

The Vermont HIV Prevention
Community Planning Group

2004
Comprehensive
HIV Prevention Plan
for Vermont

*A collaborative effort
between the
Vermont HIV Prevention
Community Planning Group
and the
Vermont Department of Health
HIV/AIDS Program*

Adopted, September 2004

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SECTION 1: INTRODUCTION AND SUMMARY

In this section:

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Introduction

The following Comprehensive HIV Prevention Plan is the fourth such plan created as a result of a collaborative effort between the HIV/AIDS Program of the Vermont Department of Health and the Vermont HIV Prevention Community Planning Group. Previous versions were issued in 1994, 1997, and 2001.

The Community Planning Group was created in response to a 1994 federal mandate to engage in a community planning process for HIV prevention. The group assembled each year is a widely diverse body, representative of the range of Vermont communities affected by HIV and AIDS. Members include people living with HIV and AIDS, professionals working in the field of HIV prevention and services, leaders and members of communities affected by HIV, and others appointed because of their field of expertise or personal commitment to HIV prevention.

Over the past ten years, hundreds of Vermonters of diverse backgrounds, perspectives, and levels of expertise, have come together and transformed (not without conflict) into a body that worked together to make decisions that are the basis for HIV prevention in our state. Hard work, struggle, patience, conflict, listening, learning, negotiating and compromising have resulted in the details encompassed in this plan.

During these years of collaboration and development, several members of the Community Planning Group have died due to AIDS-related illness. Their deaths serve as a reminder to us all of the importance of the work we do together.

Who uses the Comprehensive Plan?

The Vermont Department of Health: The Comprehensive Plan documents the decisions of the Vermont Community Planning Group. Those decisions are the basis for Department of Health funded HIV prevention activities. The plan is submitted as an attachment to the Department of Health's application to the Centers for Disease Control and Prevention (CDC) for federal HIV prevention funding, which the Department of Health then disperses to applicants through a competitive grant process. Proposal review and subsequent funding decisions are based on the recommendations outlined in this Comprehensive Plan.

HIV Prevention Providers: This document provides a description of all elements of a statewide, comprehensive approach to HIV prevention. Potential HIV prevention providers can use this document for research purposes to better understand HIV/AIDS as it exists in Vermont. It can also be used as a guide when designing HIV prevention programs. It outlines the priority target populations for which HIV prevention funding is available, as well as epidemiological information, HIV prevention needs, and other relevant information regarding those target populations. It also names service gaps, considerations, theories and strategies that should inform the creation of targeted interventions; and a description of fundable prevention activities, i.e., the interventions themselves.

Anyone Interested in HIV Prevention in Vermont: This document represents the tip of an iceberg, in terms of available information on HIV prevention. However, as a resource for HIV prevention information specific to Vermont, it is uniquely comprehensive. It may well be useful to human service workers; healthcare providers; and others who work with people living with HIV/AIDS, users of injection drugs, men who have sex with men, and/or people at increased risk through heterosexual contact, to better understand these populations, or to incorporate a greater understanding of HIV prevention into their work. It is, overall, a guide for anyone who wishes to know about the current state of HIV prevention in Vermont, or the direction in which it might go from here.

HIV Prevention in Vermont: A Rural Challenge

Many of the traditional challenges of HIV prevention don't flow specifically from working in a rural environment, but they may be exacerbated by it. Other challenges are uniquely rural. Foremost among them is the lack of prevention models created for use outside of urban areas, and interventions with studied, proven effectiveness among rurally located at-risk populations. More often than not, service providers are left to use and/or adapt interventions and models created in urban areas, for urban populations. Furthermore, the cost of intervention activities can be higher in rural areas, where smaller, more disparate populations can be harder to reach.

While rural communities can provide a unique support for those who need it, the nature of these communities can also create more obstacles than it overcomes. HIV/AIDS, and the behaviors that transmit HIV, are heavily stigmatized in our society, and that stigma often carries an even greater power in small towns and remote areas.

Confidentiality, for instance, can be difficult to maintain in small towns, and yet, crucial for those affected by the multiple stigmas of HIV. A person may be left with the choice of “outing” him/herself, or traveling a great distance to receive HIV-related healthcare services, to connect with HIV prevention programs, or even just to obtain condoms and/or clean injection equipment. Sometimes that distance itself is prohibitive in a state where public transportation is minimally available. The long, harsh winters of Vermont can also work in concert with limited transportation to keep people away from services.

Part of this constellation is also poverty, a surrogate marker for HIV risk itself, and a barrier to accessing HIV prevention services. Poverty is not limited to rural areas of course, but it does combine with the geographic isolation of living in a rural state to keep people from accessing healthcare, and other human services like HIV prevention that might be more readily available in more developed areas.

To this day, many people at increased risk, and people in general, think of HIV/AIDS as an urban phenomenon. That brings an extra layer of work to be done for HIV prevention programs in rural areas. Young people in particular, with virtually no peers living with (or openly living with) the virus, continue to operate under the assumption that preventive behaviors are “less necessary” here. Even many healthcare practitioners make assumptions about a lack of risk among the clients they are serving, and subsequently, do not screen for risk behaviors and/or HIV infection itself.

For all of these reasons and others, the Vermont Community Planning Group wishes to be a strenuous voice for continued progress in the area of rural-based HIV prevention and study. The burden that now falls on service providers here, who must be creative with limited funds and limited informational tools, will hopefully lighten over time as we continue to understand the ways in which HIV prevention can and should be implemented in our state.

CDC’S New Initiative: *Advancing HIV Prevention*

Perhaps the biggest change in HIV prevention since the creation of Vermont’s 2001 Comprehensive Plan is the Centers for Disease Control and Prevention (CDC)’s new initiative, *Advancing HIV Prevention: New Strategies for a Changing Epidemic*.

According to CDC, the new initiative “is aimed at reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and ongoing prevention services for those diagnosed with HIV.” It consists of four key strategies:

- **Make HIV testing a routine part of medical care.** CDC will work with professional medical associations and other partners to ensure that all healthcare providers include HIV testing, when indicated, as part of routine medical care on the same voluntary basis as other diagnostic and screening tests.
- **Implement new models for diagnosing HIV infections outside medical settings.** CDC will fund new demonstration projects using OraQuick®, a rapid HIV test recently approved by the U.S. Food and Drug Administration for use in clinical and non-clinical settings, to increase access to early diagnosis and referral for treatment and prevention services in high-HIV prevalence settings, including correctional facilities.
- **Prevent new infections by working with persons diagnosed with HIV and their partners.** CDC, in collaboration with the Health Resources and Services Administration (HRSA), the National Institutes of Health, and the HIV Medical Association of the Infectious Diseases Society of America, has published the *Recommendations for Incorporating HIV Prevention into the Medical Care of Persons with HIV Infection*. These groups will work to disseminate this document to a variety of health care providers.
- **Further decrease perinatal HIV transmission.** CDC will promote recommendations and guidance for routine HIV testing of all pregnant women, and, as a safety net, for the routine screening of any infant whose mother was not screened. CDC will work with prevention partners, including the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Nurse-Midwives, to disseminate the recommendations and support their implementation.

(Source: CDC: <http://www.cdc.gov/hiv/partners/AHP-brochure.htm>)

From a Community Planning perspective, the biggest change resulting from this initiative is a newly mandated emphasis on people living with HIV.

CDC [has asked] community planning groups (CPGs) to make people living with HIV the highest priority population and to prioritize services for those who are at highest risk of transmitting the virus. CPGs also must target activities to those at highest risk for becoming infected. This does not mean that all resources will go for people

living with HIV, but that their needs must be addressed first - -
because of their great potential to transmit HIV.

(Source: CDC: <http://www.cdc.gov/hiv/partners/AHP-brochure.htm>)

This new initiative has had, and will continue to have, a significant impact on the direction of HIV prevention in Vermont. These newly defined priorities are reflected in both the Vermont Department of Health's application to CDC for continued HIV prevention funding to the state, and in this Comprehensive Plan.

Guide to Acronyms and Abbreviations

ACORN	AIDS Community Resource Network
AED	Academy for Educational Development
AIDS	Acquired Immunodeficiency Syndrome
ASO	AIDS Service Organization
BRFSS	Behavioral Risk Factor Surveillance System
CBO	Community Based Organization
CDC	The Centers for Disease Control and Prevention
CLI	Community Level Interventions
CPG	Community Planning Group
CTR	Counseling Testing and Referral
CTS	(HIV) Counseling and Testing System
GLI	Group Level Interventions
HASAC	HIV/AIDS Services Advisory Council
HC/PI	Health Communication/Public Information
HE/RR	Health Education/Risk Reduction
HIV	Human Immunodeficiency Virus
IDU	User of Injection Drugs (Injection Drug User)
ILI	Individual Level Interventions
MSM	Men who have Sex with Men
NEP	Needle Exchange Program (a/k/a Syringe Exchange Program)
PCM	Prevention Case Management
PFP	Prevention For Positives
PLWHA	Person Living with HIV/AIDS
PWA	Person living With AIDS (or: Person living with HIV/AIDS)
SEP	Syringe Exchange Program (a/k/a Needle Exchange Program)
STD	Sexually Transmitted Disease (synonymous with STI)
STI	Sexually Transmitted Infection (synonymous with STD)
VDH	Vermont Department of Health
VT CARES	Vermont CARES (Committee for AIDS Resources, Education and Services)
YRBS	Youth Risk Behavior Survey

Executive Summary: Highlights of the Comprehensive Plan

The following pages provide a summary of the key points and recommendations included in the Comprehensive Prevention Plan.

Section 1: Introduction and Summary

Introductory remarks and a summary of each section of the plan.

Section 2: Community Services Assessment

Formerly referred to as Resource Inventory, Gap Analysis, and Needs Assessment, this section offers an overview of available HIV/AIDS services in Vermont, including state funded and non-state funded programs; a description of identified HIV prevention needs among target populations; and an assessment of HIV prevention service gaps in Vermont, measuring available resources against identified needs.

In 2002, the CPG's work focused primarily on the HIV prevention needs of Injection Drug Users (IDU); and in 2003, on Men who have Sex with Men (MSM). In 2004, the CPG began to focus on people living with HIV/AIDS, and to a limited extent, on people at increased risk through heterosexual contact. Accordingly, more information is included here for the former two populations than the latter two, both of which will be a primary focus for the Community Planning Group in the coming four-year work cycle.

Highlights of the MSM and IDU Needs Assessment findings are excerpted here, with full findings and discussion in Section 2.

MSM Needs Assessment – Participant Survey: Selected Findings

A 2003 survey implemented among MSM in Vermont focused on the ways in which these men spend their free time, and ways in which they would like to spend their time. The focus of the survey was to determine where HIV prevention activities might be most feasibly offered, and well received, by the MSM community. A total of 204 surveys were completed.

The most frequently-named ways in which MSM reported spending their free time were:

Response	# n=204	%
Small social events	112	55%
Going out elsewhere	109	53%
Arts/Cultural events	89	44%
Hobbies	72	35%
Outdoor activities	62	30%
Internet	60	29%
Volunteer work	60	29%
Sports/Exercise	56	27%

The most frequently-named ways in which MSM said they don't spend their free time but would like to if the named activities were available:

Response	# n=204	%
Large social events	55	33%
Small social events	52	31%
Arts/Cultural events	45	27%
Dating/Looking for a partner	37	22%
Outdoor activities	34	20%
Going to a bar	33	20%
Adult ed	32	19%

Asked about which health topics were of greatest interest, the most frequent responses were:

Response	# n=204	%
HIV/AIDS	118	56%
Physical fitness	95	47%
Diet/Nutrition	82	41%
Mental health	75	37%
Cancer	54	27%
Alternative therapies	52	26%
How to find a GLBT-friendly provider	48	24%

MSM Needs Assessment – Provider Interviews: Selected Findings

A total of 14 interviews were conducted among Vermont service providers who focus in some way on MSM. Questions centered around ways in which HIV prevention for this population might be improved and made more accessible to MSM. Some of those questions, and the most common responses to them, are excerpted here:

Question: What challenges or issues do you face in providing services to MSM?

Most common responses:

- No physical gathering space, especially outside of a bar setting
- Lack of providers (especially those who are knowledgeable, culturally competent, able to make appropriate referrals for MSM); Distrust among MSM of service providers
- Apathy; HIV education burnout; Finding fresh and interesting ways to engage MSM on this issue; Difficult to engage young MSM in particular
- Rural limitations: especially the difficulty of doing outreach in this environment, and the lack of transportation
- Lack of services awareness; difficulty promoting programs
- Rise in transmission

Question: What would you say are the major health-related issues or concerns among the MSM you serve?

Most common responses:

- HIV/AIDS prevention and care
- Mental health/Psychosocial issues
- Hepatitis C
- Substance/Alcohol use and abuse
- Access to health care
- Oral sex/HIV transmission

Question: What are the other major concerns or priorities (non-health related) among the MSM you serve?

Most common responses:

- Finances
- Social isolation
- Discrimination/Homophobia
- Dating/Relationships

Question: What are the three best venues for reaching MSM with services/messages?

Most common responses:

- Internet/Websites
- Smaller social events
- Community events/Larger social events
- Retreats
- Gay bars/Bars
- Media
- On-site/Drop-in services/Office

Question: How might HIV counseling and testing be increased among the population you serve?

Most common responses:

- Outreach/Advertising/Awareness raising
- Mobile testing and/or increased on-site testing
- Increase Orasure and/or rapid testing availability
- More MSM working as providers/counselors

Question: What groups of MSM are well-reached with HIV prevention services?

Most common responses:

- Men already accessing services/Self-actualized men
- None

Question: Who is not being well-reached?

Most common responses:

- MSM in rural areas
- Non-gay identified/closeted MSM
- Young MSM
- MSM not connected to services

Question: Are there specific geographic areas where services are most lacking, or more difficult to provide to MSM?

Most common responses:

- Northeast Kingdom
- Rutland/Rutland County
- Rural areas in general
- Everything outside of Burlington

Question: What should be the priorities for implementing effective HIV prevention for MSM?

Most common responses:

- Outreach (including but not limited to media)
- Networking among service providers
- Programs targeting young MSM
- More sex-positive material and dialogue

IDU Needs Assessment: Selected Findings

This project included in-depth interviews with 14 service providers working with injection drug users, and 10 people living in Vermont who were active injection drug users, or who had injected within the previous six months. Questions centered around improving HIV prevention for this population and ways in which IDU might more easily access those services. Some questions, and the most common responses to them, are excerpted here:

TOP NAMED IDU-TARGETED HIV PREVENTION PRIORITIES			
	IDU Responses (n=10)	Service Provider Responses (n=14)	Total (n=24)
Needle/Syringe exchange	9	7	16
Increased treatment options	3	4	7
Methadone	2	4	6
Public information	4	2	6
Group Level Intervention	5	0	5
Prevention Case Management	0	3	3
Change attitude toward risk behavior	0	2	2

TOP NAMED PRIMARY HEALTH CONCERNS FACING IDUs			
	IDU Responses (n=10)	Service Provider Responses (n=14)	Total (n=24)
Hepatitis C	3	13	16
HIV	2	8	10
Access (alienation, fear, lack of cultural competency)	4	3	7
Use of other substances	--	5	5
Abscesses/infections	1	4	5
Non-C hepatitis	2	2	4
Lack of funds	2	2	4
Diet/Nutrition	1	2	3

What should HIV prevention services look like? (Participant responses only)	
Where should services be delivered?	<p><i>Most common answers:</i> Through needle/syringe exchange programs Through substance abuse treatment centers In public places; non-threatening environment</p> <p><i>Mixed opinions:</i> Doctor's office/Hospital</p>
How would you prefer to receive services?	<p><i>Most common answers:</i> Individually/one-on-one In groups/group level intervention Public information</p>
When is a good time to discuss HIV/AIDS?	<p><i>Most common answer:</i> When connected to services (needle exchange; treatment)</p>
When is not a good time to discuss HIV/AIDS?	<p><i>Most common answer:</i> Not when using/high</p>
Who should be providing these services?	<p><i>Most common answers:</i> Current or former user Person living with HIV People who are knowledgeable but not authoritative or judgmental People who are compassionate/sincere</p>

GAP ANALYSIS

The Community Planning Group identified the following service gaps for each of the four named target populations. This list is non-exhaustive and will be the subject of continued focus by the CPG in the coming work cycle. Items listed here are discussed more fully in Section 2 of this Comprehensive Plan.

Gap Analysis: MSM

Geographic gaps

- Rural areas in general
- Northwest Counties (Franklin, Grand Isle)
- Southwest Counties (Addison, Rutland, Bennington)
- Northeast Kingdom (Caledonia, Orleans, Essex Counties)
- To some extent, central areas (Washington, Lamoille, Orange Counties)

HIV Prevention Intervention Gaps

- Internet-based prevention
- Outreach
- Public Information
- Counseling and Testing (awareness of service availability)
- Social event-based Group Level Intervention

Underserved Populations

- Non-gay identified MSM; Closeted MSM
- Young MSM
- MSM of color
- MSM who are also injection drug users
- MSM who are incarcerated
- MSM living at or below the poverty line

Related factors

- Lack of venues/safe gathering spaces
- Lack of anti-stigma activities
- Lack of community-building activities
- Lack of MSM working as service providers

Gap Analysis: IDU

Geographic gaps

- In general, most areas of the state
- In particular, northwest and southwest Vermont (Franklin, Grand Isle, Lamoille Counties; and Addison, Rutland, Bennington Counties, respectively)

HIV Prevention Intervention Gaps

- Public Information
- Group Level Intervention (GLI)
- Prevention Case Management (PCM)

Underserved Populations – IDU who are:

- Women
- Youth

Note: It is the CPG's position that all IDUs are at some level of increased risk for HIV infection and/or transmission, and that IDUs in general are an underserved population in this state, and perhaps the hardest to reach.

Related factors

- Hard-to-reach population
- Lack of funding for services
- Limitations on use of federal funds for effective prevention activities (e.g., syringe exchange; pharmacological treatment options)
- Lack of Hepatitis C awareness and prevention activities

Gap Analysis: People at Increased Risk Through Heterosexual Contact

Note: Gap analysis for this population is preliminary, pending a more formal needs assessment by the CPG in the coming four-year work cycle.

Geographic gaps and underserved populations

- Rural areas in general
- Youth: Prevention services in Franklin, Grand Isle, Lamoille, Addison, Orleans, Essex, and Bennington Counties
- Young men: Prevention services in Windham County
- Adult women at increased risk: Prevention services throughout most of Vermont (exceptions: Windsor County, Windham County, Corrections-based programs)
- Adult men at increased risk: Prevention services throughout most of Vermont (exceptions: Chittenden County, Corrections-based programs)

Gap Analysis: People Living with HIV/AIDS

Note: In early 2004, a series of meetings was held at the Vermont CPG's request to begin identifying service needs, gaps, and appropriate Prevention For Positives interventions in Vermont. This was the beginning of what will be a farther-reaching needs assessment and gap analysis process in the coming four-year work cycle.

Geographic gaps

- Looking just at organizations receiving HIV prevention funds from the Vermont Department of Health, the geographic gaps in the state may include the following counties: Franklin, Lamoille, Grand Isle, Addison, Bennington. However, all of these counties are within the service area of organizations with offices elsewhere. Pending a more formal gap analysis, it is difficult to know where services are most needed.

Underserved Populations

- The Vermont CPG's definition of this population includes MSM, IDU, and People at increased risk through heterosexual contact. Currently, all AIDS Service Organizations receiving Prevention for Positives funding serve all people living with HIV/AIDS. Whether or not Prevention for Positives can and should move toward a more targeted approach in the future will be one of the questions the CPG examines in the coming work cycle.
- In the short term, the Prevention for Positives work group highlighted the needs of two groups in particular: Communities of Color and Injection Drug Users.

Related gaps

- Lack of anti-stigma activities
- Lack of models for intervention in rural areas

Section 3: Prioritization of Populations

Under new guidance from the Centers for Disease Control, the Vermont Community Planning Group recommends that the highest priority population for HIV prevention in Vermont be for People Living with HIV/AIDS (PWA). These efforts are also known herein as Prevention for Positives (PFP).

