engaged in condomless sex with their main male partner and 70% engaged in condomless sex with their casual partner (Table 4).

Table 4. Dallas Female NHBS IDU3 Participants with Male Partners who Engaged in Condomless Sex in the Year Prior to 2012 Interview: Weighted Frequencies and Population Estimates, 2012

Partner Type	Condomless Sex w/Male	Frequency	Estimate
Main	Yes	84	91.4%
	No	8	8.6%
Casual	Yes	46	70.0%
	No	20	30.0%

Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

Only two male participants answered sexual behavior questions about their male partners specific to condomless sex with males. Both reported engaging in condomless sex with their casual partners (Table 5).

Table 5. Dallas Male NHBS IDU3 Participants with Male Partners who Engaged in Condomless Sex in the Year Prior to 2012 Interview: Weighted Frequencies and Population Estimates, 2012

Partner Type	Condomless Sex w/Male	Frequency	Estimate
Main	Yes	-	-
	No	-	-
Casual	Yes	2	100.0%
	No	-	-

Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

Last Sexual Partner Injected Drugs

In IDU3, 57% of male respondents who answered questions about their last female partners reported that the partner injected drugs, and 66%% of female respondents who answered questions about their last male partner reported that the partner had injected drugs. Of the 3 male respondents who answered questions about their last male partner, 2 indicated that the partner injected drugs (Table 6).

Table 6. Dallas NHBS IDU3 Participants with Last Sexual Partner Engaging in Injection Drugs Use: Weighted Frequencies and Population Estimates, 2012

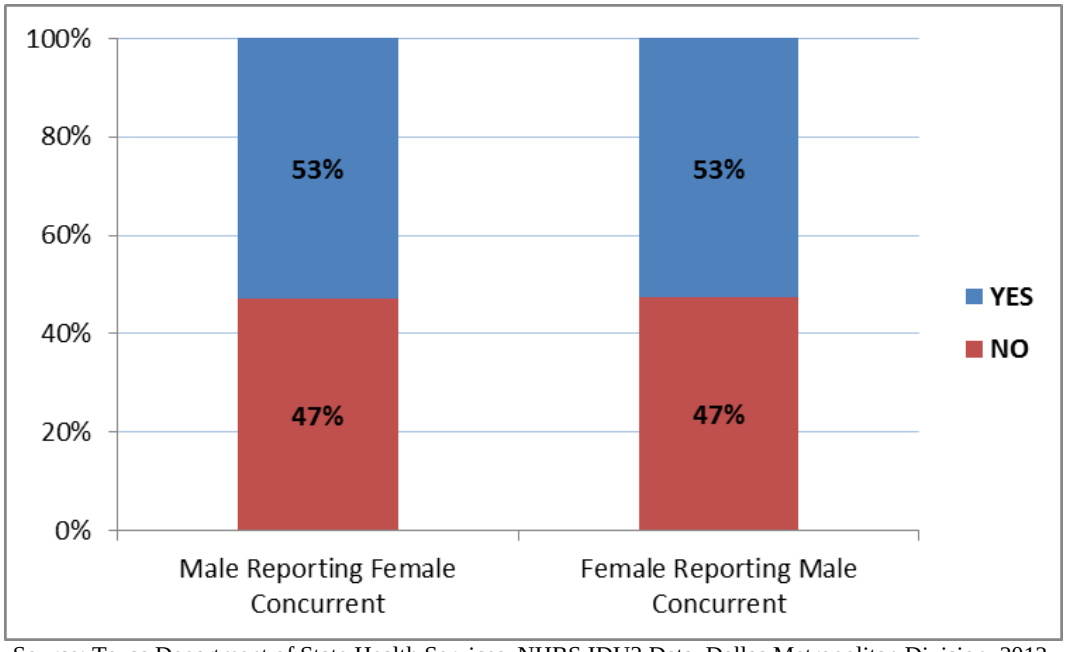
Respondent Gender	Partner Gender	Last Partner Injected Drugs	Frequency	Estimate
Male	Female	Yes No Don't Know	156 113 3	57.3% 41.5% 1.2%
Female	Male	Yes No Don't Know	78 38 1	66.3% 32.6% 1.1%
Male	Male	Yes No Don't Know	2 1 0	66.7% 33.3% -

Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

Concurrent Sex Partners

Of respondents that were sexually active in the 12 months prior to the interview, 53% of male PWID reported concurrent female sex partners and 53% of female PWID reported concurrent male sex partners (Figure 10). Three male respondents reported concurrent male sex partners.