The Vermont CPG recommends that the Vermont Department of Health increase the percentage of available HIV prevention funds for Prevention for Positives efforts, as compared to previous years. The CPG has chosen not to name a specific amount or percentage of funds to be set aside for these efforts and has left that decision to the discretion of the Department of Health.

The three other named priority populations remain unchanged from the 2001 Comprehensive Plan, although the results of the CPG's prioritization process have changed.

The CPG recommends that HIV prevention funds not allocated for Prevention for Positives be divided as follows:

Men who have Sex with Men (MSM): 38.0%

People at Increased Risk Through Heterosexual Transmission: 36.5%

Injection Drug Users (IDU): 25.5%

This section of the Comprehensive Plan gives an overview of the CPG's process, as the group examined, weighted, and scored each of these three named populations on various factors related to HIV/AIDS in Vermont, and its prevention. The weighting and scoring process resulted in the funding recommendations listed above.

Section 4: Prevention for Positives (PFP)

Section 4 is an overview of Vermont's response to the new emphasis on People Living with HIV/AIDS in our HIV prevention efforts. Guiding principles for Prevention with Positives are included, along with a discussion of related issues, specific to doing this work in Vermont.

Guiding principles discussed in this section include the following:

1. Prevention must be a shared responsibility.

2. Don't assume serostatus. HIV prevention programs should deliver messages that are inclusive, understanding that HIV positive people are in the audience for these programs.
3. HIV positive people have unique needs and concerns that require targeted approaches to reach us.
4. People living with HIV/AIDS are extremely heterogeneous and programs need to address the different needs of such a diverse group.
5. Effective programs must fully accept the right of people living with HIV/AIDS to intimacy and sexual health.
6. Effective programs must fully accept the right of people living with HIV/AIDS to autonomy over their illicit drug use choices.
7. Behavior change is tough for everyone...including people living with HIV/AIDS.
8. Knowledge of serostatus is important, but isn't enough.
9. There is no magic bullet, no single type of intervention that will work for everyone.
10. Disclosure isn't always the answer.
11. Stigma, discrimination, shame and fear drive people underground and make prevention harder for everyone, especially positive people.
12. Coercion/criminalization is not the answer.
13. Programs must be anchored in the real needs and concerns of people living with HIV/AIDS.
14. People living with HIV/AIDS need to be involved in the planning, design, delivery and evaluation of these programs .
15. Resources and capacity-building efforts must support the development of HIV+-run programs to respond to this need.
16. Effective programs for people living with HIV/AIDS will recognize the need to minimize barriers to health treatment services, including harm reduction-based programs.

Section 5: Men who have Sex with Men (MSM)

The Vermont CPG's primary focus in 2003 was on MSM. That year's efforts included an in-depth needs assessment and examination of the HIV prevention issues facing this population in Vermont, as well as the community-based organizations that serve them. Section 5 of the Comprehensive Plan is an overview of that information-gathering process and the resulting recommendations made by the CPG.

In addition to the Interventions named in this Comprehensive Plan (see Section 8), the CPG has identified a non-binding list of priority sub-populations, as well as priority venues where interventions targeting MSM should be considered. These lists are intended as informational guidance. They are not meant to exclude providers from applying to do prevention work in other locations and with other groups of MSM.

MSM Sub-Populations

The Vermont CPG has chosen to name all MSM as one of four priority target populations for HIV prevention in this state. Within the category of MSM, however, certain sub-populations are at an increased risk for HIV transmission and/or infection. Some are also underserved by HIV prevention efforts, whether for lack of infrastructure, prevention resources, or internal barriers from within that sub-population. These groups include MSM who are:

- Injection Drug Users (MSM/IDU)
- Involved with Corrections (incarcerated, probation/parole)
- Low socioeconomic status
- Members of Communities of Color
- Non-gay-identified
- Youth

Service providers mounting programs to target MSM should consider ways in which they might effectively reach members of these sub-populations.

Venues

Based on interviews with service providers around the state, and the 2003 MSM survey implemented as part of the CPG's needs assessment process, the MSM Needs Assessment Committee developed a list of venues that might be particularly appropriate for reaching MSM in Vermont with HIV prevention services. This is a non-exhaustive list, and other specific locations should be considered to meet the needs of any local population.

HIV prevention programs should consider targeting MSM in or at the following venues:

- Bars
- Internet
- Large social events/Arts and cultural events
- Public Sex Environments (PSEs)
- Retreats
- Small social events

Some of these outlets already exist within the community (e.g., bars; Internet); others are events that service providers might consider creating for their own purposes (e.g., large social events that could attract a large number of men, and that would incorporate some focus on HIV prevention).

MSM: Other Recommendations

Section 5 of the Comprehensive Plan also includes a list of recommendations for improving HIV prevention for MSM. These recommendations are divided into three categories, each of them discussed more fully in Section 5:

Prevention, with recommendations pertaining to:

- Young MSM
- Interventions
- Geographic Considerations
- Venues: Dedicated Space

Capacity Building, with recommendations pertaining to:

- Cultural Competency
- Funding
- Geography
- Linkages/Referral
- Marketing/Social Marketing
- Networking
- Training

Other Issues, with recommendations pertaining to:

- Counseling and Testing in Healthcare Settings
- Data/Information
- Partner Counseling and Referral Services (PCRS)
- Whole Health Approach

Section 6: People at Increased Risk through Heterosexual Transmission

Section 6 includes an overview of the population (i.e., working population definition) as follows:

Men, Women and Youth* who:

- are partners of people who are HIV+
- are partners of people who are injection drug users
- are partners of men who have sex with men
- are people of color
(including people who are Black/African American, Hispanic/Latino/Latina, Asian/Pacific Islander, American Indian/Alaska Native, and other people of color);
- report sexually transmitted infections (STIs) and/or unwanted pregnancy
- are incarcerated/juvenile offenders
- are homeless

Women and Youth* who:

- are dealing with, or have a history of violence or abuse
(including domestic violence, rape, emotional or physical abuse);
- seek treatment for substance abuse;
- live at or below the poverty line;
- are dealing with mental illness;
- are sex workers and/or trade sex for resources.

Youth* who are:

- runaway, “throwaway,” emancipated, abandoned, medically indigent, in foster or SRS care, out of school, and/or otherwise disconnected from traditional systems
- developmentally disabled

*For the purposes of this document, Youth are defined as ages 13-24.

Section 6 also includes a discussion of each sub-population (women, youth, and men) and discusses some specific HIV prevention issues as they relate to each of those sub-populations. The specific issues discussed are outlined in bullet form here:

Women at Increased Risk: Related Issues

- Sexually Transmitted Infections (STIs)
- Power/Gender-based Dynamics
- Trading Sex for Resources
- Racism

- Substance Use
- Corrections
- Disenfranchised Populations
- Perceptions of Risk

Youth at Increased Risk: Related Issues

- Abstinence/Postponement and the Continuum of Risk Behavior
- GLBTQ Youth

Men at Increased Risk: Related Issues

- “Traditional” Roles
- Sexual violence/Power dynamics
- Sexually Transmitted Infections
- HIV stigma/awareness
- Peers

Section 7: Injection Drug Users (IDU)

The Vermont CPG’s primary focus in 2002 was on Injection Drug Users. That year’s efforts included an in-depth needs assessment and examination of the HIV prevention issues facing this population in Vermont, as well as the community-based organizations that serve them. Section 7 is an overview of that information gathering process and the resulting recommendations made by the CPG.

In addition to the Interventions named in this Comprehensive Plan (see Section 8), the CPG has identified a non-binding list of priority sub-populations, as well as priority venues where interventions targeting Injection Drug Users (IDUs) should be considered. These lists are intended as informational guidance. They are not meant to exclude providers from applying to do prevention work in other locations and with other groups of IDUs.

IDU Sub-Populations

It is the position of the Vermont Community Planning Group that ALL IDUs in Vermont are at increased risk for HIV infection and/or transmission. Accordingly, the Vermont CPG has chosen to name IDU as one of four priority target populations for HIV prevention in this state. The need for targeting HIV prevention interventions to specific populations reflects disproportionate impact and socio-specific need among those populations, not a lack of need among the IDU population as a whole. Underserved sub-populations include:

- IDUs who are living with Hepatitis C
- Young IDUs, and young opiate users who do not inject, or those who may be at increased risk for transitioning from non-injection use to injection use
- Female IDUs and in particular, female IDUs living at or below the poverty line; who are sexual or needle-using partners of other IDUs; and/or those who are caregivers to children
- IDUs who are members of communities of color
- IDUs who are also men who have sex with men (IDU/MSM)
- IDUs who are also homeless and/or seek services relating to a need for short- or long-term shelter
- IDUs who are not currently in substance abuse treatment or seeking substance abuse treatment services; and/or IDUs who are not current clients of an existing harm reduction or HIV prevention program

Venues

Based on the 2002 needs assessment process, which involved interviews with injection drug users as well as service providers who work with them, the IDU Needs Assessment Committee developed a list of venues that might be particularly appropriate for reaching IDU in Vermont with HIV prevention services. While the primary activities that take place in some of these venues may not be fundable with federal prevention dollars, the CPG recommends that service providers consider ways in which they might leverage the opportunities presented by these venues for providing other interventions.

This list is intended as informational guidance. It is not meant to exclude providers from applying to do prevention work in other locations and with other groups of IDUs.

VENUE	DESCRIPTION/DETAIL
Syringe Exchange-based Interventions	Activities to increase access to, awareness of, and utilization of Syringe Exchange Programs (<i>excluding actual exchange of injection equipment</i>)
	Activities delivered at, through, or in conjunction with, Syringe Exchange Programs (<i>excluding actual exchange of injection equipment</i>)
Pharmacological (e.g., Methadone, Buprenorphine) Substance Abuse Treatment-based Interventions	Activities to increase access to, awareness of, and utilization of available pharmacological substance abuse treatment (<i>excluding actual delivery of pharmacological treatment</i>)
	Activities delivered at, through, or in conjunction with pharmacological substance abuse treatment facilities (<i>excluding actual delivery of pharmacological treatment</i>)
(continued)	

VENUE	DESCRIPTION/DETAIL
Non-Pharmacological Substance Abuse Treatment-based Interventions	Activities to increase linkages to, awareness of, and utilization of available substance abuse treatment services <i>(excluding actual delivery of substance abuse treatment services)</i>
	Activities delivered at, through, or in conjunction with substance abuse treatment facilities <i>(excluding actual delivery of substance abuse treatment services)</i>
Corrections/Probation & Parole-based Interventions	Activities targeting IDUs in Correctional facilities and through the Probation and Parole system/services

IDU: Other Recommendations

Section 7 of the Comprehensive Plan also includes a list of recommendations for improving HIV prevention for IDU. These recommendations touch on the following subjects:

- Cultural competency for IDUs in the delivery of interventions
- Funding Issues
- Stigma and the difficulty of doing this work
- The importance of harm reduction-based programs
- The state of Syringe Exchange and Pharmacological Substance Abuse Treatment in Vermont
- Hepatitis C

Section 8: Interventions

Since the creation of the 2001 Comprehensive Plan, some of the language used to refer to, and to categorize, the recommended interventions for meeting the needs of people at increased risk in Vermont, has changed. This section will give an overview of the “old” labels, as well as a list of HIV Prevention Interventions approved by the Vermont CPG, for use (and/or appropriate adaptation) in Vermont.

This section also includes guidance for the development of a successful intervention program, including a list of elements common to most successful programs, and the behavioral theories that underlie the creation and delivery of many, if not most, interventions. Those lists are encapsulated here and discussed further in the full text:

Elements of a Successful HIV Prevention Program:

- Behavior Change Counseling
- Skills Building
- Harm Reduction
- Peer Involvement
- Cultural Competency and Appropriateness
- Defining the Target Population
- Holistic Services
- Multiple Approaches
- Prevention Messages
- Recruitment and Retention
- Risk Reduction
- Special Needs
- Combating Stigma
- Frank talk about sex and/or drug use

Behavioral Theories:

- Health Belief Model (Rosenstock et al, 1994)
- Theory of Reasoned Action (Fishbein, 1989)
- Social Cognitive Theory (Bandura, 1994)
- Diffusion of Innovation (Rogers, 1983)
- Stages of Behavior Change Model (Prochaska et al., 1992)
- Harm Reduction (Brette, 1991)
- Empowerment Education Theory (Wallerstein, 1992)

The specific interventions named in Section 8 are largely based on (but not exclusively limited to) the Diffusion of Effective Behavioral Interventions for HIV Prevention (DEBIs) and the CDC's Compendium of Effective HIV Prevention Interventions.

In addition to those resources, the Vermont CPG has also approved an additional list of specific HIV prevention interventions for Prevention with Positives. As with all of the above, these programs should be undertaken with an eye on the specifics of doing this work in a rural state like Vermont. A non-exhaustive list of noted reservations and recommendations for some of these programs is also included in this section.

Interventions described in Section 8 are listed in bulleted form here:

Diffusion of Effective Behavioral Interventions for HIV Prevention (DEBIs)

- The MPowerment Project
- Community PROMISE
- Popular Opinion Leader (POL)
- Real AIDS Prevention Project (RAPP)
- Teens Linked to Care
- VOICES/VOCES
- Healthy Relationships

- Holistic Harm Reduction Program
- Man Men, Many Voices
- Safety Counts
- The SISTA Project
- Street Smart

Compendium of HIV Prevention Interventions with Evidence of Effectiveness

- AIDS Community Demonstration Project
- AIDS/Drug Injection Prevention
- Skills Building
- Intensive AIDS Education in Jail
- Informational and Enhanced AIDS Education
- Condom Skills Education
- Group Discussion Condom Promotion
- Social Skills Training
- Reducing AIDS Risk Activities
- Project RESPECT
- Cognitive-Behavioral Skills Training Group
- Women and Infants Demonstration Projects (WIDP)
- VOICES/VOCES
- HIV Education, Testing, and Counseling
- Mpowerment Project
- Behavioral Self-Management and Assertion Skills
- Popular Opinion Leader (POL)
- Small Group Lecture Plus Skills Training
- Be Proud! Be Responsible!
- Reducing the Risk
- Get Real about AIDS
- StreetSmart
- Focus on Kids
- Becoming a Responsible Teen (BART)

Prevention For Positives (PFP) Interventions

In addition to the above-named interventions, the following programs were approved by the CPG for implementation with people living with HIV/AIDS (a/k/a, Prevention with Positives). While all of these programs have some history of demonstrated effectiveness in their original format, the Vermont CPG and the Vermont Prevention For Positives work group have noted their reservations, sometimes strong reservations, where they exist for each of the following. Rather than ruling out any given program, which might be successfully adapted for use here, the CPG has chosen to include the full list of interventions that were considered.

- Tarzana HIV Service, Los Angeles
- Brief Motivational Interviewing
- HIV Prevention Education and Risk Reduction (Wisconsin)
- HIV Stops with Me
- Teens Linked to Care
- Holistic Harm Reduction Program
- Los Angeles Clinic-Affiliated Intervention
- Stop AIDS Project, San Francisco
- Positive Images, Los Angeles
- Prevention in Medical Care Settings
- Healthy Relationships
- Power Program Los Angeles
- HTPP HIV Transmission Prevention Project
- Peer Based Intervention to Promote Condom and Contraceptive Use Among HIV Positive and At-Risk Women
- Project Connect

Section 9: Vermont Department of Health Activities

This section gives an overview of HIV prevention-related programs and activities administered by the Vermont Department of Health. Where applicable, this section also includes the Vermont Community Planning Group's recommendation(s) for implementation of these programs.

- Community Planning
- Partner Counseling and Referral Services
- Capacity Building
- Counseling and Testing
- Surveillance and Research
- Health Education/Risk Reduction (HE/RR)
- Evaluation
- Collaboration and Coordination
- Quality Assurance
- Perinatal Transmission

APPENDICES

Appendix 1: Epidemiological Profile

An overview of the epidemic in Vermont. The full profile itself is attached as Appendix 1 to the Comprehensive Plan.

Key findings from this section include the following:

The Epidemic in Vermont

- At the end of 2002, nearly 400 persons were known to be living in Vermont with HIV or AIDS.
- The actual number of persons in Vermont with HIV/AIDS, including those who have not yet been diagnosed, has been estimated by the Centers for Disease Control and Prevention to lie between 590 and 660.
- Chittenden County, where about a quarter of the state's population resides, was the county of residence reported by nearly half of the persons living in Vermont with HIV/AIDS. Chittenden County had approximately 115 persons per 100,000 population living with HIV/AIDS, while most other counties had prevalence rates between 25 and 50 per 100,000.
- The majority of those living with HIV and AIDS in Vermont are among the white, non-Hispanic population, a population which comprises the majority of the state's population.
- For the period 2000-2002, persons between the ages of 30 and 49 represented well over half of newly diagnosed AIDS cases; 77 percent of those living in Vermont with HIV/AIDS at the end of 2002 were within this age group.

Communities of Color

- Blacks represented 10 percent of the population living with HIV/AIDS at the end of 2002, and 15 percent of newly diagnosed AIDS cases during the three-year period 2000-2002. Less than one percent of the state's population is black.
- While there was an overall decline in AIDS cases from 1997-1999 to 2000-2002, newly diagnosed AIDS cases among Hispanic men and women increased.

Women

- The female proportion of those newly diagnosed with AIDS nearly doubled from 1997-1999 to 2000-2002.

Modes of Exposure

- White men who reported having had sex with men continue to be the group most affected by the epidemic in Vermont.
- The proportion of cases attributed to injection drug use has declined, while the proportion reporting heterosexual contact with a person or persons with, or at increased risk for, HIV infection has increased.
- More than half of persons with new AIDS diagnoses during 2000-2002 reporting heterosexual contact as a risk factor were female. The predominant transmission mode reported among females newly diagnosed with AIDS during 2000-2002 was heterosexual contact, while for 1997-1999, most females reported injection drug use as mode of exposure.
- At the end of 2002, roughly 75 percent of adults living in Vermont with HIV/AIDS reported men who have sex with men and/or injection drug use as transmission mode.

Appendix 2: Prevention For Positives - Interventions Fact Sheets

This Appendix supplements Section 4 of the Comprehensive Plan, Prevention for Positives. It contains a collection of informational sheets describing each of the interventions considered by the CPG for HIV prevention efforts targeting people living with HIV/AIDS.

Appendices 3 and 4: MSM and IDU Needs Assessment

These appendices include the one survey instrument and three interview guides used as part of the Community Planning Group's needs assessment efforts in 2002 (regarding the HIV prevention needs of Injection Drug Users) and 2003 (for MSM). In both cases, interviews and/or surveys were conducted among members of the target population, as well as with service providers who work with that population. Findings from these projects are included in Section 2 of this Comprehensive Plan (Community Services Assessment).

- END OF SECTION 1: INTRODUCTION AND SUMMARY -

SECTION 2: COMMUNITY SERVICES ASSESSMENT

*In this section:
 Resource Inventory
 Needs Assessment
 Gap Analysis*

RESOURCE INVENTORY

Department of Health Funded Community-based HIV Prevention Programs

Since 1993, the Vermont Department of Health AIDS Program has funded HIV prevention programs targeting members of priority populations. In 1994, an annual competitive grants process that included a community review panel was instituted. Each year, the HIV prevention programs funded by the AIDS Program have become increasingly more sophisticated as they have moved away from information dissemination to programs that incorporate behavioral science in their design.