Figure 10. Dallas NHBS IDU3 Participants who Reported Concurrent Sex Partners in the Year Prior to 2012 Interview (N= 264 Male, N=112 Female): Weighted Population Estimates



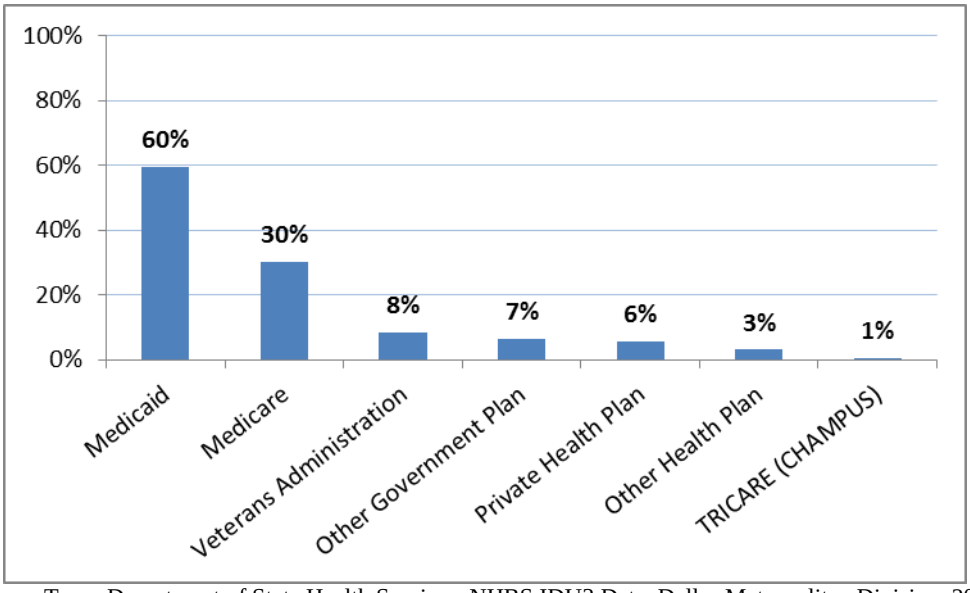
Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

ACCESS TO HEALTH CARE

Health Insurance

Only 47% of participants reported having some type of health insurance at the time of interview. Of the 235 respondents with health insurance, the most frequently reported insurance type was Medicaid with 60%, followed by Medicare with 30% and Veterans Administration coverage with 8%. Private insurance was reported by only 6% of those with insurance coverage. The remainder reported having some other government plan or TRICARE (CHAMPUS) coverage (Figure 11).