The following programs were funded in 2004:

Grant Amount (\$)	Target Population	Interventions
CLI = Community Level Intervention CTR = HIV Counseling and Oral Testing GLI = Group Level Intervention HC/PI = Health Communication/Public Information ILI = Individual Level Intervention PCM = Prevention Case Management		
AIDS Community Resource Network (ACORN)		
10,134.50	IDU	CTR, GLI, HC/PI, Outreach, PCM
21,782.50	MSM	CLI, CTR, GLI, HC/PI, ILI, Outreach, PCM
17,100.00	Youth	CTR, HC/PI, Outreach
	Incarcerated men and women	GLI, HC/PI

- continued next page -

Grant Amount (\$)	Target Population	Interventions (see key, previous page)
AIDS Project of Southern Vermont		
38,137.66	IDU	CTR, Outreach
43,847.67	MSM	CLI, CTR, GLI, HC/PI, as well as capacity building efforts for improving HIV prevention efforts targeting MSM of color, and MSM in rural areas
18,014.67	Women at increased risk through heterosexual sex	CTR, GLI
	Younger women, ages 13-24	CTR, GLI
Community Health Center of Burlington		
23,600.00	All	CTR
Howard Center for Human Services (Champlain Drug and Alcohol Services)		
100,000	IDU	CTR, PCM
IMANI Health Institute		
37,711.00	Incarcerated individuals	CTR, GLI, Outreach
Outright Vermont		
46,363.00	GLBTQ Youth ages 13-22	GLI, HC/PI, ILI, Outreach
Planned Parenthood of Northern New England		
29,600.00	All	CTR
R.U.1.2? Community Center / VTM4M Project		
30,690.00	MSM	HC/PI, HC/PI, and Capacity Building for internet outreach
Spectrum Youth and Family Services		
20,000.00	Runaway and homeless youth	CTR, HC/PI, ILI, Outreach
Twin State Network		
24,208.00	Women at increased risk	GLI, ILI
23,156.00	Women living with HIV	GLI, ILI
Vermont Committee for AIDS Resources, Education and Services (CARES)		
26,651.00	IDU	CTR, GLI, Outreach
19,127.00	MSM	CTR, GLI, Outreach
25,559.00	Individuals at high risk through heterosexual contact	CTR, GLI, Outreach
16,424.00	People Living with HIV	CLI, Outreach
Vermont Harm Reduction Coalition (VHRC)		
50,000.00	IDU	HC/PI, ILI, PCM
Vermont PWA Coalition		
21,333.00	People Living with HIV	GLI – workshops/retreat
Women of Color Alliance		
13,333.00	Women of color	HC/PI; Capacity building (diversity and cultural competence training to service providers)

DISTRIBUTION OF HIV PREVENTION AWARDS BY POPULATION, FY2004

GRANTEE	IDU	MSM	Heterosexual	People with HIV/AIDS
ACORN	10,134.50	21,782.50	17,100.00	
AIDS Project of Southern VT	38,137.66	43,847.67	18,014.67	
Howard Center for Human Services	100,000.00			
IMANI Health Institute			37,711.00	
Outright Vermont <i>[plus \$41,516 attributed Other, for GLBTQ youth]</i>		4,847.00		
Spectrum Youth and Family Services			20,000.00	
Twin State Network			24,208.00	23,156.00
R.U.1.2? Community Center		30,690.00		
Vermont CARES	26,651.00	19,127.00	25,559.00	16,424.00
Vermont Harm Reduction Coalition	50,000.00			
Vermont PWA Coalition				13,333.00
TOTAL:	\$224,923.16	\$120,294.17	\$142,592.67	\$60,913.00

DEPARTMENT OF HEALTH FUNDED SUPPORT PROGRAMS

In addition to grants for community-based prevention and related activities, the Department of Health AIDS Program administers a number of other programs.

AIDS Medication Assistance Program (AMAP)

AMAP provides financial assistance for the purchase of prescription medications to low income Vermonters living with HIV disease. The medications for which this program provides funding are listed on the AMAP formulary. For eligible people, this program helps pay for medication even if the client has alternate coverage. All current protease inhibitors and FDA approved antiretrovirals are included in the formulary.

Counseling and Testing

Vermont's Counseling, Testing and Referral Program (CTR) presently includes a total of 40 locations statewide. These sites are a combination of AIDS Service Organizations, publicly-funded health clinics, hospitals, private medical providers, family planning clinics, minority-based community organizations, youth-based community organizations, drug treatment facilities, and correctional facilities. Of these 40 sites, 17 offer free anonymous oral testing, 14 offer free anonymous blood testing, and 13 offer free confidential blood testing. The anonymous oral sites are customized to reach those most at risk in non-medical and outreach settings.

Partner Counseling and Referral Services

PCRS is the systematic approach and anonymous notification of sex and needle-sharing partners of HIV-infected clients. Contacts are informed of their possible exposure to HIV and given information on HIV testing. Other referrals for care and support are given as needed. (For more information on PCRS, see Section 9B of this Comprehensive Plan.)

Public Health Nurses HIV/AIDS Education Program

A statewide system of Public Health Nurse (PHN) HIV Educators is trained to provide linkages between the Vermont Department of Health and community agencies that serve communities at risk. They assist Community Public Health programs, other state agencies, and community based organizations to integrate HIV prevention into already existing programs. This includes a new emphasis on incorporating principles of harm reduction into HIV prevention and being a referral source for Counseling and Testing Services.

This program coordinates quarterly trainings, monitors monthly activities, provides updates, and supervises the activities of PHNs located in each of 12 health districts. The PHNs each work for a total of three to four hours per week: disseminating HIV/AIDS prevention/risk reduction information in their communities and schools; working with the Advisory Boards of various AIDS Service Organizations (ASOs) and Community Based Organizations (CBOs); providing in-service education programs to agencies such as the staff in local health offices to integrate risk reduction information into their existing programs. This program also emphasizes access to prevention

services for women and children in hard-to-reach communities including racial and ethnic minorities and low-income individuals.

Early Intervention

The Early Intervention Program targets newly HIV-diagnosed individuals and offers them an entry to HIV specialty care. This service, which serves as a bridge to treatment for people with HIV who might not otherwise have access to primary and secondary prevention services, is available through any primary care provider or specialist in the state. In 2003, twelve people accessed early intervention services.

Hotline

The Department of Health also operates a statewide toll-free AIDS hotline, with TTY access, for HIV/AIDS information during business hours, providing general information, referral, testing information, and prevention counseling. The HIV/AIDS program also maintains the STD Hotline which covers all sexually transmitted infections, including Hepatitis B and C. A total of 260 calls were completed through the AIDS hotline in 2000.

HIV/AIDS Program Clearinghouse

A total of 266 requests for information were made and completed by the clearinghouse at the HIV/AIDS Program in 2003. 293,292 male condoms were distributed along with 6,193 female condoms, 6 Female Condom training kits, 11,910 packets of lubricant, 560 bleach kits, 10,043 dental dams, 2000 latex and non-latex gloves and 3,796 non-latex male condoms.

With regards to educational material 2,783 Youth brochures were distributed through community organizations and the Public Health Nurses Program, as well as 526 prevention brochures targeting African-Americans; 270 targeting Latinos/Latinas; 1,334 dealing with abstinence; 1,360 targeting users of injection drugs; 95 targeting Transgender; 977 targeting Pregnancy & HIV; 3,635 targeting Hepatitis; and 9,899 targeting other STDs.

RELATED PROGRAMS AND SERVICES

State of Vermont

Department of Education

Receives approximately \$185,000 annually from the CDC to support HIV/AIDS education and prevention activities for school-aged youth. These funds are used primarily to support professional development and technical assistance for those who work with youth, training on effective curriculum, curriculum and assessment development, standards-based education, and salaries for the Program Coordinator and staff. This funding also supports regionally-based health

education resource centers and the acquisition of current HIV prevention materials for statewide use.

Department of Social and Rehabilitation Services (SRS)

Provides risk reduction services to youth in foster care and other forms of state care/custody.

HIV/AIDS Prevention/Education/Services

HIV/AIDS Services Advisory Council

The HASAC is the HIV/AIDS services equivalent to the Community Planning Group, which focuses on HIV prevention. The HASAC is a community-based advisory board, implemented by the Vermont Department of Health, and charged with examining HIV/AIDS services in Vermont, determining the needs of people living with the virus, and reporting its findings and recommendations back to the state.

Vermont HIV/AIDS Education Network

Administered by the Northern Vermont Chapter of the American Red Cross. In addition to Department of Health funded HIV/AIDS educator trainings, the Network also publishes a bi-monthly newsletter; provides HIV/AIDS training for alcohol and substance abuse providers; as well as technical assistance and other training for educational and other institutions.

Vermont People living With AIDS (PWA) Coalition

In addition to a Department of Health partially funded retreat, the Coalition provides a variety of services including healthcare advocacy, workshops, an annual retreat, and a newsletter for people living with HIV/AIDS in Vermont. The organization also runs a buyer's cooperative for nutritional supplements, with available scholarships for people living with HIV/AIDS.

Hilltop Ministries

Hilltop Ministries, Inc., a non-profit, faith-based, community organization receives \$137,900 yearly in direct funding from the CDC for a four-year cooperative agreement targeting African American Youth in Vermont with street outreach and group-level interventions.

Healthcare

Community Health Center

In addition to the Vermont Department of Health-funded counseling and testing efforts, CHC, with its office in Burlington, provides quality primary care at a reasonable cost and emphasizes a philosophy of care based on prevention and education. Interpretive services are available for Vietnamese and Bosnian

speakers, with additional services available on demand through the Vermont Refugee Resettlement Project.

Comprehensive Care Clinics

The Comprehensive Care Clinics, located in four locations throughout Vermont (St. Johnsbury, Brattleboro, Burlington, and Rutland), offer a full range of medical services for people living with HIV/AIDS. The Comprehensive Care Clinics are teams of health professionals consisting of physicians, nurses, social workers, dietitians and support personnel. Through Ryan White funding, they provide early intervention services (including Orasure counseling and testing), and treatment adherence.

Dartmouth Hitchcock Medical Center HIV/AIDS Program

The DHMC in Lebanon, New Hampshire, offers a full range of medical services for people living with HIV/AIDS. Its team consists of physicians, nurses, social workers, and support personnel. Mental health services are also available on-site and by referral. Other referral sources include those that provide drug/alcohol treatment, case management, pastoral counseling, support groups, and emergency food and shelter. Other services through DHMC include HIV prevention education; Prevention Case Management; and HIV Counseling and Testing.

Planned Parenthood of Northern New England

In addition to the Vermont Department of Health-funded HIV Counseling and Testing program at 13 offices around the state, Planned Parenthood also offers an array of sexual health education programs, and counseling services.

Veterans Medical Center

The Veterans Administration Hospital in White River Junction has an HIV/AIDS treatment program, which is operated in conjunction with the Dartmouth-Hitchcock Medical Center in New Hampshire.

Substance Use/Abuse

Syringe Exchange Programs

Vermont now has three syringe exchange programs in operation. Because of limitations on use of federally provided funds, these programs are independently funded. They are operated respectively by Champlain Drug and Alcohol Services in Chittenden County, by Vermont CARES in Caledonia County, and by the AIDS Project of Southern Vermont in Windham County.

Pharmacological Opiate Addiction Treatment:

Buprenorphine

- The University of Vermont Substance Abuse Treatment Center has an opiate treatment program offering comprehensive, outpatient treatment for opioid dependence to both adults and adolescents. Clients receive pharmacotherapy using a medication known as buprenorphine. Individuals are required to attend the clinic 3-7 times per week to receive their medication; all clients also receive 3-8 months of behavioral counseling from Substance Abuse Counselors.
- Buprenorphine is also available through certified private healthcare providers.

Methadone

- The Chittenden Center, part of University Health Care in Burlington, offers methadone-based pharmacological treatment for opiate addiction. It is the only on-site methadone clinic in the state.
- A contract has been awarded by the Office of Alcohol and Drug Abuse Programs for implementation of mobile methadone provision in Vermont's Northeast Kingdom (Orleans, Essex, and Caledonia Counties). This service is expected to begin in 2005.

Vermont Department of Health Office of Alcohol and Drug Abuse Programs

Provides funding and training for substance abuse treatment facilities throughout the state, including training to ensure that clients entering drug and alcohol treatment programs receive HIV education.

The Office of Alcohol and Drug Abuse Programs lists the following Approved Vermont Substance Abuse Treatment Centers, locations, and services:

ADAP Approved Substance Abuse Treatment Centers

Addison County	
Counseling Service of Addison County	Outpatient
Bennington County	
United Counseling Service	Outpatient, Project CRASH
Northshire UCS	Outpatient
Chittenden County	
Champlain Drug and Alcohol Services	Outpatient, Project CRASH
Adolescent Family Services	Outpatient
University of VT Treatment Research Ctr.	Outpatient, Adolescent
Day One	Intensive Outpatient, Adolescent
Howard Center for Human Services	Outpatient
Maple Leaf Farm	Residential, Detoxification
Center Pont	Adolescent, Outpatient, Intensive Outpatient
Act One – Bridge Program	Residential, Detoxification
Family Therapy Associates	Outpatient
Lund Family Center	Adolescent, Outpatient
Spectrum Youth and Family Services	Adolescent, Outpatient
The Chittenden Center	Methadone
Franklin/Grand Isle Counties	
Champlain Drug and Alcohol Services	Outpatient, Adolescent, Project CRASH
Lamoille County	
Copley Hospital Behavioral Medicine	Outpatient, Adolescent, Project CRASH
Northeast Kingdom – Orleans/Essex/Caledonia Counties	
Tri-County Substance Abuse Services	Outpatient, Adolescent, Intensive Outpatient, Project CRASH
Orange County	
Clara Martin Center	Outpatient, Adolescent
Rutland County	
Evergreen Services	Outpatient, Intensive Outpatient, Project CRASH
Serenity House	Residential, Detoxification, Halfway
Spectrum Youth and Family Services	Adolescent, Outpatient
Washington County	
Central Vermont Substance Abuse Services	Outpatient, Adolescent, Project CRASH
Maple Leaf Counseling	Intensive Outpatient
Washington County Youth Services	Adolescent, Outpatient

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ADAP Approved Substance Abuse Treatment Centers (continued)

Windham County	
Brattleboro Retreat	Residential
Phoenix House Brattleboro Center	Halfway, Outpatient, Adolescent
Starting Now	Intensive Outpatient
Youth Services of Windham County	Outpatient, Adolescent
Health Care & Rehabilitation Services of Southeastern Vermont	Outpatient, Intensive Outpatient, Adolescent
Windsor County	
Health Care & Rehabilitation Services of Southeastern Vermont	Outpatient, Adolescent, Project CRASH
Quitting Time	Intensive Outpatient
Out of State/nearby	
Phoenix Marathon Center (Dublin, NH)	Residential, Outpatient
Odyssey House, Inc. (Hampton, NH)	Residential, Outpatient
Conifer Park (Glenville, NY)	Detox, Residential, Family

NEEDS ASSESSMENT

**Men who have Sex with Men (MSM)
Injection Drug Users (IDU)
Heterosexual at Increased Risk
People Living with HIV/AIDS (PWA)**

MSM: NEEDS ASSESSMENT

This section describes the activities and findings of the CPG's MSM Needs Assessment Committee, and the recommendations made by the full CPG as a result of that process. These activities took place between September 2002 and August 2003.

- **MSM Service Provider Interviews**
 - The CPG's MSM committee developed a phone interview/survey instrument, for implementation with service providers. The interview questions focused on the perceived HIV prevention needs, general health concerns, and the population characteristics among those MSM providers are seeing in their work. (A copy of this instrument is included as Appendix 3B to the Comprehensive Plan.)
 - 14 phone interviews were conducted with various service providers (including social organizations, human services, and HIV prevention providers) around the state. For reasons of feasibility, and due to limited resources, these provider interviews were conducted only with organizations that focus in some way on reaching MSM. This project did not attempt to speak with all organizations serving MSM—for example, substance abuse providers, mental health providers, and others who are no doubt seeing MSM, but are not specifically targeting them in their work.
- **MSM Survey**
 - The CPG's MSM committee developed a brief written survey for implementation among Vermont's MSM population. In addition to demographic information, the survey focused on three very basic questions: What are the primary ways MSM are spending their free/social time? What are the ways in which MSM would most *like* to spend their free/social time? What are the primary health concerns among MSM? The intention was to begin examining ways in which HIV prevention messages and services can best reach MSM, and also ways in which these efforts can most feasibly be integrated with other activities and messages that are naturally interesting to members of the population. (A copy of this survey is included as Appendix 3A to this Comprehensive Plan.)
 - 7,000 surveys were printed and distributed, the bulk of them through Vermont's statewide LGBTQ newspaper, *Out in the Mountains*. Others were

passed out through service providers and social networks, and at the 2003 Gay Pride festival. The survey was also posted on VTM4M.org, a health-focused website for MSM in Vermont. A total of 204 surveys were completed and returned.

- Gathering and synthesis of additional data (epidemiological profile, HITS survey)
 - The CPG's MSM committee looked at results from the above-mentioned surveys, along with available epidemiological information and behavioral data, and used these resources to create updated recommendations for HIV prevention efforts targeting MSM in Vermont.

Both survey instruments can be found in Appendix 3 of this Comprehensive Plan:

MSM Survey: See Appendix 3A

MSM Service Provider Interview Guide: See Appendix 3B

Results of the MSM Survey and Provider Interviews are on the following pages.

MSM SURVEY RESULTS – pg. 1 of 4

What are the primary ways you spend your free time?

Rank	Choice	#	%	% below*	Rank below*
1	Small social events	112	55%	31%	2
2	Going out elsewhere	109	53%	14%	8
3	Arts/Cultural events	89	44%	27%	3
4	Hobbies	72	35%	14%	8
5	Outdoor activities	62	30%	20%	5
6	Internet	60	29%	2%	21
6	Volunteer work	60	29%	8%	14
8	Sports/Exercise	56	27%	13%	10
9	Religious/Spiritual gatherings	37	18%	8%	15
10	Shopping	34	17%	7%	16
11	Going to a bar	29	14%	20%	6
12	Other	27	13%	5%	17
13	Large social events	25	12%	33%	1
14	Political work	21	10%	12%	11
15	Parenting/Mentoring	17	8%	5%	17
16	Dating/Looking for a partner	12	6%	5%	17
16	Adult ed	12	6%	19%	7
16	Support groups	12	6%	9%	12
19	Connecting/Cruising for sex	10	5%	9%	12
20	Individual/Couples counseling	5	2%	4%	19
21	Telephone Chat Lines	<3	--	4%	19

* “% Below” and “Rank Below” refer to the following survey question (next page), where respondents were asked to rank the same list of activities in terms of things they don’t currently participate in but would like to. These columns are included here for comparison purposes.

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2. Which of the following do you not participate in but would most like to if it was available? Note: 39 of the 204 survey respondents did not reply to this question)

Rank	Choice	#	%		% above*	Rank Above*
1	Large social events	55	33%		12%	13
2	Small social events	52	31%		55%	1
3	Arts/Cultural events	45	27%		44%	3
4	Dating/Looking for a partner	37	22%		6%	16
5	Outdoor activities	34	20%		30%	5
6	Going to a bar	33	20%		14%	11
7	Adult ed	32	19%		6%	16
8	Going out elsewhere	23	14%		53%	2
8	Hobbies	23	14%		35%	4
10	Sports/Exercise	22	13%		27%	8
11	Political work	20	12%		10%	14
12	Connecting/Cruising for sex	15	9%		5%	19
12	Support groups	15	9%		6%	16
14	Volunteer work	14	8%		29%	6
15	Religious/Spiritual gatherings	13	8%		18%	9
16	Shopping	12	7%		17%	10
17	Parenting/Mentoring	9	5%		8%	15
17	Other	8	5%		13%	12
19	Individual/Couples counseling	7	4%		2%	20
19	Telephone Chat Lines	6	4%		--	21
21	Internet	4	2%		29%	6

* “% Above” and “Rank Above” refer to the previous survey question (see previous page), where respondents were asked to rank the same list of activities in terms of how they actually spend their free time. These columns are included here for comparison purposes.

MSM SURVEY RESULTS – pg. 3 of 4

What health topics are of greatest interest to you?

Rank	Choice	#	%
1	HIV/AIDS	118	56%
2	Physical fitness	95	47%
3	Diet/Nutrition	82	41%
4	Mental health	75	37%
5	Cancer	54	27%
6	Alternative therapies	52	26%
7	How to find a GLBT-friendly provider	48	24%
8	Other STDs	40	20%
9	Diabetes	38	19%
10	Prostate health	32	16%
11	Heart disease	29	14%
12	Hepatitis	26	13%
13	Substance use/abuse/addiction	24	12%
14	Tobacco cessation	23	11%
15	Alzheimer's	22	11%
16	Other addictions	14	7%
17	Other	7	3%

How did you hear about this survey?

Out in the Mountains	39%
Other	22%
Community organization/agency	18%
Word of mouth	10%
Email	9%
Case worker	7%
Internet	3%
Advertisement	2%

Would you describe yourself as...