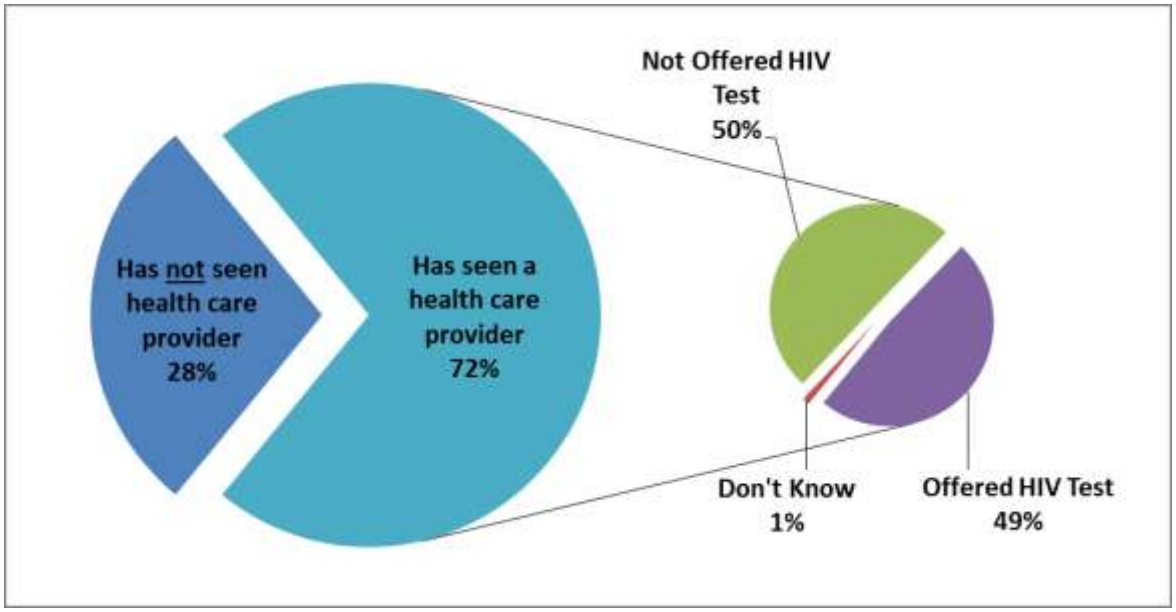
Figure 11. Dallas NHBS IDU3 Participants who Reported Type of Insurance at the time of Interview (N=235): Weighted Population Estimates, 2012



Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

A visit to a health care provider during the 12 months prior to the interview is one of the proxy measures used to assess access to care. The national data on participating sites for NHBS IDU3 indicate that during the 12 months preceding their interviews, approximately 53% of participants had been tested for HIV infection (Centers for Disease Control and Prevention, 2015). Seventy-two percent of the Dallas NHBS IDU3 participants visited a healthcare provider in the past 12 months and of those who visited a healthcare provider, approximately 49% were offered a HIV test (Figure 12).

Figure 12. Dallas NHBS IDU3 Participants Reporting Access to Health Care and HIV Testing in the Year Prior to 2012 Interview (N=506): Weighted Population Estimates, 2012

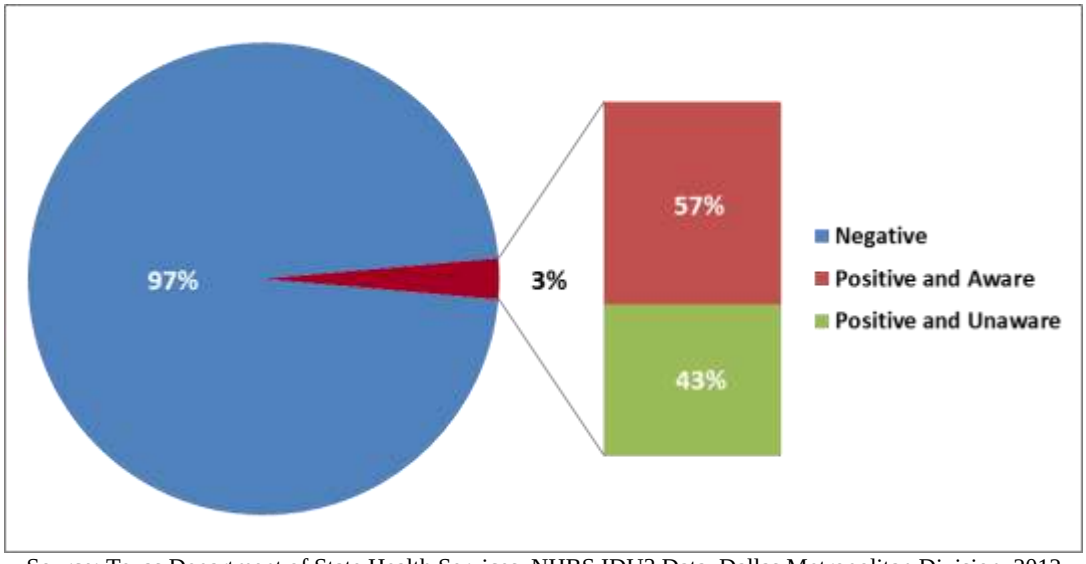


Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

Awareness of HIV Status

In the NHBS IDU3 sample, 506 participants were tested for HIV. Three percent were HIV positive; of those 14 HIV positive persons, 6 (43%) were unaware of their infection (Figure 13).