Gay	86%
Bisexual	9%
Queer <i>(not mutually exclusive to other responses)</i>	10%
Other	4%
Transgender	3%
Heterosexual	2%

MSM SURVEY RESULTS – pg. 4 of 4

Highest grade completed

College graduate/post-grad	59%
Some college	25%
High school or GED	11%
Some high school	1%

Annual household income

<\$12K	9%
12-24K	24%
24-36K	19%
36-48K	12%
48K+	35%

Number of people in household

- 1: 54%
- 2: 33%
- 3: 9%

Race

- White: 93%
- American Native/Alaskan Native: 4%
- Black/African American: <3
- Asian: <3

Ethnicity

- Not Hispanic/Latino: 96%
- Hispanic/Latino: 4%

HIV Status

- HIV-: 79%
- HIV+: 13%
- Don't know: 8%

end of MSM Survey Results

MSM SERVICE PROVIDER INTERVIEWS: RESULTS, page 1 of 11

I. PROVIDER PROFILE

The following organizations participated in the survey:

Organization	Type of Services	Service Area
AIDS Community Resource Network (ACORN)	AIDS Service Organization	Orange and Windsor County (and 2 counties in NH)
AIDS Project of Southern Vermont – Prevention	AIDS Service Organization	Bennington and Windham County
AIDS Project of Southern Vermont – Direct Services	AIDS Service Organization	Bennington and Windham County; southern Windsor County
Comprehensive Care Clinic	Health/ HIV/AIDS services	Vermont (Clinics in Burlington, Brattleboro, Rutland, and St. Johnsbury)
Faerie Camp Destiny	Spiritual, Educational Community	Vermont
Outright Vermont	Queer Youth (Cultural, Educational, Health, Social, etc.) Services	Vermont
Pride Healthcare of Southern Vermont	Healthcare	--
Private Therapist	Mental Health	---
PWA Coalition	HIV/AIDS-related advocacy; Social; Educational; other services	Vermont
R.U.1.2? Community Center	Education; Health; Community Organizing; Social; for the LGBT community	Primarily Champlain Valley and Washington County
SafeSpace	Advocacy, Referral, Legal for LBGTQQ survivors of domestic violence, sexual assault, and hate crimes	Vermont
Vermont CARES	AIDS Service Organization	10 Vermont Counties (not Orange, Windsor, Bennington, or Windham)
Vermont Gay Social Alternatives	Social	Vermont
VTM4M (A project of the Chronic Conditions Information Network)	Internet-based services (education, referral, HIV/AIDS information, social) for MSM and those who are transgender	Vermont

MSM SERVICE PROVIDER INTERVIEWS: RESULTS, page 2 of 11

What challenges or issues do you face in providing services to MSM?

n=14	Issue	Selected Comments
5	No physical gathering space, especially outside of a bar setting	No social focal point; no sense of community among MSM Lack of safe venues where men can be discreet but also have a space that culturally represents who they are
5	Lack of providers (especially those who are knowledgeable, culturally competent, able to make appropriate referrals for MSM); Distrust among MSM of service providers	We have to jump a lot of hurdles to make sure they feel safe to be in touch with us Referrals are pretty useless—too many gates to go through
4	Apathy; HIV education burnout; Finding fresh and interesting ways to engage MSM on this issue; Difficult to engage young MSM in particular	How do we engage them? Get them to listen to old, stale messages? Raise their awareness about the seriousness of HIV? Everyone has the information – How do we address the next level of prevention?
4	Rural limitations: especially the difficulty of doing outreach in this environment, and the lack of transportation	Many MSM are going to other areas (Boston, Montreal) to socialize and connect
3	Lack of services awareness; difficulty promoting programs	We depend heavily on word of mouth for program awareness
3	Rise in transmission	Especially among non-gay identified MSM
2	Internalized sense of oppression (Self-oppression) keeping men from accessing services; Closeted men difficult to reach	
2	The difficulty of implementing behavior change, in general	Negative influence of peer pressure on risk behavior; People will not change behavior unless the substituted behavior is of acceptably equal value

How can the above-named challenges be addressed?

- Empowerment program
- More funding, especially for a gathering space
- Working against homophobia
- Provider education (cultural competency for MSM)
- More opportunities for providers to network, share strategies, etc.
- More research on successful approaches used outside of Vermont
- Find creative outreach methods, ways of reaching MSM physically and cognitively
 - Develop an infrastructure (e.g., reaching MSM through gyms, etc.)
 - Find ways to reach non-gay identified MSM

MSM SERVICE PROVIDER INTERVIEWS: RESULTS, page 3 of 11

What resources would help you better serve MSM?

	Resources	How would you use the resources?
12	Funding	Most common responses: <ul style="list-style-type: none"> • Marketing/Advertising; • Increase staff; • Increase staff salaries; • More programming/Broader reach around the state; • Outreach/Increasing program awareness and participation; • Build organization's sustainability/Finding multiple year grants
11	Staff/Human Resources	Most common responses: <ul style="list-style-type: none"> • Dedicated MSM program staff • Increased capacity for outreach to MSM
10	Training/T.A.	Most common responses: <ul style="list-style-type: none"> • Strategic and/or Project Planning • Networking/Collaboration with other programs • Skills development for staff (negotiation skills, harm reduction proficiency, client counseling)
7	Print Materials	<ul style="list-style-type: none"> • Outreach and publicity materials to promote our services • Large supply of brochures that are sex positive, accurate, correct • Jazzy new stuff to attract attention; especially youth-specific materials • Health info that goes beyond HIV, to hepatitis prevention, vaccination and STD prevention
5	Other Desired Resources	<ul style="list-style-type: none"> • Networking opportunities/More statewide coordination among MSM providers • Van - transportation to events and/or to travel as a group to events (e.g., Pride); or for mobile counseling/testing • Coordinated outreach effort to reach MSM

How do MSM access your services?

	Never	Rarely	Sometimes	Frequently
By Phone	0	1	2	7
By appointment	0	2	3	5
At Community/Public	1	0	6	3
Events				
Referral/Word of Mouth	0	0	0	10
Outreach	0	2	4	4
Website	1	1	6	2
Other (specify):	<ul style="list-style-type: none"> • Person to person • Through other providers (medical, mental health, substance abuse) • Email • People seek us out • <i>Out in the Mountains</i> and other media 			

MSM SERVICE PROVIDER INTERVIEWS: RESULTS, page 4 of 11

SECTION II. DESCRIPTION OF MSM

In general terms, how would you describe the MSM you work with/serve?

<p>Self-identity: <i>Gay, bisexual, trans, hetero, etc.</i></p>	<p>Most common response: Gay. All providers indicated that all or most of the MSM they serve identify as gay.</p> <p>Other responses:</p> <ul style="list-style-type: none"> • A few bisexual, even fewer transgender and heterosexual • Some bisexual, and lots of questioning men • 16% transgender (9% MTF, 6% FTM) • Some bisexual; Seeing an increase in MSM who don't identify as gay • One outreach worker reaching a large transgender population • See quite a few transgender (more MTF than FTM perhaps) • Lots of bisexual and questioning
<p>Age</p>	<p>Most common responses: Nine of thirteen respondents indicated that the bulk of the MSM they serve are over 30 years old.</p> <p>Other responses:</p> <ul style="list-style-type: none"> • Mid-20s through 45 • 19-60 (no concentration in one bracket) • 78% are over 22; 22% are 22 or younger • 21-63
<p>Race/Ethnicity</p>	<p>Most common response: All respondents indicated that all or most of the MSM they serve are White.</p> <p>Other responses: Among those who reported reaching MSM of color, African American MSM are reported as the most frequent contact, followed by Hispanic MSM and Native American MSM.</p>
<p>Other sociodemographic characteristics <i>Socioeconomic status, HIV status, etc.</i></p>	<p>Responses regarding socioeconomic status were mixed, but there seemed to be a vague dichotomy between lower SES men accessing direct services of varying kinds, and middle/upper middle class men accessing social outlets.</p> <p>Many providers made mention of the lack of financial resources among HIV+ MSM accessing services, and the preponderance of financial challenges for them.</p>
<p>Risk behaviors <i>Engaging in sexual or needle-related HIV risk, or other risk behaviors</i></p>	<p>Most common responses: Most providers indicated limited knowledge of the risk behaviors among the MSM they serve. Among known risks, much more seems to be known about sexual behaviors than needle use. Also, most providers indicated that the MSM they serve are well-educated about HIV risk behaviors, and that a lack of this knowledge is not the problem.</p> <p>Other responses:</p> <ul style="list-style-type: none"> • High awareness of risk behaviors but not uniform action based on that knowledge • Oral sex without condoms • No-strings-attached relationships • Multiple partners • Domestic and sexual violence • High degree of substance use/abuse • Injection of hormones and steroids

MSM SERVICE PROVIDER INTERVIEWS: RESULTS, page 5 of 11

Do you work with, or come into contact with MSM who are in any of the following categories?

	n= 12					
	0 not at all	1 a little	2 some	3 a lot	4 exclusively	? don't know
Youth (13-24)	1	5	5	0	1	0
Older (55+)	0	4	6	2	0	0
HIV+	1	1	4	1	3	2
Men in serodiscordant relationships	1	2	5	0	0	4
Men of color*	0	9	3	0	0	0
Men who are substance users and/or abusers	0	1	5	4	0	2
Injection Drug Users (current or recent)	2	3	2	0	0	5
Non-gay- or bisexual-identified	4	5	3	0	0	0
Living at or below the poverty line	0	0	5	6	0	1
Homeless/seeking temporary shelter	2	6	1	2	0	1
Incarcerated/involved with Corrections, Probation/parole	5	6	1	0	0	0
Dealing with mental illness/mental health issues	1	1	8	2	0	0
Dealing with or who have a history of violence or abuse (perpetrators or survivors)	0	5	5	0	1	1
Dealing with any other specific challenges (developmentally delayed, hard of hearing, visually impaired)	0	9	2	1	0	0
Other groups (<i>each mentioned once</i>): Questioning; Lack of access to health care/no insurance; Transgender						

*Re: Men of Color: Five organizations commented that among MSM of color, the majority were men who are African American, followed by those who are Hispanic. One provider also mentioned reaching men who are Native American. None indicated that they are reaching MSM who are Asian/Pacific Islander.

MSM SERVICE PROVIDER INTERVIEWS: RESULTS, page 6 of 11

What would you say are the major health-related issues or concerns among the MSM you serve?

n= 10	Health Concern	Comments
9	HIV/AIDS (prevention and care)	<ul style="list-style-type: none"> • Treatment as well as prevention • Interrelated with depression, substance abuse, hepatitis • Medical concerns related to HIV • Side effects from HIV medications • Opportunistic infections • HIV transmission (semen vs. sperm, oral sex, gum disease)
7	Mental Health/ Psychosocial Issues	<ul style="list-style-type: none"> • Living as a queer man in a homophobic society • Fear of violence • Relationships • Depression • Aging and prejudice against aging
4	Hepatitis C	
4	Substance/alcohol use and abuse	
3	Access to health care	<ul style="list-style-type: none"> • Finding a gay-friendly provider • Lack of insurance or financial resources
3	Oral sex/HIV transmission	

What are the other major concerns or priorities (non- health related) among the MSM you serve?

n= 10	Concern/Issue	Comments
5	Finances	<ul style="list-style-type: none"> • Low-paying jobs; just scraping by
5	Social isolation	<ul style="list-style-type: none"> • Lack of a sense of belonging • Finding a place in the community • Limited social opportunities in a small state
4	Discrimination/ Homophobia	<ul style="list-style-type: none"> • Variable family support, due to sexuality and/or HIV status • Fear of effect of homophobia on men's jobs and standing in the community • Diminishing but still present
3	Dating/Relationships	<ul style="list-style-type: none"> • Concerns about relationships as HIV+ men; negotiating HIV in a relationship
2	Violence/Abuse	<ul style="list-style-type: none"> • I suspect there is more physical abuse than I hear about, often triggered by backgrounds, which can have an impact now, whether or not abuse is currently happening • Violence and discrimination associated with being transgender
2	Housing	
2	Political concerns	

MSM SERVICE PROVIDER INTERVIEWS: RESULTS, page 7 of 11

III. SERVICES

What are the three best venues for reaching MSM with services/messages?

n= 13	Venue	Comments
7	Internet/Websites	
6	Smaller social events	<ul style="list-style-type: none"> • Potlucks, movie nights, gatherings • Things sponsored by an MSM program • Should be slightly structured with an unstructured feeling
5	Community events/Larger social events	<ul style="list-style-type: none"> • Should be well advertised • Dances • Things that will draw a variety of folks, especially new faces • Events scheduled and promoted through the electronic format • Events where the message is really clear (e.g. AIDS Walk); events designed to deliver a message; events that get media attention
4	Retreats	<ul style="list-style-type: none"> • e.g., PWA Retreat
3	Gay bars/Bars	<ul style="list-style-type: none"> • e.g., Rainbow Cattle Company, 135 Pearl
3	Media	<ul style="list-style-type: none"> • e.g., Hot Flashes newsletter • Newsletters • Out in the Mountains
3	On-site/Drop-in services/Office	<ul style="list-style-type: none"> • Have specific activities during drop-in hours
2	Referrals/Networking	<ul style="list-style-type: none"> • Referral through queer-identified agencies • Referral through other human services, law enforcement

How might HIV counseling and testing be increased among the population you serve? How might the barriers to testing be removed?

n= 13	Response	Comments
8	Outreach/Advertising/Awareness raising	<ul style="list-style-type: none"> • Advertising that appeals to the specific concerns of gay men in different age groups • Highly targeted advertising/ mailing campaigns • Dispel the myth that you need parental permission for testing • Let people know it's free and anonymous • Especially to reach rural areas, maybe through media (radio, signs in bathrooms, etc.) • Promote via Internet message boards, support groups, etc.
6	Mobile testing and/or increased on-site testing	<ul style="list-style-type: none"> • Create specific hours at specific sites • Testing at gay bars and public sex environments • A more comprehensive program within our agency, advertised in the newsletter • Mobile testing to reach pockets of people around the state • Physical space on-site for private counseling
5	Increase Orasure and/or rapid testing availability	Eliminate the waiting period
3	More MSM working as providers/ counselors	Train MSM as Peer Outreach Workers to provide testing in homes, etc.

MSM SERVICE PROVIDER INTERVIEWS: RESULTS, page 8 of 11

Are you aware of any issues facing MSM living with HIV with regard to medical care and services? Are they receiving the care they need? Why or why not?

All respondents indicated they thought that MSM living with HIV (who are aware of their HIV status) were generally receiving appropriate medical care in Vermont.

Some comments indicated a lack of culturally competent health care providers for MSM.

Additional comments included the following:

- As near as I can tell, they are, except if they have chosen against receiving care for lack of interest in available treatment.
- Economic factors may be barriers for some (lack of health care, insurance, etc.)
- Anecdotally -- It can be difficult to get good care, as in non-judgmental, up-to-date, knowledgeable and respectful practitioners
- There is no outreach regarding hepatitis among people living with HIV
- There is a lack of sensitivity to transgender issues in care;
- There is a lack of MSM case workers to serve MSM
- Many hoops to jump through for medications

What services or community functions do the MSM you serve want, but aren't receiving? What are the unmet needs?

n= 11	Response	Comments
7	Social outlets	<ul style="list-style-type: none"> • Things outside of the bar scene • Hangout opportunities with like-minded men – more powerful than any workshop or message could be • Parties • Places to meet men • Especially outside of Montpelier and Burlington
3	Health care/ Advocacy	<ul style="list-style-type: none"> • Primary care providers trained and advocating with their patients for regular rectal exams • Knowledgeable and queer-youth-friendly, willing to have sex/sexuality discussions not steeped in taboo • Whole health approach to services in general • Comfortable health care provider settings
Other responses: <ul style="list-style-type: none"> • Gyms • Services/Support in general outside Burlington • Support groups • Emergency shelter • Financial support • More GLBT organizations statewide in general • Religious/Spiritual (open and affirming) 		

MSM SERVICE PROVIDER INTERVIEWS: RESULTS, page 9 of 11

Would you say there are specific groups of MSM who are being well reached with HIV prevention services?

n= 14	Response	Comments
6	Men already accessing services/ Self-actualized men	<ul style="list-style-type: none"> • Southeast Vermont, gay-identified men who are seeking healthy communities • Youth who can access services where there are folks like them, similar to teen centers • Those associated with ASOs • People connected to LGBTQ-identified organizations • Those connected to existing MSM programs, and who are getting the message over and over
4	None	<ul style="list-style-type: none"> • No men are being well reached
2	Out men	<ul style="list-style-type: none"> • Men who are out and open, with high self-esteem

Who is NOT being well reached?

n= 13	Response	Comments
5	MSM in rural areas	<ul style="list-style-type: none"> • The lack of infrastructure is a big issue
5	Non-gay identified/ closeted MSM	<ul style="list-style-type: none"> • Those who don't identify with the queer movement
3	Young MSM	<ul style="list-style-type: none"> • How can we reach older teenagers, young adults, etc., who don't have an established sense of health as gay men? • 18-25 group • Teenagers
3	MSM not connected to services	

Are there specific geographic areas where services are most lacking, or more difficult to provide to MSM?

n= 13	Response	Comments
<p>The most common responses to this question were:</p> <ul style="list-style-type: none"> • Northeast Kingdom • Rutland/Rutland County • Rural areas in general • Everything outside Burlington <p>Other responses included:</p> <ul style="list-style-type: none"> • Bennington County • Franklin County • Deerfield Valley; Bennington • Anything outside Burlington • Most of VT • South of Waterbury and north of Rutland; Washington/Orange Counties; Ludlow, Tunbridge, etc.; • Southern Vermont 		

MSM SERVICE PROVIDER INTERVIEWS: RESULTS, page 10 of 11

**Do you provide any of the following services?
 Do you make referrals for these services? If so, to which organizations?**

Service	n=10		Refer to...
	Provide	Refer only	
ILI Individual Level Intervention	10	0	
GLI Group Level Intervention	8	1	ASOs
CLI Community Level Intervention	9	0	
CTS Counseling and Testing Services	6	4	Vermont CARES Department of Health Comprehensive Care Clinics Outright Spectrum Community Health Center (Burlington) State testing sites
Outreach	7	0	VENUE(S): Social events Schools/Colleges Community functions Gay bars Website Events with other organizations Homes Internet chat rooms, message boards, etc.
PCM Prevention Case Management	2	2	Peer outreach program Vermont CARES
Info/Hotline	7	3	Vermont CARES Other states National hotline Vermont state hotline
PI Public Information	8	2	Vermont CARES Out in the Mountains
NEP Needle Exchange Program	3	6	Local NEPs Vermont CARES
Online/Internet services	4	1	VTM4M.net

MSM SERVICE PROVIDER INTERVIEWS: RESULTS, page 11 of 11

Based on everything we've discussed, what do you think should be the priorities for implementing effective HIV prevention for MSM in your area? How could HIV prevention be more effective targeting MSM in Vermont?

n= 13	Response	Comments
7	Outreach (including but not limited to media)	<ul style="list-style-type: none"> • More creative outreach; find ways to reach MSM • Be more creative – e.g., utilize gyms and other venues • More “down and dirty” outreach at spots where MSM congregate • More connection needed on the local level • Street outreach • PSAs at the state level • Outreach messages in public places where men go, especially expanding into rural areas
5	Networking among service providers (with help from the state)	<ul style="list-style-type: none"> • More funding to organizations that aren't specifically HIV/AIDS but are drawing people for other reasons and can have prevention built into those programs • More collaborative efforts between the state and grassroots organizations • Greater coordination between MSM providers in Vermont • Coordination at the state level
4	Programs targeting young MSM	<ul style="list-style-type: none"> • Especially target young MSM in Burlington • Target 18-22 year old MSM • Combat the perception that HIV is not a problem in Vermont (Youth don't feel affected until it's “in my backyard”)
3	More sex positive material and dialogue	<ul style="list-style-type: none"> • Open and honest discussions about sex/sexuality
2	More internet outreach and programming	
2	Community building	<ul style="list-style-type: none"> • Increased sense of community among MSM • Large events/functions, well advertised • Use Mpowerment model • More community building activities, with enough publicity to pull in a lot of men
2	More MSM working as providers	<ul style="list-style-type: none"> • Greater degree of services by MSM for MSM (case management, prevention, etc.)
2	Address rural-specific issues	
2	Anti-homophobia work / Increase provider cultural competency	
2	Revitalize the discussion	<ul style="list-style-type: none"> • Address HIV/AIDS burnout in the MSM community • Summit or conference to talk about the reality that a lot of MSM don't want to talk about HIV anymore

end of MSM Service Provider Interview Results

INJECTION DRUG USERS: NEEDS ASSESSMENT

This section (Along with Appendix 4 of this Comprehensive Plan) describes the activities and findings of the CPG's IDU Needs Assessment Committee. These activities took place between September 2001 and August 2002.

IDU Needs Assessment: Collection of Data

The CPG worked with the Vermont Department of Health HIV/AIDS Program and Office of Alcohol and Drug Abuse Programs, to identify and examine Vermont-based resources for information and statistics wherever possible. Those resources included the following:

- IDU Needs Assessment Provider and Participant interviews (process and findings detailed on the following pages)
- 1999 Behavioral Risk Survey
A study conducted by the Vermont Department of Health (n=113), including inquiries regarding injection and sexual behaviors, as well as specific risk behaviors. This study was not previously reviewed by the CPG.
- "Injection Behaviors"
An overview of injection practices, prepared for the CPG by the Vermont Harm Reduction Coalition.
- "A Comprehensive Approach: Preventing Blood-Borne Infections Among Injection Drug Users."
A document produced by the Academy for Educational Development. The comprehensive approach described included four basic principles and eight strategies for prevention work with users of injection drugs. All were considered as the CPG worked to craft a core set of prioritized strategies of its own, taking into account the rural nature of Vermont, and the specific needs of IDUs in our state, to the extent that they may be distinctive from IDUs in other (specifically, more urban) areas.

IDU Needs Assessment: Participant and Provider Interviews

The Vermont CPG initiated a series of interviews, making contact with Vermont providers, as well as active and recent needle users who have lived for at least six months in Vermont. The purpose of these interviews was to answer the following questions:

- What do injection drug users think about the HIV prevention interventions they have used or received?
- What do injection drug users think about existing HIV prevention providers?
- What are the best venues for reaching high-risk injection drug users with HIV prevention interventions?
- What kind of message would IDUs listen to?
- What are the barriers to HIV prevention among injection drug users?
- What are injection drug users' service needs/priorities?

The project included interviews with 14 service providers and 10 active or recently active needle-using clients of various programs. This project provided the CPG with a great amount of first-hand information and relevant opinions from IDUs and their advocates, which had previously been a distinct gap in available, Vermont-specific information.

Additional information can be found in Appendix 4 of this Comprehensive Plan:

IDU Needs Assessment, Materials and Methods: See Appendix 4A

IDU Participant Interview Guide: See Appendix 4B

IDU Service Provider Interview Guide: See Appendix 4C

Basic findings from the IDU Needs Assessment interviews are on the following pages.

IDU NEEDS ASSESSMENT: BASIC FINDINGS, page 1 of 5

For a full listing of participant and service provider responses to the needs assessment interviews, contact the Vermont Department of Health HIV/AIDS Program. The following pages give an overview of basic findings, comparing responses between IDU participants and IDU service providers, where applicable.

TOP NAMED IDU-TARGETED HIV PREVENTION PRIORITIES			
	IDU Responses (n=10)	Service Provider Responses (n=14)	Total (n=24)
Needle/Syringe exchange	9	7	16
Improved/Increased treatment options	3	4	7
Methadone	2	4	6
Public information	4	2	6
Group level intervention/ support groups	5	0	5
Prevention Case Management	0	3	3
Change attitude toward risk behavior	0	2	2
<i>Other individual answers: One-on-one counseling; condom availability; food/housing; halfway houses; one-stop shopping; dual diagnosis (mental health) proficiency</i>			

IDU NEEDS ASSESSMENT: BASIC FINDINGS, page 2 of 5

TOP NAMED PRIMARY HEALTH CONCERNS FACING IDUs			
	IDU Responses (n=10)	Service Provider Responses (n=14)	Total (n=24)
Hepatitis C	3	13	16
HIV	2	8	10
Access (alienation, fear, lack of cultural competency)	4	3	7
Use of other substances	0	5	5
Abscesses/infections	1	4	5
Non-C hepatitis	2	2	4
Lack of funds	2	2	4
Diet/Nutrition	1	2	3
Other STDs	0	2	2
Hygiene	1	1	2
Overdose	1	1	2
Mental health issues	0	2	2
Smoking/Drinking	0	2	2
Chronic pain	0	2	2
<p><i>Other individual answers:</i> cotton fever; arm bruises; liver disease; heart problems; lack of substance abuse treatment options; withdrawal</p>			

IDU NEEDS ASSESSMENT: BASIC FINDINGS, page 3 of 5

What should HIV prevention services look like? (Participant responses only)	
Where should services be delivered?	<p><i>Most common answers:</i> Through needle/syringe exchange programs Through substance abuse treatment centers In public places; non-threatening environment</p> <p><i>Mixed opinions:</i> Doctor's office/Hospital</p>
How would you prefer to receive services?	<p><i>Most common answers:</i> Individually/one-on-one In groups/group level intervention Public information</p>
When is a good time to discuss HIV/AIDS?	<p><i>Most common answer:</i> When connected to services (needle exchange; treatment)</p>
When is not a good time to discuss HIV/AIDS?	<p><i>Most common answer:</i> Not when using/high</p>
Who should be providing these services?	<p><i>Most common answers:</i> Current or former user Person living with HIV People who are knowledgeable but not authoritative or judgmental People who are compassionate/sincere</p>

IDU NEEDS ASSESSMENT: BASIC FINDINGS, page 4 of 5

OTHER ISSUES/ THEMES

Some of the common themes and issues that emerged through the needs assessment interviews were as follows:

Access to services:

- Access to injection equipment as a primary barrier to HIV prevention and safer injection. This includes transportation issues; limited number of syringe exchange programs; limited hours of operation for syringe exchange and pharmacies; a reluctance among some to purchase injection equipment; age limits (18+) on syringe exchange.
- The difficulty of getting IDUs to actively connect with services; the impenetrable wall of addiction. The consequent need for outreach and other mobile services.
- Double stigma – injection drug use is heavily stigmatized in our culture, as is HIV. This population is often dealing with both; and providing information on either (or both) of these topics can be impeded by this stigma.
- “Not wanting to know” (about one’s HIV status) as a barrier to accessing services.
- Confidentiality in a small town/state, and the difficulty of maintaining it.
- Need for ongoing contact, trust and relationship between IDUs and service providers.

Treatment:

- Lack of long-term treatment and support; lack of transitional housing; lack of treatment options. All of these are barriers to providing a more comprehensive web of support to people who are needle users and/or opiate dependent in Vermont.
- The difficult but evolving relationship between harm reduction- and abstinence based- approaches (particularly in substance abuse treatment settings).

IDU NEEDS ASSESSMENT: BASIC FINDINGS, page 5 of 5

Risk Behavior:

- Sharing of injection equipment occurring in small groups and among couples – anecdotally reported as much more frequent than large groups, shooting galleries, etc.
- High degree of sexual risk behavior – trading sex for resources; sex while under the influence.

Other:

- Youth and Women were the most frequently named IDU sub-populations for whom there are particular HIV prevention needs and barriers.
- There is a high degree of involvement with the criminal justice system among IDUs, including people who are and are not incarcerated. This stems from the illegality of opiate use, as well as the criminal behaviors that can flow from the needs that come with an addiction.
- Hepatitis C as a greater concern among IDUs than HIV. It is more prevalent than HIV, more openly discussed, and seen by IDUs as a greater, more present, health threat.
- “People know about HIV – that isn’t the issue.” (i.e., the need for services and connections to service, not just didactic education)

end of IDU Needs Assessment Basic Findings

PEOPLE AT INCREASED RISK THROUGH HETEROSEXUAL TRANSMISSION: NEEDS ASSESSMENT

The past three-year cycle of work by the CPG has focused on MSM, IDUs, and to some extent, People Living with HIV/AIDS. The population of people at increased risk through heterosexual transmission has not been the subject of a formal needs assessment since the creation of the previous Vermont Comprehensive Plan in 2001. The CPG intends to turn its attention to this population in the coming work cycle.

PEOPLE LIVING WITH HIV/ AIDS (PREVENTION FOR POSITIVES): NEEDS ASSESSMENT

In early 2004, a series of meetings was held at the Vermont CPG's request. These meetings included representatives from the Vermont PWA Community, CPG, AIDS Service Organizations, other service providers working with PWA, and the Vermont Department of Health. Their purpose was to review CDC-recommended Prevention for Positives interventions and to make specific recommendations about the feasibility and appropriateness of these interventions in Vermont.

For an overview of conclusions and recommendations thus far, see Section 4 of this Comprehensive Plan (Prevention for Positives); and Section 8 (Interventions).

As with the Heterosexual target population, the Vermont CPG intends to continue its examination of these issues, and to execute a more formal HIV prevention needs assessment for the population of people living with HIV/AIDS in Vermont, in the coming four-year work cycle.

GAP ANALYSIS

What are the primary HIV prevention gaps in Vermont?

Working with what is sometimes limited information, the following pages outline HIV prevention gaps as identified by the CPG, in terms of 1) geographic service area; 2) populations served; 3) interventions available; and 4) in some cases (MSM, and IDU, for which more formal needs assessment has taken place), other priority services.

GAP ANALYSIS: MEN WHO HAVE SEX WITH MEN

Geographic gaps

HIV prevention programs targeting MSM in Vermont are concentrated in Chittenden County (Vermont's most populous); Windsor and Windham Counties; and to some extent, Caledonia County. Services are minimal or completely absent in the northwest and southwest areas of the state (Franklin, Grand Isle, Lamoille Counties; and Addison, Rutland, Bennington Counties, respectively); and to some extent, in the central area of Washington and Orange County.

Among service providers interviewed for the CPG's needs assessment, the following areas were most commonly identified as lacking services for MSM:

- Northeast Kingdom (Caledonia, Orleans, Essex Counties)
- Rutland County; Rutland town
- "Everything outside Burlington"
 - Rural areas in general (defined by some as being most of Vermont outside of Burlington, the state's largest city) were highlighted as a particular challenge for reaching MSM with HIV prevention programs.

HIV Prevention Intervention gaps

Internet: Many MSM who participated in the needs assessment survey indicated that time on the internet was a common way of connecting with other MSM. Internet-based HIV prevention is a relatively new, and growing, aspect of comprehensive prevention, and may represent a unique opportunity for reaching MSM in a rural state like Vermont.

Outreach and Public Information: One barrier to HIV prevention frequently identified in the needs assessment process was a lack of awareness among

MSM regarding available HIV prevention services and HIV testing options. These gaps include the more resource-intensive use of media, but also the more creatively-based incorporation of venues where MSM congregate; proactively created word of mouth; and peer-to-peer networking.

Counseling and Testing: Many MSM are unaware of the HIV testing options available in Vermont. Awareness of services has improved with the advent of counseling and testing through outreach, as well as some effort to promote oral testing among high risk populations. However, these efforts are a relatively urban phenomenon (i.e., in the larger cities and towns), and it is still believed that many MSM do not get tested simply for lack of knowledge about their options. Continued effort in this area, particularly in rural areas, would help to close this gap.

Social Event-based Group Level Intervention (GLI): Group Level Interventions are a relatively common aspect of existing HIV prevention programs for MSM in Vermont. However, large and small social events were named by providers as well as individual MSM who participated in the needs assessment surveys as particularly lacking for MSM in Vermont. This includes things like potlucks, house parties, larger dances and outings, etc. Mounting these events in a way that incorporates HIV prevention activities could close a public health service gap by addressing the perceived social needs of the community.

Populations

The most commonly named underserved sub-populations in the CPG's needs assessment process were:

Non-gay identified MSM; Closeted MSM: This is the most "hidden" sub-population of MSM, and very likely the least connected to available HIV prevention services. Virtually all HIV prevention activities targeting MSM in Vermont are predicated on some level of self-actualization, "outness," and/or personal identification with the larger gay/bisexual men's community. Programs that effectively reach non-gay identified MSM and/or closeted MSM are rare in the literature, and all but non-existent in rural, small population jurisdictions like Vermont.

Young MSM: HIV prevention efforts specifically for young MSM are scarce in Vermont, where specialized efforts aimed at an already small population can be difficult to sustain. Young MSM also have a distinct apathy toward HIV, when it is not an apparent problem among their peers, especially in rural areas. Efforts that could raise awareness of sexual and needle-using risks among young MSM, and arm them with real-life prevention skills, would close another considerable gap in the current web of services.

Other underserved sub-populations of MSM include the following:

- MSM of color;
- MSM who are also injection drug users;
- MSM who are incarcerated;
- MSM living at or below the poverty line.

Other activities/ issues

Some gaps in HIV prevention for MSM in Vermont do not fall within the arena of activities that are fundable with federal HIV prevention dollars, but bear mentioning nonetheless.

Venues: Prevention funds cannot be used for the creation of physical spaces. However, a lack of central, safe gathering spaces for MSM was commonly identified as a barrier to more effective prevention efforts in the CPG's needs assessment.

Systemic issues: As with all populations disproportionately affected by HIV/AIDS, stigma plays a major part. For MSM, there is the double stigma associated with homosexuality, and with HIV itself. Attempts to fight these prejudices, both systemically and among MSM themselves (i.e., internalized homophobia) should be considered a much-needed HIV prevention activity.

Social issues: As mentioned above, community building efforts, and specifically large and small social events for MSM, were named by needs assessment participants as the primary service gap for this population. To the extent that these kinds of events can be integrated with HIV prevention efforts, there is every indication that MSM would be eager to participate.

Human resources: MSM working as service providers is key to HIV prevention where peer-to-peer education and support is the cornerstone. The lack of gay, bisexual, and other men who have sex with men working as staff on prevention programs was a commonly named concern among those interviewed for the MSM needs assessment.

GAP ANALYSIS: INJECTION DRUG USERS

Many of the service gaps for this population flow from three factors:

- **Hard to Reach Population:** The population of injection drug users is extremely difficult to reach with services and prevention messages, largely due to stigma, the powerful force of opiate addiction, and the limitations of doing this work in a rural environment.
- **Funding:** The most effective media tools for reaching IDU with prevention messages would likely be television and radio, which are prohibitively expensive. Also, because group level interventions are difficult to launch (much less maintain) in a rural state like Vermont, IDUs are most often reached individually, one user at a time. This, too, is a labor- and cost-intensive process.
- **Limited Fundable Activities:** The most frequently named HIV prevention priorities for IDUs in the CPG's needs assessment were 1) syringe exchange programs, and 2) pharmacological treatment options. However, federal HIV prevention funds may not be used for either of these activities, and Vermont does not provide any state funding for HIV prevention.

Geographic gaps

Based on availability of HIV prevention services targeting IDUs in Vermont, it is fair to say that geographic access is a barrier in most areas of the state.

In particular, services are minimal or completely absent in the northwest and southwest areas of the state (Franklin, Grand Isle, Lamoille Counties; and Addison, Rutland, Bennington Counties, respectively).

HIV Prevention Intervention gaps

Public Information: Injection drug users are not being sufficiently reached with up-to-date and relevant information about the availability of services, harm reduction, and specific HIV prevention strategies.

Group Level Intervention (GLI): In the CPG's needs assessment, injection drug users and the providers who serve them agreed that opportunities for group-level interaction and facilitated support for groups of IDU could be a useful part of comprehensive HIV prevention, if they were more feasible to mount and/or more available in Vermont.

Prevention Case Management (PCM): PCM was also named in the CPG's needs assessment as a high priority prevention activity for IDUs. While it is currently available in some locations (as compared to the minimal reach of GLIs), PCM should be a staple of HIV prevention for IDUs throughout the state.

Populations

In the CPG's needs assessment, IDU sub-populations most frequently named as being underserved are women and youth. At the same time, however, it is the CPG's position that all IDUs are at some level of increased risk for HIV infection and/or transmission, and that IDUs in general are an underserved population in this state, and perhaps the hardest to reach.

Other activities

Some of the most pressing service gaps in HIV prevention for IDUs in Vermont fall outside of the CPG's "jurisdiction." These are activities for which federal HIV prevention dollars may not be used. However, no gap analysis for this population would be complete without some mention of the following:

Syringe Exchange Programs (SEPs): Vermont currently has three SEPs up and running. SEPs are widely regarded as a primary opportunity (if not the primary opportunity) for reaching IDUs who are not in substance abuse treatment; for providing them with specific HIV prevention tools in the form of clean injection equipment; for providing them with HIV prevention and other health-promotional information; and for making referrals for services, including substance abuse treatment.

An increase in the number of syringe exchange programs, and the flexibility of existing programs (to include longer hours of operation, as well as mobile syringe exchange) would close a significant HIV prevention gap in this state.

Improved/Increased Treatment Options: Vermont has many high quality substance abuse treatment facilities, and would also benefit from a wider array of available services. Gaps include more specialized programs for youth and women; long-term treatment options; transitional services for those leaving inpatient care; opiate-specific substance abuse treatment/specialization; and more widely available pharmacological treatment for opiate addiction, most specifically, methadone maintenance treatment, and treatment with buprenorphine.

While methadone is currently available through one clinic in Burlington, and mobile distribution is expected to begin in Vermont's Northeast Kingdom in 2005, it is still widely unavailable to many Vermonters who need it, and who cannot make the frequent trips necessary (either to northern Vermont, or out of state to New York or Massachusetts) to maintain an appropriate treatment regimen.

Buprenorphine is available through one clinic in Burlington, and through a limited number of private healthcare providers, though not nearly enough to satisfy the current demand for this form of pharmacological treatment.

Hepatitis C (HCV) Prevention: There is a fast-growing awareness among service providers of the prevalence of HCV among injection drug users. Services for this population have begun to reflect that awareness. To the degree that HCV and HIV prevention intersect, and to the degree that HCV is less stigmatized, more prevalent, and more on the minds of injection drug users (as compared to HIV), the integration of these services would close an existing prevention gap in Vermont.

GAP ANALYSIS:
PEOPLE AT INCREASED RISK THROUGH HETEROSEXUAL CONTACT

Gap analysis for this population is preliminary, pending a more formal needs assessment by the CPG in the coming four-year work cycle.

Geographic gaps

Youth: HIV prevention services targeting youth are especially scarce in seven of Vermont's fourteen counties: Franklin, Grand Isle, Lamoille, Addison, Orleans, Essex, and Bennington. In addition, no programs targeting young men are in place in Windham County.

As with many populations in Vermont, the more rural areas are the most difficult to serve. The transportation issues that can exacerbate this problem are especially relevant with a youth population, many of whom can not drive.

Women: Besides one Windsor County-based statewide program, one multi-intervention program for women in Windham County, two corrections-based educational programs, and several programs based in Chittenden County, most of Vermont lacks HIV prevention services targeted towards women.

Men: Programs targeting adult men at increased risk through heterosexual contact are a relative rarity in Vermont. Outside of Chittenden County, and three correctional facilities, the rest of the state is uncovered in this regard. Also, among the services that are in place, some are exclusively outreach-based, and not well-linked to skills-building activities and interventions.

Populations

The CPG's population definition for people at increased risk through heterosexual contact includes many sub-categories, most of which are not specifically targeted under the current web of HIV prevention programs in Vermont:

Men, Women and Youth* who:

- are partners of people who are HIV+
- are partners of people who are injection drug users
- are partners of men who have sex with men
- are people of color
(including people who are Black/African American, Hispanic/Latino/Latina, Asian/Pacific Islander, American Indian/Alaska Native, and other people of color);
- report sexually transmitted infections (STIs) and/or unwanted pregnancy
- are incarcerated/juvenile offenders
- are homeless

Women and Youth* who:

- are dealing with, or have a history of violence or abuse
(including domestic violence, rape, emotional or physical abuse)
- seek treatment for substance abuse
- live at or below the poverty line
- are dealing with mental illness
- are sex workers and/or trade sex for resources

Youth* who are:

- runaway, “throwaway,” emancipated, abandoned, medically indigent, in foster or SRS care, out of school, and/or otherwise disconnected from traditional systems
- developmentally disabled

*For the purposes of this document, Youth are defined as ages 13-24.