Figure 13. HIV Status and Awareness of HIV Status among Dallas NHBS IDU3 Participants (N=506), Weighted Population Estimates, 2012



Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012

HEALTH CONDITIONS

According to the Centers for Disease Control and Prevention, PWID are at high risk of acquiring hepatitis B and hepatitis C because these viruses are transmitted through exposure to infected blood and body fluids (2002). Within five years of beginning injection drug use, 50-70% of PWID are likely to become infected with HBV and 50-80% of PWID are likely to become infected with HCV (CDC, 2002).

Among PWID in this project, 52% reported having ever been diagnosed with hepatitis. Of those ever diagnosed, 89% stated they were diagnosed with HAV, 5% with HBV, and approximately 1% with HCV (Table 7). The remaining 5% reported a previous diagnosis of hepatitis, but did not know which type they had.

Twenty-five percent of participants reported they received a hepatitis vaccination at some point in their lives: 3% were for HAV, 18% for HBV, 66% for the combined HAV/HBV vaccine, and 14% reported they had received a hepatitis vaccine but did not know which type they received.

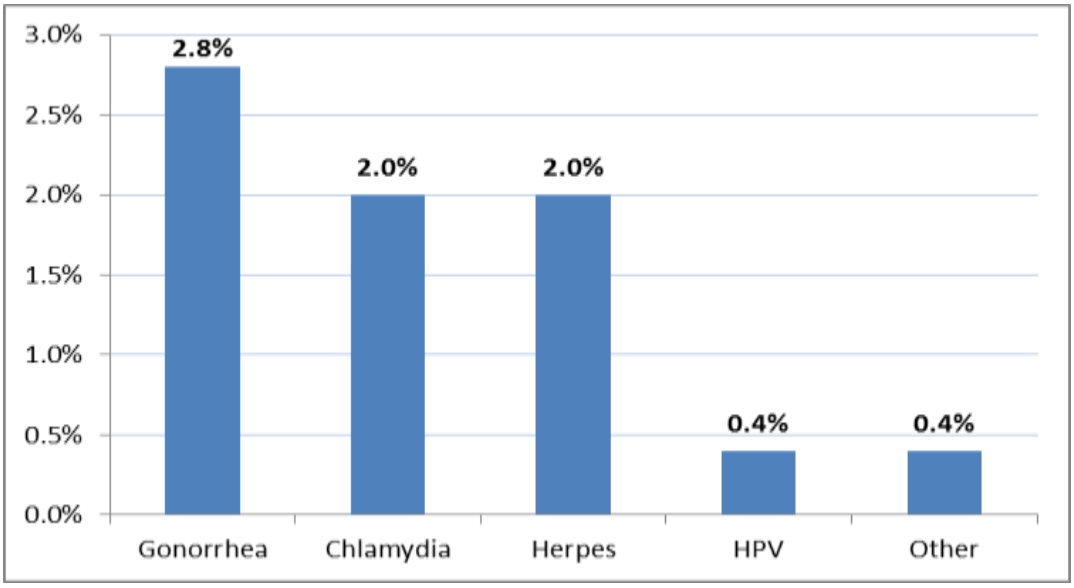
Table 7. Hepatitis Testing and Vaccination among Dallas NHBS IDU3 Participants, 2012: Weighted Frequencies and Population Estimates, 2012

Characteristic	Group	Frequency	Estimate
Ever Had Hepatitis	Yes	261	52.1%
	No	238	47.6%
	Unknown	1	0.3%
Hepatitis Type*	HAV	233	89.1%
	HBV	13	5.1%
	HCV	1	0.5%
	Unknown	14	5.3%
Ever Tested for HCV	Yes	360	72.0%
	No	132	26.4%
	Unknown	8	1.6%
Ever Had Hepatitis Vaccine	Yes	124	24.8%
	No	352	70.4%
	Unknown	24	4.8%
Type of Hepatitis Vaccine**	Hep A	3	2.7%
	Hep B	22	17.6%
	Hep A&B	82	66.0%
	Unknown	17	13.8%

*Among participants who reported ever having hepatitis.
**Among participants who reported ever receiving a hepatitis vaccine.
Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

People who inject drugs are at an increased risk for contracting not only HIV or hepatitis, but also other sexually transmitted diseases. Of the PWID who were diagnosed with a sexually transmitted infection (STI) in the previous 12 months, 3% reported being diagnosed with Gonorrhea, 2% with Chlamydia, 2% with Herpes, less than 1% for HPV and less than 1% for other STIs. Figure 14 shows the weighted population estimates of STI diagnosed among study participants.