GAP ANALYSIS: PEOPLE LIVING WITH HIV/AIDS

In early 2004, a series of meetings was held at the Vermont CPG’s request. These meetings included representatives from the Vermont PWA Community, CPG, AIDS Service Organizations, other service providers working with PWA, and the Vermont Department of Health. Their purpose was to review CDC-recommended Prevention for Positives interventions and to make specific recommendations about the feasibility and appropriateness of these interventions in Vermont. The group also highlighted specific issues relevant to Prevention for Positives, which should be considered when implementing any HIV prevention program with HIV+ people as part of all of its intended audience. (See Section 4: Prevention for Positives; and Section 8: Interventions, for full details.)

This process constituted the beginning of what will be a farther-reaching needs assessment and gap analysis process in the coming four-year work cycle. That process will include further collaboration with the Vermont HIV/AIDS Services Advisory Council (HASAC), as well as service providers and consumers who participated in the Prevention for Positives work group.

Geographic gaps

Vermont's population of people living with HIV/AIDS is served by a network of healthcare facilities, private practitioners, AIDS Service Organizations, and other human service providers. It is difficult to know where PWA are (or are not) also receiving prevention services alongside healthcare and/or case management services.

Looking just at organizations receiving HIV prevention funds from the Vermont Department of Health, the geographic gaps in the state may include the following counties: Franklin, Lamoille, Grand Isle, Addison, Bennington. However, all of these counties are within the service area of funded organizations whose offices are based in other counties. Pending a more formal gap analysis, it is difficult to know where services are most needed, geographically.

Populations

The Vermont CPG's definition of this population includes MSM, IDU, and People at increased risk through heterosexual contact. Currently, all AIDS Service Organizations receiving Prevention for Positives funding serve all people living with HIV/AIDS. One Windsor County-based program specializes in serving women who are living with the virus. Whether or not Prevention for Positives can and should move toward a more targeted approach in the future will be one of the questions the CPG examines in the coming work cycle.

The 2004 Prevention for Positives (PFP) work group also named specific considerations (related to potential service gaps) for two populations:

Communities of Color: PFP efforts should be reflective of the specific needs of people of color who are living with the virus, and should do so without stigmatizing the population based on race/ethnicity.

Injection drug users (IDU): People who are users of injection drugs and also living with the virus should be granted rapid access to substance abuse treatment.

Other activities/ issues

These additional considerations represent systemic issues which go beyond the scope of HIV prevention funding, but which bear mentioning nonetheless.

HIV-related stigma: This was the first issue to be discussed by the PFP work group. In many ways, stigma can prevent HIV prevention interventions from being effective, or in some cases, from taking place at all. There is a need to address larger systemic issues, most particularly HIV-related stigma, as part of an effective and comprehensive HIV prevention effort. This is not the exclusive responsibility of providers receiving HIV prevention funds, but it is a key issue when considering the HIV prevention needs of this, or any, population. Part of the solution should come in the form of a state implemented anti-stigma public awareness campaign.

Models for intervention in rural areas: In order to be effective in Vermont, any intervention model must be considered in the context of our rural environment. Programs should be adapted as needed. Sometimes this means implementing core elements of a successful program from elsewhere and not the whole program itself. Overall, existing curricula, studies, and formal interventions created for rural environments are a major gap in the prevention landscape.

SECTION 3 : PRIORITIZATION OF TARGET POPULATIONS

For the purpose of prioritizing target populations, the Vermont Community Planning Group used a model suggested by guidance from the Academy for Educational Development, *Setting HIV Prevention Priorities: A Guide for Community Planning Groups*. It is a seven-step process:

- 1) Identify target populations
- 2) Determine factors to use for priority setting
- 3) Weight factors
- 4) Rate target populations using factors
- 5) Score target populations: rating x weight
- 6) Rank target populations (add scores)
- 7) Review rankings and prioritize target populations

The CPG used a consensus model for decision-making wherever rating or scoring was done. All conclusions were the result of full group agreement amongst those voting members who were present.

A description of each step is included below.

Step 1) Identify target populations

In accordance with CDC guidance, the Vermont CPG agreed in 2004 that HIV prevention for people living with HIV/AIDS would be Vermont's top prevention priority, and would recommend that the Vermont Department of Health increase its existing level of funding for Prevention for Positives efforts.

For the purposes of further prioritizing target populations in Vermont, the CPG also agreed to continue using the existing, behaviorally-based categories named in the previous (2001) Comprehensive Plan: Injection Drug Users (IDU); Men who have Sex with Men (MSM); and People at Increased Risk through Heterosexual Transmission (Heterosexual).

Therefore, Vermont's priority populations are as follows:

Top priority:

- People Living with HIV/AIDS (PLWHA) who are:
 - Men Who Have Sex with Men (MSM)
 - Heterosexuals at Increased Risk
 - People Who Inject Drugs (IDU)

Additional Populations, to be Prioritized:

- Men Who Have Sex With Men (MSM)
- Heterosexuals at Increased Risk. This group includes:
 - Men, Women and Youth who:
 - are partners of people who are HIV+
 - are partners of people who are injection drug users
 - are partners of men who have sex with men
 - are people of color (*including people who are Black/African American, Hispanic/Latino/Latina, Asian/Pacific Islander, American Indian/Alaska Native, and other people of color*)
 - report sexually transmitted infections (STIs) and/or unwanted pregnancy
 - are incarcerated/juvenile offenders
 - are homeless
 - Women and Youth who:
 - are dealing with, or have a history of violence or abuse (*including domestic violence, sexual assault, emotional or physical abuse*)
 - seek treatment for substance abuse
 - live at or below the poverty line
 - are dealing with mental illness
 - are sex workers and/or trade sex for resources.
 - Youth who are:
 - runaway, "throwaway," emancipated, abandoned, medically indigent, in foster or SRS care, out of school, and/or otherwise disconnected from traditional systems
 - developmentally disabled
- People Who Inject Drugs (IDU)

Step 2) Determine factors to use for priority setting
- and -
Step 3) Weight factors

The CPG took three things into account when discussing and ultimately choosing the factors to be used in this step:

- Academy for Educational Development guidance (*Setting HIV Prevention Priorities: A Guide for Community Planning Groups*)
- Factors used by the Vermont CPG in 2001
- Factors used by CPGs from other jurisdictions

Once the CPG decided upon five factors to be used for rating the target populations, the group then determined relative weights to be assigned to each factor, for scoring purposes. This was done by individual balloting among CPG members. The results were as follows:

<u>Factor</u>	<u>Weight</u>
Barriers to reaching the population	8
Magnitude HIV/AIDS within the population	7
Riskiness of behaviors	7
Markers of risk behavior	7
Size of population	6

Step 4) Rate target populations using factors

The CPG rated each target population (IDU, MSM, Heterosexual) on each of the five named factors, using straightforward data where possible; and a combined process of group discussion and individual balloting where more qualitative and/or anecdotal information was the most relevant to a given factor.

Some factors were comprised of separately rated/scored pieces, in which case a sub-weighting process was used toward a final result. See below for details.

Once populations were rated on a given factor, the population to receive the highest rating was then assigned a score of 10 for that factor, and the two remaining

populations were assigned a proportionally lower score, from 1 to 9, determined by their relative rating to that of the top-rated population.

Details of the rating process were as follows:

Factor 1: B arriers to reaching the population

DEFINITION: This factor was defined by five components:

- 1) Socioeconomic and/or cultural barriers (*Including poverty, education, homelessness, language and literacy, race/ethnicity, sexual orientation, sex/gender*)
- 2) Lack of HIV prevention services available to the population (*e.g., lack of services throughout the state; lack of specific interventions available to the population*)
- 3) Policy/Legislative barriers (*Laws and policies that impact HIV prevention for the population*)
- 4) Population-specific stigma (*Societal phobias and “isms” directed against the population; subsequent lack of will within communities to meet the needs of that population*)
- 5) Population-specific barriers (*Internal barriers; things that keep members of the population from advocating for themselves for risk reduction/safer sex/safer injection, such as: population norms against preventive behavior; lack of social networks; apathy or lack of risk awareness within the population.*)

PROCESS: Following a CPG discussion of each of these elements, the target populations were sub-scored by individual balloting on a 1-3 scale for each of the above-named components. The total points earned in this process were:

	MSM	HETERO	IDU
Total points earned	166	168	223
Relative rating <i>highest point total = 10; others rated accordingly</i>	.753 rounds to 8	.744 rounds to 7	10

Factor 2: Magnitude of HIV/ AIDS within the population

DEFINITION: This factor was defined by three components:

- 1) HIV/AIDS prevalence as of December 2002
- 2) Comparison of newly diagnosed AIDS cases: 1997-99 compared to 2000-02.
- 3) Percentage of newly diagnosed HIV cases, 2000-02

PROCESS: The CPG agreed to look at each of the above-named epidemiological sub-factors and assign sub-weights to each by individual balloting. (Note: Because HIV reporting is a relatively recent component of surveillance in Vermont (as of 2000), the CPG chose to continue looking at Vermont AIDS case data as well, which has been tracked for a much greater length of time.)

After sub-weighting these three components, the rating process for each population was a matter of straightforward data incorporation. The entire calculation process is reflected in the following table:

	MSM	HETERO	IDU
Percentage of newly diagnosed HIV cases 2000-02	55	14	8
Sub-score <i>highest rate = 10; others scored relatively</i>	10	2.54 rounds to 3	1.45 rounds to 1
x Sub-weight	10	10	10
= Sub-total	100	30	10

	MSM	HETERO	IDU
HIV/AIDS prevalence as of December 2002 <i>Percentage of those living with HIV or AIDS</i>	54	12	16
Sub-score <i>highest rate = 10; others scored relatively</i>	10	.22 rounds to 2	.29 rounds to 3
x Sub-weight	8	8	8
= Sub-total	80	16	24

Comparison of newly diagnosed AIDS cases:
1997-99 and 2000-02

	MSM	HETERO	IDU
Percentage of newly diagnosed AIDS cases, 97-99	46	7	17
Relative score	10	.152 rounds to 2	.36 rounds to 4
Percentage of newly diagnosed AIDS cases, 00-02	66	15	6
Change from 1997-99 to 2000-02 <i>Higher # divided by lower #</i>	Increase: +1.43 rounds to +1	Increase +2.14 rounds to +2	Decrease: -2.8 rounds to -3
Relative score +/- movement score	10+1 =11	2+2 = 4	4-3 = 1
Sub-score <i>highest rate = 10; others scored accordingly</i>	10	3.6 rounds to 4	.09 rounds to 1
x Sub-weight	6	6	6
= Sub-total	60	24	6

**TAB UL ATION FOR FACTOR 2:
MAGNITUDE OF HIV/AIDS WITHIN THE POPULATION**

	MSM	HETERO	IDU
Newly diagnosed HIV cases, 2000-02 Sub-total =	100	30	10
HIV/AIDS prevalence as of December 2002 <i>Percentage of those living with HIV or AIDS</i> Sub-total =	80	16	24
Comparison of newly diagnosed AIDS cases: 1997-99 compared to 2000-02 Sub-total =	60	24	6
Total points =	240	70	40
<i>highest rate = 10; others scored accordingly</i> Final magnitude rating =	10	2.9 rounds to 3	1.6 rounds to 2

Factor 3: Riskiness of behaviors

DEFINITION: The relative likelihood of HIV transmission from an infected partner to another person during the engagement of specific risk behaviors.

DISCUSSION: The CPG agreed to use data provided by the Vermont Department of Health, comparing the relative risk of unprotected receptive anal intercourse with an HIV-infected partner; unprotected receptive vaginal intercourse with an HIV-infected partner; and sharing injection equipment with an HIV-infected partner. Each of these behaviors were “assigned” to the corresponding target population (MSM, Heterosexual, IDU) with one caveat:

Because unprotected anal intercourse (UAI) is statistically more risky than unprotected vaginal intercourse, and because some heterosexually-identified adults do engage in this behavior with opposite-sex partners, the CPG took into account behavioral data indicating the frequency of UAI among heterosexually-identified adults. This frequency was factored into the final considerations for scoring purposes, as detailed below.

MSM Unprotected Anal Intercourse

- 1 – 7 % Receptive Anal Intercourse (RAI) (CAPS data)
- .1 – 3 % Receptive Anal Intercourse (MMWR, 1998)

(Took averages of both Receptive Anal Intercourse Ranges from CAPS and MMWR and then averaged those together.)

Heterosexual Unprotected Sex

- 1 -7 % Receptive Anal Intercourse (RAI) (Center for AIDS Prevention Studies (CAPS) data)
- .06 – 1% Receptive Vaginal Intercourse (RVI) (CAPS data)
- .03- 0.1% Insertive Vaginal Intercourse (IVI) (CAPS data)
- .1 - .2% Receptive Vaginal Intercourse (MMWR, 1998)

SCORE: $((.06 + 1) / 2) + ((.1 + .2)/2)) / 2 = .34 \% \text{ or } .0034$
 $(17.6\% * .0278) = .489 \% \text{ or } .00489$

$.0034 + .00489 = .00829 \text{ or } .829\%$

(Took averages of Receptive Vaginal Intercourse from CAPS data and averages from Receptive Vaginal Intercourse from the MMWR data and then averaged those together. Receptive Anal Intercourse was multiplied by the total percent of men and women

recruited at STD clinics in the 2001 HITS Surveys who reported Anal Intercourse with primary partner).

IDU Needle Sharing Risks

- .7 - 1% Needle Sharing Events (NSE) (CAPS data)
- .67 % Needle Sharing Event (MMWR, 1998)

SCORE: $((.7 + 1) / 2) + .67 / 2 = .76 \% \text{ or } .0076$

(Took average of CAPS data range and averaged it with the MMWR data)

	MSM	Heterosex uals	IDU
Scores:	.0278	.00829	.0076
1 – 10 Scores:	10	2.98	2.7
Rounded rating:	10	3	3

Data Sources:

- Transmission Rates, Co-Factors for HIV Transmission, and Sexual Assault Provincial HIV Prevalence: Slide Show Presentation for Indications for and Use of Post-Exposure Prophylaxis (PEP) Following Sexual Assault: A Two-Day Workshop September 2002 Michelle Roland, MD, Ian Sanne, MD, Linda-Gail Bekker, MD <http://hivinsite.ucsf.edu/InSite?page=pr-rr-07-01-03>
- MMWR, 1998 47 (RR17); 1-14 Management of Possible Sexual, Injecting-Drug-Use, or Other Nonoccupational Exposure to HIV, Including Considerations Related to Antiretroviral Therapy Public Health Service Statement www.cdc.gov/mmwr/preview/mmwrhtml/0054952.htm
- National HITS Data, 2001, CDC
- This data is also substantiated in the document: The Risk of HIV-1 Transmission by Type of Exposure (Communicable Disease Prevention & Control), www.cdpc.com/s6.htm

Factor 4 : Markers of risk behavior

DEFINITION: Indications of engagement by members of the target population in specific risk behaviors directly linked to HIV transmission, i.e., unprotected sex, needle sharing.

DISCUSSION: The CPG agreed to look at available Vermont-specific data as well as nationally-based statistics for each of the target populations, and to calculate an average between the two. That average would then be the basis for rating and scoring the populations.

INFORMATION SOURCES: The Vermont HIV Testing Survey (HITS); the Vermont Behavioral Risk Factor Surveillance System (BRFSS) 2001 data; and the HIV/AIDS Special Surveillance Report from the Centers for Disease Control and Prevention.

MSM reporting unprotected receptive anal intercourse with a non-primary partner:

Vermont HITS survey: 40%
 HIV/AIDS Special Surveillance Report: 40%

Average: 40%

Men and women reporting no barrier use during vaginal intercourse with a non-primary partner:

Vermont BRFSS – Men: 38%
 Vermont BRFSS – Women: 29%
 HIV/AIDS Special Surveillance Report – Men: 70%
 HIV/AIDS Special Surveillance Report – Women: 59%

Average: 49%

IDUs reporting needle sharing:

Vermont HITS survey: 39%
 HIV/AIDS Special Surveillance Report: 43%

Average: 41%

Markers of Risk Behavior – Final Rating

	MSM	HETERO	IDU
Average	40	49	41
Relative rating <i>highest point total = 10; others rated accordingly</i>	8	10	8

Factor 5 : Size of population

DEFINITION: Estimated number of people in Vermont within the identified target population (IDU, MSM, Heterosexuals at increased risk)

DISCUSSION: The CPG took a variety of approaches to estimating population sizes, and agreed that the population with the largest estimated size would be given a rating of 10; and the other two populations would be rated with a relative number on the 1-10 scale.

MSM

For the population of MSM in Vermont, the CPG looked at a variety of informational resources: the Vermont 2001 BRFSS (Behavioral Risk Factor Surveillance System); the Vermont YRBS (Youth Risk Behavior Survey) from 1997, 1999, and 2001; the population estimate provided to the CPG by the Vermont Department of Health for use in the 2001 Comprehensive Plan; and the going norm among Community Based Organizations, who use an estimate of 5% when estimating MSM population.

All of the statistics gathered were averaged to an estimate of 5.8% of the total population. Measured against the Vermont population of 608,827 (2000 Census), that translates into an estimated population size of 35,311.

HETEROSEXUAL

This was, by far, the most complex category for estimating population size. The CPG used a variety of informational resources to try and “count” the number of people within each of the sub-categories in the CPG’s definition of People at Increased Risk through Heterosexual Transmission.

The following numbers are based on an overall estimate that there are 467,989 men, women, and youth over age twelve in Vermont. This number comes from subtracting 7.5% from the overall Vermont population (which accounts for an estimated number of non-heterosexual people); and subtracting an additional 16.9% to account for the number of children under age thirteen, as this population definition only includes youth aged 13 and older.

Of those 467,989 people, 51% are estimated to be women, and 16.7% are estimated to be youth between the ages of 13 and 24, based on 2000 Census data. Another way of expressing these numbers:

Men/Women/Youth*: 467,989
Women/Youth*: 284,960
Youth*: 94,048

**For the purposes of this document, the Youth category includes ages 13-24 only.*

Estimating the population of Heterosexual at Increased Risk:

Sub-category	Estimate	Source/Explanation
Men, women and youth who are:		
People who are HIV+	136	VT HIV/AIDS report
Partners of people who are HIV+	136	Estimate a duplicate number to PWA
Partners of people who are injection drug users	1800	Estimate a duplicate number to estimated IDU population size; source: VT Office of Alcohol and Drug Abuse Programs
Partners of MSM	?	Unknown; no estimate
Reported STIs and/or unwanted pregnancy	1149	VT. Dept. of Health (healthyvermonters.info): 2003 chlamydia, syphilis, gonorrhea;
Incarcerated/Juvenile offenders	2043	VT Department of Corrections
Homeless	889	VT housing data 2002 (0.19%)
Women and youth who are:		
Dealing with or have history of violence/abuse	3704	VT Network Against Domestic Violence/Sexual Abuse (2002) (1.3%)
Seek treatment for substance abuse	4017	ADAP (2002) (1.41%)
People of color*	20631	2000 Census data (7.24%)
Living at or below poverty line	28182	2000 Census data (9.89%)
Dealing with mental illness	13877	VT Dept. of Mental Health (4.87%)
Sex workers/trade sex for resources	?	Unknown; no estimate
Youth who are:		
Runaway, throwaway, Social and Rehabilitation Services (SRS), etc.	1470	www.state.vt.us/SRS (average daily figure in 2003)
Developmentally disabled	889	VT Developmental Services 2004 Annual Report # served in 2003
TOTAL	7 8 ,9 2 3	

Notes on the above:

- *People of Color: When the calculations detailed on this page were made in June 2004, the population definition of People at Increased Risk through Heterosexual Transmission included women and youth of color, but not adult men of color. The population definition was amended in August 2004 to include adult men of color, and the resulting funding allocations were adjusted, as detailed at the end of this section.
- Many of the sub-categories within the Heterosexual at Increased Risk population overlap with one another, which could result in over-counting (for example, some people who report STIs may also be living below the poverty level; some people

who are homeless may also be dealing with mental illness, etc.). At the same time, however, many people in this category are not accounted for here, including partners of MSM; people with non-reportable STIs; sex workers; and runaway youth. To whatever extent these factors may or may not cancel each other out, the CPG accepted the above-listed calculations in the absence of a more precise system.

IDU

For the population of injection drug users in Vermont, the CPG accepted an estimate of 1,800 from the Vermont Department of Health’s Office of Alcohol and Drug Abuse Programs. This estimate is widely accepted and used around the state by organizations who serve the needs of injection drug users.

POPULATION SIZE: Final rating

	MSM	HETERO	IDU
Estimated population size	35,311	78,923	1,813
Relative rating <i>highest point total = 10; others rated accordingly</i>	4	10	1

Step 5) Score target populations: rating x weight
 - and -
Step 6) Rank target populations (add scores)
 - and -
Step 7) Review rankings and prioritize target populations

FACTOR	WEIGHT	MSM		HETERO		IDU	
		rating	weight x rating	rating	weight x rating	rating	weight x rating
Barriers to Reaching Population	8	7	56	8	64	10	80
Magnitude of HIV/AIDS within the population	7	10	70	3	21	2	14
Riskiness of behaviors	7	10	70	3	21	3	21
Markers of risk behavior	7	8	56	10	70	8	56
Size of population	6	4	24	10	60	1	6
TOTAL SCORE			276		236		177

Each score was determined as a percentage of the total points earned.

MSM = 276
 Heterosexual = 236
 IDU = 177

Total points earned: 689

Therefore:

MSM (276) earned 40% of total points

Hetero (236) earned 34% of total points

IDU (177 points) earned 26% of total points

- continued next page -

August 2004 Amendment

At the August 2004 CPG meeting, the CPG listened to and discussed concerns from the community about the population definition for People at Increased Risk through Heterosexual Transmission. The CPG then agreed to amend the population definition to include adult men of color. Previously, the definition had only included women and youth of color.

After further discussion, the CPG also agreed that given the lack of available time in the planning year, they would not re-calculate and score all three target populations. Instead, the CPG charged the Vermont Department of Health HIV/AIDS program with re-allocating up to 2% of HIV prevention funds from the MSM and IDU populations to the Heterosexual population, to allow for the now-expanded Heterosexual population definition.

Accordingly, the CPG's final recommendations for Target Population Prioritization are as follows:

RANK ED PRIORITY POPUL ATIONS	FUNDING ALLOCATION RECOMMENDATIONS
1) People Living with HIV/AIDS (PLWHA) who are: <ul style="list-style-type: none"> • Men Who Have Sex with Men (MSM) • Heterosexuals at Increased Risk • People Who Inject Drugs (IDU) 	CPG recommends that the Vermont Department of Health increase its existing level of funding for Prevention for Positives efforts. All remaining prevention funds should be allocated as detailed below:
2) Men who have Sex with Men (MSM)	38% of available prevention funds for programs targeting MSM
3) People at Increased Risk through Heterosexual Transmission	36.5% of available prevention funds for programs targeting Heterosexuals at Increased Risk
4) Injection Drug Users (IDU)	25.5% of available prevention funds for programs targeting IDU

- END OF SECTION 3 PRIORITIZ ATION OF TARGET POPUL ATIONS -

SECTION 4 : PREVENTION FOR POSITIVES

Related information elsewhere in the Comprehensive Plan:
Appendix 1: Epidemiological Profile
Appendix 2: Prevention for Positives Intervention Fact Sheets
Section 8: Interventions

Introduction/ Process

In early 2004, a series of meetings was held at the Vermont CPG's request. These meetings included representatives from the Vermont PWA Community, CPG, AIDS Service Organizations, other service providers working with PWA, and the Vermont Department of Health. Their purpose was to review CDC-recommended Prevention for Positives (PFP) interventions and to make specific recommendations about the feasibility and appropriateness of these interventions in Vermont.

See Section 8: Interventions in this Comprehensive Plan for a list of interventions and the recommendations concerning each. See also Appendix 2 to the Comprehensive Plan for further detailed information on each of these recommended programs.

In addition to recommending Interventions, the PFP work group, in conjunction with the CPG, adopted and amended the National Association of People with AIDS (NAPWA)'s *Principles of HIV Prevention with Positives*, included below.

The group also highlighted specific issues relevant to PFP, which should be considered when implementing any HIV prevention program with HIV+ people as part or all of its intended audience. Those issues are listed and discussed in this section as well.

National Association of People with AIDS (NAPWA)'s Principles of HIV Prevention with Positives

For far too long, we have paid too little attention to the very real issue of meeting the prevention needs of people living with HIV/AIDS. HIV prevention was something that was done for HIV negatives to keep them negative, ignoring the central role of people living with HIV/AIDS. Successful strategies for preventing new HIV infections must engage people living with HIV/AIDS as partners. As people living with HIV/AIDS, we welcome the enhanced interest in prevention service for people living with HIV/AIDS. As programs are implemented in this area, several important understandings and principles must inform and shape the effort to do prevention work with positive people. These principles were developed in a series of meetings with diverse groups of HIV+ people from around the country, and represent the essential perspective of the people who will be most directly impacted.

1. Prevention must be a shared responsibility.

Developing prevention programs for positive people must not become an excuse for shifting all responsibility for prevention (or blame for new infections) onto the shoulders of people living with HIV/AIDS. A culture of shared responsibility that encourages communication and equality in relationships should be a goal of our prevention programming.

2. Don't assume serostatus. HIV prevention programs should deliver messages that are inclusive, understanding that HIV positive people are in the audience for these programs.

It needs to be assumed that any HIV prevention effort will reach some people living with HIV/AIDS. Messages that are meant to apply only to uninfected people ("Stay negative," "Don't have sex with a person with AIDS," etc) will be heard and understood differently by different people. Think about how these messages shape the way people living with HIV/AIDS think about prevention, and the way others think about us.

3. HIV positive people have unique needs and concerns that require targeted approaches to reach us.

It isn't the same for positive people and people of unknown or negative status.

4. People living with HIV/AIDS are extremely heterogeneous and programs need to address the different needs of such a diverse group.

It simply isn't the same for everyone, and we need culturally competent interventions for diverse populations: race, gender, sexual orientation, age, language, geography, addiction, etc. all impact the type of programming needed. One size does not fit all.

5. Effective programs must fully accept the right of people living with HIV/AIDS to intimacy and sexual health.

Few issues are as emotionally charged as sexual activity by people living with HIV/AIDS. Providers must learn to be truly non-judgmental and support the human right to a fulfilling sexual life, while working with people to decrease potential risk to others and themselves.

6. Effective programs must fully accept the right of people living with HIV/AIDS to autonomy over their illicit drug use choices.

Providers must remember that the use of illicit drugs is an individual choice and must be truly non-judgmental while working with people to decrease potential risk to others and themselves.

7. Behavior change is tough for everyone ...including people living with HIV/AIDS.

Expecting 100% perfection from people who are HIV+ is as unrealistic as expecting it from the uninfected. Creating and sustaining behavior change is rarely instantaneous.

8. Knowledge of serostatus is important, but isn't enough.

Knowing is the first step, but it still requires support and skills. Most people who know they are HIV+ will take steps to avoid infecting others – but it is unrealistic to expect people to make and maintain change solely based on knowledge of status.

9. There is no magic bullet, no single type of intervention that will work for everyone.

Just like every other population, people living with HIV/AIDS need a variety of interventions delivered in a variety of settings, and sustained over time. While medical settings offer one important venue for interventions, there are many drawbacks to relying on them for positive prevention. A diverse range of interventions, delivered in diverse settings, is required.

10. Disclosure isn't always the answer.

Disclosure doesn't guarantee safe behavior. Disclosure may produce severe and negative consequences. Helping people assess their readiness to disclose and developing the skills to do so is different than telling people they must disclose.

11. Stigma, discrimination, shame and fear drive people underground and make prevention harder for everyone, especially positive people.

Programs must function with an acute understanding of the centrality of these issues in the experience of people living with HIV/AIDS, must help people cope with their impact, and should challenge these harmful attitudes in communities.

12. Coercion/ criminalization is not the answer.

It is impossible to retain the trust and honest engagement of people if our prevention strategies are predicated on the threat of criminal prosecution for engaging in consensual activities.

13. Programs must be anchored in the real needs and concerns of people living with HIV/AIDS.

If it is driven solely by a prevention agenda without considering the priorities of people living with HIV/AIDS, it will fail. Listen to what is important to your population. Addressing relationships, housing, economic security, personal safety, etc., are all important in engaging people in prevention.

14. People living with HIV/AIDS need to be involved in the planning, design, delivery and evaluation of these programs.

Things that are "done to us" won't work as well as things that are "done with us."

15. Resources and capacity- building efforts must support the development of HIV+ - run programs to respond to this need.

There is an important role for PWA coalitions and other organizations run by and for positive people in these programs. We must invest in the capacity of organizations to do this work, creating sustainable PLWHA-led prevention efforts.

16. Effective programs for people living with HIV/AIDS will recognize the need to minimize barriers to health treatment services, including harm reduction-based programs.

HIV prevention with positives must recognize the following: 1) For at least some people, risk elimination is not always possible, and harm reduction-based programs should be part of the continuum of available prevention services; 2) Increasing access to all health treatment services (including but not limited to medical treatment, substance abuse treatment, and mental health treatment) positively affects HIV prevention; and 3) Increasing access to services in rural areas brings unique challenges which must be met.

Prevention for Positives: Additional Issues

The following should be taken into account when designing and implementing HIV prevention programs focused on people living with HIV. This list was developed by the Vermont Prevention for Positives work group, in conjunction with the Vermont CPG, and was subsequently adopted by the CPG for inclusion here.

- 1) **Sometimes it is possible and/ or necessary to integrate HIV prevention messages with other health-related messages**, such as overall sexual health, comprehensive health, or messages related to other specific conditions (such as hepatitis). This type of integration can help combat the prohibitive stigma that HIV can carry. It may also create messages that are more immediate and/or relevant to the lives of some HIV+ people.
- 2) **No one intervention can meet all needs.** All discussed Prevention for Positives (PFP) activities and interventions should be considered and implemented as part of a larger, comprehensive prevention effort, i.e., no one intervention can meet all needs.
- 3) **HIV- related stigma.** There is a need to address larger systemic issues, most particularly HIV-related stigma, as part of an effective and comprehensive HIV prevention effort.
- 4) **Many interventions are based on urban models.** In order to be effective in Vermont, these models must be considered in the context of our more rural environment. They should be adapted as needed. Sometimes this means implementing core elements of a successful program from elsewhere and not the whole program itself.
- 5) **We need to be thoughtful about how we define, and sub-divide, the population of people living with HIV in Vermont.** While some sub-populations have specific needs, we should work to avoid polarizing the PWA community by sub-dividing it.
- 6) **Marketing and language:** PFP efforts should be thoughtfully brought to the community in terms of marketing and language, to maximize the role PWA play, as well

as community receptivity to these efforts. For example, some people might be alienated by the idea of a "support group" but more interested in a "meeting" or "get-together."

7) **Specific and universal needs:** HIV prevention efforts targeting PWA should be cognizant of the unique needs of that population, as well as the ways in which PFP programs may intersect with prevention efforts targeting other people at increased risk.

8) **Communities of color:** PFP efforts should be reflective of the specific needs of people of color who are living with the virus, and should do so without stigmatizing the population based on race/ethnicity.

9) **Injection drug users (IDU):** People who are users of injection drugs and also living with the virus should be granted rapid access to substance abuse treatment.

- END OF SECTION 4 : PREVENTION FOR POSITIVES -

SECTION 5 : MEN WHO HAVE SEX WITH MEN (MSM)

Related information elsewhere in the Comprehensive Plan:

Appendix 1: Epidemiological Profile

Appendix 3: MSM Needs Assessment survey instruments and results

Section 2: Community Services Assessment

Section 8: Priority Interventions

Introduction

From the beginning of the epidemic in Vermont, the largest percentage of reported diagnoses of AIDS, and more recently, of HIV, has occurred among men who have sex with men (MSM). As of the most recent Vermont Quarterly HIV/AIDS report, MSM account for:

- 59% of persons living with HIV;
- 54% of persons living with AIDS;
- and 59% of cumulative AIDS cases since reporting began

with an additional 4%, 6%, and 6%, respectively, attributed to MSM who are or were also users of injection drugs.

The presence of the virus in the community in large numbers, combined with continued risk activities, creates the necessary circumstances for ongoing transmission. This situation continues to demand that significant attention be paid to HIV prevention needs of this population in Vermont.

As in the rest of the country, the early association of AIDS with the gay community shaped social attitudes and responses to the epidemic in Vermont. In the mind of much of the public, AIDS was a “gay disease.” This attitude fostered denial that AIDS was a problem for the general population, allowing many people to deny their own potential risk. At the same time, this attitude marginalized the needs of men who have sex with men, and society as a whole displayed an almost complete indifference. Some factions even seemed to take satisfaction in the disease, which was, in their estimation, a sign of “God’s vengeance.” Much, although far from all, of the early work establishing AIDS service organizations and programs in the state was done by members of the gay and lesbian community (with the very significant contributions of lesbians to these efforts frequently overlooked), who came together to deal with a community threat when government and “mainstream” institutions were unwilling to step forward.

Ironically, the long association of the epidemic with the gay community has often led to the assumption that the prevention needs of men who have sex with men are already well-met and that these men are no longer practicing unsafe sex or becoming infected. A frequently expressed attitude seems to be that a large amount of resources has

historically been devoted to meeting these needs, and that they have come at the expense of other populations.

Epidemiological and behavioral studies in both Vermont and the rest of the country indicate continuing risk and new infections in this population. Of particular concern are studies indicating new infections among young men who have sex with men and among men of color who have sex with men. Likewise, even among men who have long adopted safer sex practices, sustaining those practices for years is a challenge that demands support and reinforcement.

Sustaining an HIV prevention message, as well, is an ongoing challenge as HIV/AIDS progresses into its third decade. Whether targeting older MSM, who have “heard it all,” or younger MSM, for whom HIV/AIDS in Vermont is an invisible phenomenon, HIV prevention providers are challenged to capture both the good news of advancing treatment, and the inevitable fact that HIV infection remains a threat to the health and well-being of our community and ourselves.

In addition to prevention relating to transmission of HIV, a range of secondary prevention issues dealing with the prevention of illness associated with disease progression and opportunistic infections are highly important to HIV-positive men. The artificial wall between prevention and care must be challenged, as we increase our understanding of the role that people with HIV play in our communities and in HIV prevention. We must seek to preserve the health of all, regardless of HIV status. Early access to quality health care will help both maintain the health of the man living with HIV and connect him to systems of support services that will encourage prevention. Prevention, in turn, will help the growing number of men living with the virus deal with choices around sexual and drug using behaviors, and issues of transmission and re-infection.

While HIV prevention moves toward greater inclusivity regardless of HIV status, it should not lose sight of the realities of living with HIV. Amidst the excitement of emerging treatments, many people are still dealing with extreme side effects (physical, emotional, psychological, social, and financial) and even death. HIV prevention efforts targeting men who have sex with men will need to meet the challenge of embracing HIV-positive men as an integral part of their audience, and at the same time, be responsive to the issues that are unique to those living with the virus.

Notes on Terminology

In this plan the term “men who have sex with men” is used to broadly include all men who engage in sexual activity with other men, regardless of how they may identify their own sexual orientation. This may include men who identify as gay, men who identify as bisexual, and men who identify as heterosexual. This is the terminology used in most instances to refer to members of this population. Despite the sometimes awkward word

constructions produced, it is preferred as a more inclusive term than others. Its use is not intended to negate the identity and hard HIV work done by those who proudly self-identify as gay or bisexual. When used in this plan, the terms “gay” and “bisexual” refer specifically to those men who have sex with men and also self-identify as belonging to those categories. “Non-gay-identified men who have sex with men” refers to men who engage in sexual activity with other men, but who do not self-identify as gay or bisexual and who cannot be easily reached through the social or community support systems associated with the so-called gay/bisexual community.

It is important to remember that these labels do not necessarily reflect actual activities. For example, a heterosexually identified man may have only male partners, while a gay-identified man may also have sex with women. Social identity and sexual activity are not always congruent.

Similarly, sexual activity itself may take a variety of forms: a man in any of these categories could be celibate, in a sustained monogamous relationship, in a primary nonexclusive relationship, in a series of monogamous relationships, or with multiple partners. Any of these men may or may not engage in anal intercourse or other higher risk sexual activities.

Prevention Priorities

In addition to the recommended Interventions named in this Comprehensive Plan (see Section 8), the CPG has identified a non-binding list of priority MSM sub-populations, as well as priority venues where interventions targeting MSM should be considered. These lists are intended as informational guidance. They are not meant to exclude service providers from applying to do prevention work in other locations and with other groups of MSM.

MSM Sub-Populations

The Vermont CPG has chosen to name all MSM as one of four priority target populations for HIV prevention in this state. Within the category of MSM, however, certain sub-populations are at an increased risk for HIV transmission and/or infection. Some are also underserved by HIV prevention efforts, whether for lack of infrastructure, prevention resources, or internal barriers from within that sub-population.

These groups include MSM who are:

- Injection Drug Users (MSM/IDU)
- Involved with Corrections (incarcerated, probation/parole)
- Low socioeconomic status
- Members of Communities of Color
- Non-gay-identified
- Youth

Service providers mounting programs to target MSM should consider ways in which they might effectively reach members of these sub-populations.

Venues

Based on interviews with service providers around the state, and the 2003 MSM survey implemented as part of the CPG's needs assessment process, the MSM Needs Assessment Committee developed a list of venues that might be particularly appropriate for reaching MSM in Vermont with HIV prevention services. This is a non-exhaustive list, and other specific locations should be considered where appropriate to meet the needs of any local population.

HIV prevention programs should consider targeting MSM in or at the following venues:

- Bars
- Internet
- Large social events/Arts and cultural events
- Public Sex Environments (PSEs)
- Retreats
- Small social events

Some of these outlets already exist within the community (e.g., bars; Internet); others are events that service providers might consider creating for their own purposes (e.g., large social events that could attract a large number of men and that would incorporate some focus on HIV prevention).

Related Information and Recommendations

The following pages include additional information and recommendations for improving HIV prevention for MSM in Vermont. They are divided into three categories:

- Prevention
- Capacity Building
- Other Issues

Related Information/Recommendations: Prevention

Young MSM

Young MSM, specifically those aged 18-29, are notoriously underserved by HIV prevention, in Vermont and elsewhere. Service providers interviewed for this report named young MSM more than any other population as particularly needy of specific, targeted, and effective prevention efforts. Vermont has seen a surge

in this general age group with regard to heroin and needle usage, homelessness, and involvement with the Department of Corrections. All of these are surrogate markers for HIV risk behavior. The CPG recommends a strong effort to reach this population of young MSM.

Further, the CPG encourages organizations providing HIV prevention services in Vermont to collaborate with colleges and universities to assist with and/or supplement on-campus prevention efforts for this population.

Interventions

The Vermont CPG recommends that the following be taken into account when developing HIV prevention programs for MSM in Vermont:

- Social events (large and small) should be treated as opportunities for outreach and program recruitment, and as opportunities to further involve MSM in such prevention activities as Individual Level Interventions (ILI); Group Level Interventions (GLI); and Prevention Case Management (PCM).

Large social events were the most frequently cited social gap by MSM participating in the CPG survey this year. The CPG recommends that service providers consider ways in which large events might be offered with a maximum response and turnout; perhaps by collaborating with other organizations on large, well-publicized social functions around the state. These events could also be considered platforms for outreach, counseling/testing awareness, etc.

Large events coordinated statewide may also be a means for reaching smaller sub-populations of MSM (such as men of color, young men, etc.) with targeted social opportunities which are similarly used as platforms for HIV prevention awareness, messages, and/or intervention. The CPG encourages funded HIV prevention organizations to consider this as a means for more effectively serving small, localized pockets of men who might not otherwise be reached.

- HIV “burnout” - Providers are encouraged to remember that despite the challenges of “HIV burnout” and the fact that many prevention messages are considered stale, or passé, or both among many MSM, this population remains interested in HIV/AIDS as a major health concern. It was in fact the number one health topic noted on the CPG’s 2003 MSM survey.

Service providers are encouraged to continue seeking ways of reaching MSM with HIV/AIDS-related messages that are fresh and engaging, and through events that are of interest to this population.

One exception to this (i.e., the idea that MSM are concerned about HIV/AIDS) may be among young MSM. Additional research is needed before strong conclusions can be reached here, but the CPG recommends that providers work to develop tailored messages and interventions meant to specifically appeal to the needs and circumstances of young MSM.