Figure 14. STIs Diagnosed among Dallas NHBS IDU3 Participants in the Year Prior to 2012 Interview(N=500): Weighted Population Estimates, 2012



Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

HIV TESTING EXPERIENCES

HIV testing is integral to HIV prevention, treatment, and care efforts. Testing provides an opportunity for people to receive counseling and information about risk reduction. Early knowledge of HIV status is also important for linking those who are HIV positive to medical care and services that can reduce morbidity and mortality and improve quality of life.

Among Dallas NHBS IDU3 participants, 87% reported having ever been tested for HIV. Forty-seven percent of PWID that had ever been tested for HIV had 1-2 tests in the past two years. Of the 341 participants who responded to the question about the HIV test they received in the past 2 years being a rapid test, 49% stated they received a rapid test with results available within 30 minutes (Table 8).

Table 8. HIV Testing Characteristics among Dallas NHBS IDU3 Participants (N=506): Weighted Frequencies and Population Estimates, 2012

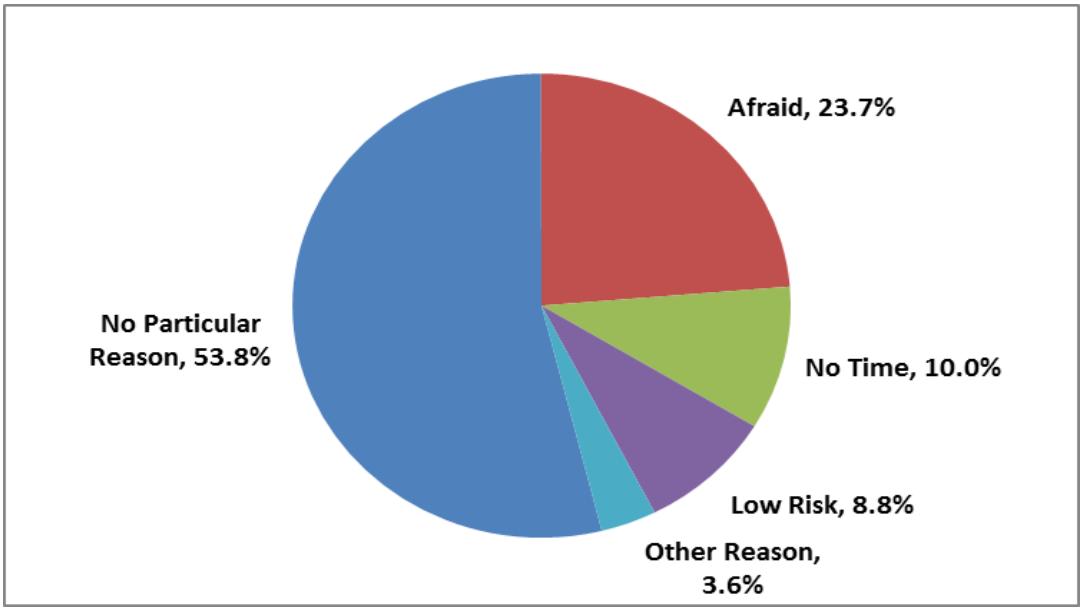
Characteristic	Group	Frequency	Estimate
Ever tested for HIV	Yes	440	87.0%
	No	64	12.6%
	Unknown	2	0.4%
Number of HIV tests in past 2 yrs*	None	162	36.8%
	1 to 2	208	47.3%
	3+	61	13.8%
	Unknown	9	2.1%
Recent test rapid**	Yes	168	49.2%
	No	172	50.4%
	Unknown	1	0.4%

*Among participants who have ever tested for HIV.
**Among participants who gave reason for recent HIV test.
Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

Study participants reported testing for HIV at a variety of locations. Of the 340 participants that reported a location of their last HIV test, 20% tested in a correctional facility, 18% at a public health clinic or community health center, 17% tested in a hospital inpatient setting, 15% at street outreach/mobile units, 9% in an emergency room, or 9% in a drug treatment program. The remaining 12% tested in private doctor's offices, HIV counseling and testing sites, at home or other testing sites. One percent did not know the location of their test.

For the 329 participants who have never tested positive and indicated they did not test for HIV in the past 12 months, 54% stated there was no particular reason for not testing, 24% reported not testing because they were afraid of the result, 10% said they had no time, 9% felt they were low risk, and 4% listed other reasons (Figure 15).

Figure 15. Most Important Reason Reported by Dallas NHBS IDU3 Participants for not Testing for HIV in the Year Prior to 2012 Interview (N=329): Weighted Population Estimates, 2012

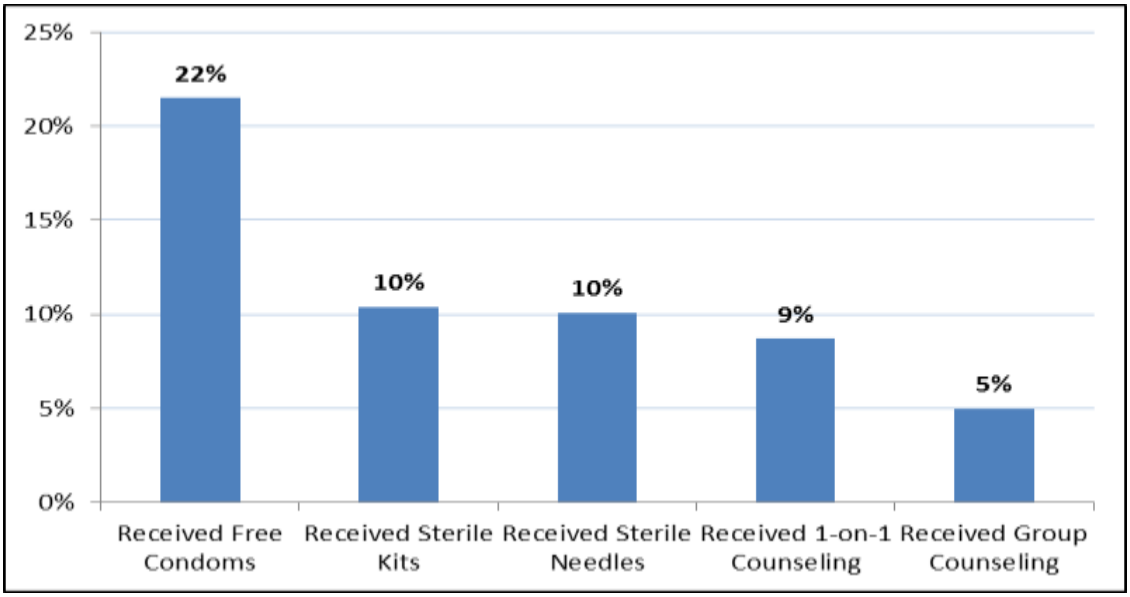


Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

HIV PREVENTION ACTIVITIES

People who inject drugs were asked questions about prevention activities they may have engaged in during the 12 months prior to their interview date (Figure 16). For each of the following categories, responses indicated at least 78% of participants did not receive the listed prevention activity: group counseling, sterile kits, sterile needles, individual counseling or free condoms.

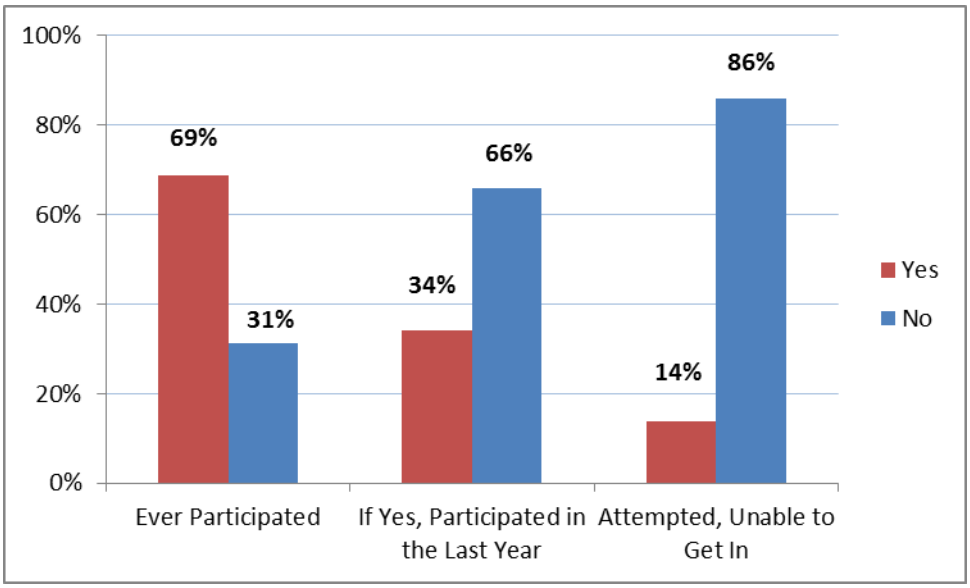
Figure 16. Free Prevention Activities Received by Dallas NHBS IDU3 Participants in the Year Prior to 2012 Interview (N=506): Weighted Population Estimates, 2012



Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

As illustrated in Figure 17, 69% of PWID reported ever participating in a drug or alcohol treatment program and of those, 34% reported participating in one of those programs within the past 12 months. Inability to get into a drug or alcohol treatment program was reported by 14% of participants.

Figure 17. Dallas NHBS IDU3 Participation in Drug or Alcohol Treatment Program (N=500): Weighted Population Estimates, 2012



Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

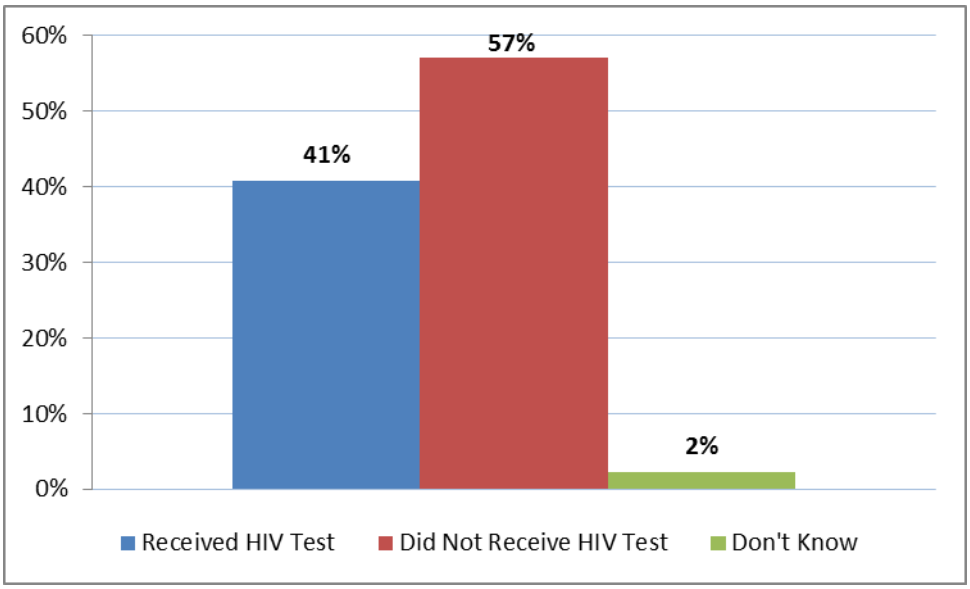
INCARCERATION

According to an article from AIDS Action, although the majority of HIV-positive prisoners are infected prior to entering jails and prisons: individuals who are not HIV-positive at intake may be at increased risk of contracting HIV from participating in activities that can lead to HIV infection, such as continued injecting drug use, tattooing, and consensual sexual activity (AIDS Action, 2001). For this NHBS cycle, participants were asked about their arrest history, HIV and hepatitis C testing during last incarceration, and if they received those test results.

Of the 452 participants who reported ever being held in a detention center, jail or prison for more than 24 hours, 33% percent reported being arrested in the year prior to their interview.

Only 41% of the 149 participants who had been incarcerated in the past 12 months reported being tested for HIV during their incarceration (Figure 18). Of those, five participants (or 9%) who were tested for HIV reported that they did not receive the results of the test.

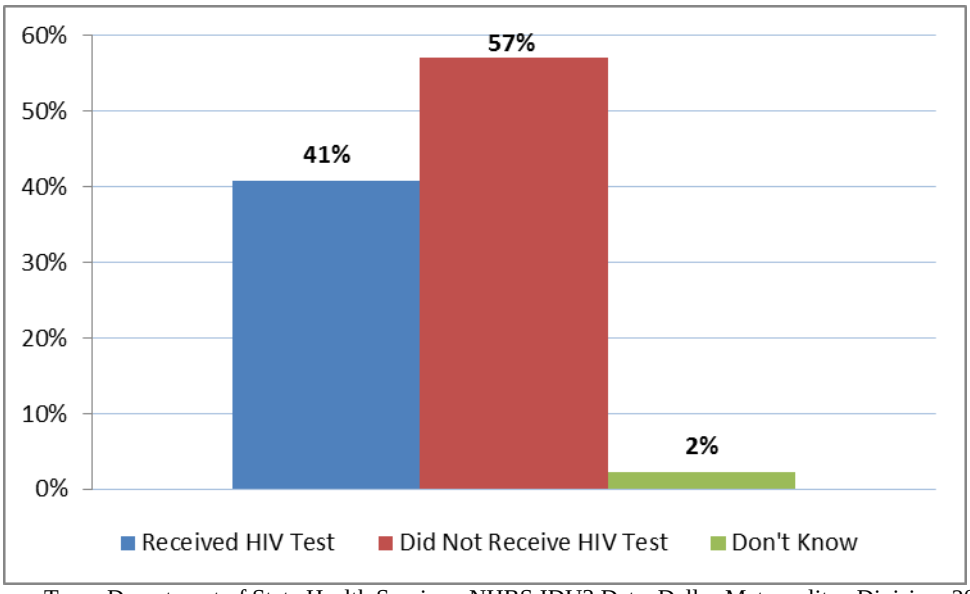
Figure 18. Dallas NHBS IDU3 Participants Tested for HIV During Last Incarceration (N=149): Weighted Estimates, 2012



Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

Only 27% of participants who had been incarcerated in the past 12 months reported being tested for the hepatitis C virus during their last incarceration (Figure 19). Of those, 8 participants (or 20%) did not receive their test results.

Figure 19. Dallas NHBS IDU3 Participants Tested for HCV During Last Incarceration (N=149): Weighted Estimates, 2012



Source: Texas Department of State Health Services, NHBS IDU3 Data, Dallas Metropolitan Division, 2012.

LIMITATIONS

Data are self reported and thus may be subject to certain biases. Because participants are asked about sexual or drug-use behaviors that may be interpreted as undesirable, the IDU3 data are prone to social desirability bias (Gallagher et al., 2007). Social desirability bias is described as the tendency of individuals to say things that will make them look good (Cohen, 2008). However, because the interview is anonymous and participants are assured that their responses will be kept confidential, this bias most likely has a minimal impact on the findings. Participants had to remember past behaviors to answer interview questions; therefore, recall bias may affect study results since the quality and completeness of the data collected is limited by participants' ability to correctly recall certain facts and details. Furthermore, given the sensitive nature of this study, positive HIV status may be under reported due to the fact that an interviewer directly asks the participant questions related to HIV risk behaviors. This method of questioning can lead to inflated estimates of individuals who are unaware of his/her HIV infection. There may be under reporting in the areas of drug use and sexual behaviors (especially among non-gay identified MSM) due to stigma associated with engaging in risky behaviors or being infected with HIV. In addition, the data is a snapshot of risky behaviors among people who inject drugs in the Dallas Metropolitan Division population and cannot be generalized beyond this population.

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