- **Outreach** - The CPG encourages service providers to continue seeking new means for conducting outreach to MSM. It can and should be used as a means of providing information; promoting norms around protective behaviors; promoting awareness of services and available programs; and reaching MSM who might not otherwise be reached.

Outreach in a rural state like Vermont presents some unique challenges, none of which are “news” to prevention providers, but do continue to challenge them. The CPG encourages providers to continue seeking creative solutions to reaching a disparate and sometimes hidden population; to overcoming the resource-intensity of doing outreach in this state; and to finding outreach models that are adaptable to a rural environment.

Geographic Considerations

Specifically, the CPG recommends that efforts to reach young MSM in Vermont be focused where this population is concentrated.

Venues: Dedicated Space

One of the most commonly agreed-upon service gaps for MSM in Vermont are dedicated spaces where men can comfortably congregate for any number of purposes (social, services, support, meetings, etc.). Outside of two bars, most of the state is severely lacking in such spaces, and alternatives to a bar setting are much in demand. This idea of a dedicated space is distinct from (but not exclusive to) the use of temporary locations (e.g., church basements, libraries, conference rooms, coffeehouses, etc.) where organizations may hold events, but which are not a place for ongoing, consistent services. While HIV prevention funds cannot be used for the creation of a physical space, the CPG recognizes the potential value of such a resource.

Related Information/ Recommendations: Capacity Building

Cultural Competency

The CPG encourages the Vermont Department of Health to offer trainings to HIV prevention- and other service providers, the focus of which would be increased cultural competency for meeting the service needs of MSM. This recommendation flows from two points:

- 1) MSM, like any other group of people, have socio-cultural and personal needs which are in some ways similar to the general population, and in some ways distinct.
- 2) There is a relative lack of MSM themselves in Vermont who are working as service providers, a gap filled by people who are not peers to this population. To this end, the CPG further encourages the Vermont Department of Health to provide capacity building assistance (training, infrastructure, and available resources) to organizations with a goal of increasing the number of MSM working as providers of HIV prevention (and other) services to other MSM.

Funding

No organization has too much money for their HIV prevention efforts. In an environment of increased competition, and level- or decreased funding, the CPG encourages the Vermont Department of Health to provide assistance to community-based organizations, helping them identify and even apply for alternate funding streams for this work.

Geography

Services should be available for MSM throughout the state. Anecdotal evidence suggests that particular capacity building for services is necessary in Vermont's Northeast Kingdom, Rutland County, and Bennington County.

Provider interviews, along with strong anecdotal evidence, suggest that in general, Vermont's more rural areas are both lacking in HIV prevention services, and difficult areas in which to provide these services. This actually includes *most* areas of the state, outside of Vermont's county seats (such as Burlington, Middlebury, Montpelier, St. Johnsbury, and Brattleboro).

Linkages/ Referral

One way to overcome a lack of resources, particularly in our rural environment, is to minimize duplicative efforts among service providers. The CPG encourages the Vermont Department of Health to work with HIV prevention providers to help them increase linkages to, and collaborations with, other service providers, in such areas as Mental Health, Substance Abuse Treatment, Healthcare, Corrections, and other human services.

Marketing/ Social Marketing

Many MSM service providers in the CPG's survey indicated that they would benefit greatly from stronger marketing efforts—to promote HIV prevention and risk reduction behaviors, as well as the available services themselves. These

efforts, however, can be cost-prohibitive. The CPG recommends that the Vermont Department of Health provide technical assistance to funded HIV prevention programs, to help them increase their social marketing skills, and to help them find ways of marketing their programs on a limited budget.

Networking

The CPG also recommends that the Vermont Department of Health continue supporting a statewide networking effort among organizations providing HIV prevention services to MSM. This support should include funding for regular meetings among providers, as well as administrative support and coordination of the process.

Training

In what areas would HIV prevention providers most benefit from technical assistance? What are the service gaps in Vermont that might be more quickly filled if providers were given specific training?

The CPG recommends that the Vermont Department of Health continue its efforts to gauge service providers' training needs and to offer training and technical assistance opportunities accordingly. In particular, based on the CPG's provider survey and other anecdotal information, there is a need for increased capacity among service providers so they may more effectively reach young MSM with HIV prevention messages and services.

Technical assistance and training should emphasize increasing proficiency with interventions that are proven effective among MSM. Examples of these interventions include (but are not necessarily limited to) the Mpowerment program and other programs listed in the CDC's Compendium of Effective Interventions.

Related Information/ Recommendations: Other Issues

Counseling and Testing in Healthcare Settings

Medical and other health care providers should be encouraged, and supported, to make HIV counseling and testing a routine part of health care. In supporting these providers, the Vermont Department of Health should place emphasis on increasing and/or maintaining MSM-specific cultural competency in the healthcare setting.

Data/ Information

Effective HIV prevention planning hinges in part on the availability of relevant data. The CPG strongly encourages a collaborative effort between the Vermont

Department of Health, the CPG itself, and other interested parties, to continue learning as much as possible about the HIV prevention needs of MSM in Vermont, as well as effective prevention approaches and interventions for this population and its sub-populations.

Highest priority for future needs assessment should be the following populations:

- MSM who are HIV+
- MSM of color
- Young MSM
- MSM who are of low socioeconomic status

Other needs assessment should also focus on:

- MSM in corrections (incarcerated, probation/parole)
- Non-gay-identified MSM
- MSM who are injection drug users (IDU)

Partner Counseling and Referral Services (PCRS)

Continuing, consistent PCRS should be available in Vermont, for MSM and other populations. The CPG encourages the Vermont Department of Health to continue these efforts.

Whole Health Approach

HIV prevention efforts targeting MSM should incorporate a “whole health” approach, recognizing HIV/AIDS as part of a spectrum of issues and priorities in the lives of Vermont MSM. Where possible, providers should consider incorporating the following (and other) health-related subjects. (Those specifically listed below were most frequently cited by MSM who completed the CPG’s survey this year):

- mental health
- diet/nutrition
- physical fitness

SECTION 6 : PEOPLE AT INCREASED RISK THROUGH HETEROSEXUAL TRANSMISSION

Related information elsewhere in the Comprehensive Plan:

Appendix 1: Epidemiological Profile

Section 8: Priority Interventions

Defining the Population

The Vermont Community Planning Group (CPG) has chosen to define and prioritize at-risk populations first and foremost by behavioral categories. These categories are based on the behaviors known to transmit HIV from an infected partner to another person: injection drug use (specifically, needle sharing) and sexual interaction (specifically, those sexual behaviors that may allow entry of virus into the bloodstream – oral, anal and vaginal sex).

The category “people at increased risk for HIV infection or transmission through heterosexual contact” does not exclusively refer to people who self-identify as heterosexual. The behaviors that put people at risk exist independently of sexual identity. Likewise, the recommendations within this section, at the most basic level, attempt to capture a behavioral category, not a demographic one.

At the same time, however, HIV prevention work is often appropriately predicated upon reaching people within defined communities and on targeting groups as specifically as possible. The Vermont CPG has a working definition for the category of “People at increased risk through heterosexual contact” and recommends that highest funding priority for HIV prevention programs targeting this group be given to programs addressing the prevention needs of the following:

Men, Women and Youth* who:

- are partners of people who are HIV+
- are partners of people who are injection drug users
- are partners of men who have sex with men
- are people of color
(including people who are Black/African American, Hispanic/Latino/Latina, Asian/Pacific Islander, American Indian/Alaska Native, and other people of color);
- report sexually transmitted infections (STIs) and/or unwanted pregnancy
- are incarcerated/juvenile offenders
- are homeless

Women and Youth* who:

- are dealing with, or have a history of violence or abuse
(including domestic violence, rape, emotional or physical abuse);
- seek treatment for substance abuse;
- live at or below the poverty line;
- are dealing with mental illness;
- are sex workers and/or trade sex for resources.

Youth* who are:

- runaway, “throwaway,” emancipated, abandoned, medically indigent, in foster or SRS care, out of school, and/or otherwise disconnected from traditional systems
- developmentally disabled

*For the purposes of this document, Youth are defined as ages 13-24.

Note on Youth:

Where youth at increased risk are noted, the Vermont Community Planning Group recommends that Department of Health prevention funding be prioritized for programs that take place in non-school settings only. In-school HIV/AIDS education and prevention receives dedicated funds through the Vermont Department of Education.

Special Issue: Women Who Have Sex With Women

Women who have sex with women is a category often left aside when determining HIV prevention priorities. Part of this may well be due to epidemiological evidence; women who have sex with women represent a significantly smaller portion of U.S. AIDS cases than do people defined by other behavioral categories. However, it is also quite possible that women who have sex with women are sometimes forgotten in the prevention planning process, or left out for no better reason than a lack of an appropriate “place” within defined high-priority categories.

Whatever the reason, it remains true that women who have sex with women are indeed at risk for HIV infection and should not remain invisible in this process. In addition to female/female sex, women who have sex with women may also be at risk as sexual partners of users of injection drugs; of men who have sex with men; or of heterosexual males at increased risk.

Programs targeting women at increased risk will inevitably be in a position to deliver prevention messages to lesbians, bisexual women, and other women who have sex with women. The Vermont CPG feels that it is appropriate, if somewhat incongruous, to recommend within this section that programs targeting women at increased risk be mindful and inclusive of women who have sex with women, when planning and delivering print materials, prevention messages, and educational efforts, such as skills building and negotiation for safer sex.

Women at Increased Risk: Related Issues

In the minds of much of the American and Vermont public, HIV remains an epidemic of men, especially gay and drug-using men. As the epidemic has grown and expanded to affect new populations, original public perceptions of AIDS have been slow to change.

Heterosexual sex with a man identified as infected with or at risk for HIV and sharing of injection drug equipment together account for nearly 83% of reported AIDS diagnoses among women in Vermont. The women at most imminent risk for HIV in Vermont are those who share needles themselves or those who are the sexual partners of men with HIV, especially men who inject drugs.

While needle-sharing by women themselves and the risk behaviors of their partners are the defining characteristics of women's HIV risk, there are other factors that increase women's vulnerability to HIV infection. These factors do not themselves constitute HIV risk, but they influence the environment in which transmission might take place and should be understood and factored into the development and implementation of HIV prevention programs for women at risk.

Sexually Transmitted Infections (STIs)

Infection with sexually transmitted diseases may enhance women's vulnerability to HIV infection. Many of these infections may damage the integrity of mucosal tissue in a woman's vagina, potentially increasing risk of HIV transmission if sexually exposed to the virus.

Besides HIV, reportable sexually transmitted infections in Vermont include chlamydia, gonorrhea, hepatitis (all strains), and syphilis, with chlamydia and gonorrhea by far the most commonly reported.

Power/Gender-based Dynamics

Power imbalances in relationships contribute to women's risk for HIV. The challenge of expecting a male partner to wear a condom is made more difficult if a woman has reason to fear physical violence or emotional battering in her relationship. A woman who is economically dependent on her partner may feel powerless to insist on changes in sexual behaviors for fear of loss of income, housing, and other daily necessities, fears that may be enhanced if children are also affected by the potential loss of support.

At the extreme of powerlessness, sexually abused and sexually assaulted women have no control over their potential HIV risk, and are vulnerable to HIV if their abuse or assailant is HIV infected.

Trading Sex for Resources

While there is a minimal commercial sex industry in Vermont, there is no question that this is a growing issue here. Reports of sex for money, sex for drugs, or survival sex for shelter and food (especially among young runaways) are on the rise. In July of 2004, many Vermonters were surprised by the exposure of a human trafficking operation, which brought Asian women to Vermont, where they were held against their will for sexual trade.

Women in these situations are even less likely than other women to be able to insist on protection in sexual relations, and therefore are placed in a vulnerable position for HIV transmission.

Racism

Racism also increases vulnerability for women of color, as the double stigma of being female and of color enhances powerlessness. Racism and sexism conspire to reinforce stereotypes of women of color and their sexual roles that contribute directly to an environment of increased risk. Women of color may also be at greater risk because of the disproportionate prevalence of HIV in communities of color, increasing the statistical likelihood that they may come in contact with the virus through a sexual partner.

Substance Use

Addictions to a variety of substances may increase women's vulnerability to HIV infection. While not universally well-documented to have a direct effect on HIV risk-taking behaviors, the widely understood disinhibiting and judgment-impairing effects of many intoxicating substances raise serious concerns for HIV prevention.

Corrections

Women who are involved in the criminal justice system may be at particular risk as there is a great correlation with substance use and entry into the correctional system. Women in custody or on probation may be in extremely vulnerable economic and social

positions, and this lack of power may particularly enhance their risk in sexual relationships. Within correction facilities, access to clean injection equipment and latex barriers for sex is absent or severely restricted, further increasing possible HIV risk.

Disenfranchised Populations

In addition to these factors that increase women's vulnerability to HIV infection, some groups of women are systematically disenfranchised and not necessarily reached by general HIV education and prevention efforts. Women in these categories who are also in high-risk situations may be at increased risk because they lack adequate information or skills to protect themselves.

Women who may experience this systematic disenfranchisement include: women living in poverty; women with limited literacy; very young women and older women; refugees and recent immigrants; women for whom English is not their first language; lesbians and bisexual women; women who are Deaf or hard of hearing; women who are migrant, homeless, or incarcerated; women who have developmental disabilities; and women with psychiatric disabilities. HIV prevention programs and agencies serving women should be particularly aware of the barriers to reaching these groups, including the possible gaps in HIV awareness and knowledge that may exist.

Perceptions of Risk

Finally, it must be remembered that larger numbers of women may have some risk for HIV infection without belonging to any of the particular identifiable risk populations. Sexually active women who have sex with men (particularly young women, college students and high school students) may not be statistically likely to encounter a sexual partner with HIV, but some number of them may. Efforts to target women at imminent risk should not give the message that other women have no reason to be concerned about protection. General information campaigns should help support all HIV-negative women in maintaining their status through the adoption and maintenance of safer sex practices or deferral of sexual intercourse.

Youth at Increased Risk: Related Issues

NOTE: Where youth at increased risk are noted, the Vermont Community Planning Group recommends that Department of Health prevention funding be prioritized for programs that take place in non-school settings only. In-school HIV/AIDS education and prevention receives dedicated funds through the Vermont Department of Education.

No single program will reach or meet the needs of all at-risk youth. A variety of approaches must be developed to access different pockets of youth at risk in the community. One study notes, "Social and cultural factors, such as religion, values,

gender roles, economic conditions and individual differences must be considered in designing effective programs. Because of the differences in the culture of various adolescent groups, an effective educational program for one group may not be effective for another group.” (Yarber and Parillo, “Adolescents and Sexually Transmitted Diseases,” *Journal of School Health*, 62 [7], 1992.)

Some youth, because of their own risk-taking practices and the amount of virus present among their pool of potential sexual or needle-sharing partners, are at much more imminent risk than others. While all youth are entitled to quality HIV prevention services, HIV prevention efforts should particularly focus on the needs of youth facing an immediate and significant risk of infection. This concern particularly applies to youth from communities with a well-documented over-representation in reported AIDS data.

Abstinence/Postponement and the Continuum of Risk Behavior

More than any other targeted population, we cannot assume that young people are or are not sexually active, or active substance users. Young people have a variety of levels of experience with these activities, and HIV prevention program design must reflect that fact.

It is important to recognize and acknowledge the choices young people make, whether they are choosing to abstain from or postpone sex or drug use; or if they are actively engaging in these behaviors. It is also important to allow for the fact that young people who are abstinent will likely choose not to remain so at some point in their lives; and some who are drug users and/or sexually active may choose to cease those behaviors and become abstinent. All of these points on the continuum of drug use and sexual activity are part of a comprehensive approach to HIV prevention._

GLBTQ Youth

It is important for programs targeting youth at increased risk to take into account the HIV prevention issues specific to young people who are questioning their sexuality or who already self-identify as gay, lesbian, bisexual or transgendered. The recommendations in this sub-section, it should be noted, come under the umbrella of “people at increased risk for heterosexual transmission.” While this is in some ways an incongruity, it also is an attempt to address the artificiality of certain kinds of categorical line-drawing. Many people do not exist or self-identify within neatly drawn definitions.

An increasing number of GLBT and questioning youth have access to groups and activities focused on their needs. School-based gay-straight alliances, for example, are fairly common as compared to several years ago. However, it is also true that many of these youth are more likely to be involved with more general, out-of-school, youth-targeted programming. Consequently, it is important that such programming, where it is the channel for HIV prevention messages, be as inclusive as possible.

For many adolescents (and others coming out), experimentation and participation in sexual activity is frequently an important and powerful stage of sexual orientation integration. The presence of a significant rate of HIV in the population of men who have sex with men means these young people face an increased chance of contact with an infected partner early in their sexual activity. Information, skills, and support to reduce the risk during this experimentation period are especially important.

Gay, lesbian, bisexual, and transgendered, youth have been largely overlooked in many school-based HIV programs and in public education efforts. Our society's fear of acknowledging young people's sexuality, coupled with the pervasive homophobia in our society, makes such school and public advertising efforts fraught with controversy, and therefore rarely implemented. This invisibility only adds to the isolation of these youth, and makes many of the most widely available prevention efforts barely relevant or accessible to the population most in need.

HIV education and prevention efforts must specifically include representation of young people of all sexual orientations in their materials and curricula. These efforts should directly address the specific risk situations and prevention needs of gay, lesbian, bisexual, transgendered, and questioning youth. Such efforts should also work to create safer space for all youth by encouraging wider acceptance of young gay, lesbian, bisexual, transgendered, and questioning youth. As with other programs, GLBTQ youth must be integrally involved in the design and delivery of these programs to enhance the chances of success.

Men at Increased Risk: Related Issues

In a 2000 report for World AIDS Day ("AIDS; All Men – Make A Difference"), the American Association for World Health suggested a framework for male-focused prevention:

Men should be encouraged to:

- Accept greater responsibilities for being providers of care and support for their families
- Take a greater role in helping end the spread of HIV
- Change harmful sexual stereotypes (of male dominance, women's roles, homophobia, etc.)
- Change the way they view risk taking, sexuality and violence
- Address their sexuality honestly and responsibly
- Be a positive role model for boys
- End their silence on issues of sexuality
- Support one another

These recommendations touch on risk for infection among men, as well as their role in prevention for women. Both of these are key factors when addressing HIV with this population.

Addressing the sexual behaviors of heterosexual women without men does not take into account gender and power imbalances and does not encourage men to take responsibility for their own health and the health of their families. Therefore, heterosexual men, in and of themselves, should be targeted for HIV prevention.

While heterosexually transmitted infection among men who have sex with women represents a small portion of the AIDS epidemic, it is important to target the need for prevention among those men who are in known high risk situations and/or engaging in specific behaviors that put both themselves and their female partners at risk. _

Risk B ehaviors

HIV risk practices among men who have sex with women can include the following:

- Sexual intercourse while under the influence of drugs/alcohol
- Unprotected anal intercourse (this can include men who have sex with both men and women; men who have sex with women)
- Unprotected vaginal intercourse and unprotected oral sex
- Sex with multiple partners and sex with a partner who has multiple partners
- Sex with partners of positive/unknown HIV status
- Injection drug use *(The rise in infections from injection drug users who are heterosexual men has led to the rise among heterosexual women. This trend, in turn, puts other heterosexual men at risk because they may have sex with these HIV+ women who are users of injection drugs, or sexual partners of people who use injection drugs.)*

Special consideration: Men who have Sex with Men

There is some overlap between this population and the population of men who have sex with men. Common understandings of sexual orientation or identity do not always mesh with behaviors. Some men who identify as heterosexual also have sex with men. This section is concerned with male-female (heterosexual) transmission (not to be considered synonymous with heterosexual identity or orientation). The HIV prevention needs of men who self-identify as heterosexual, but also have sex with men, are addressed in a separate section.

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Other considerations for programs targeting men who have sex with women:

The following factors should be considered when creating HIV prevention programs for men who have sex with women. While each of them may not apply to *all* men at increased risk, this list represents some potential barriers to HIV prevention that providers should be prepared to address.

“Traditional” Roles

While the historically “traditional” role of heterosexual men as providers, husbands and fathers is in some ways outdated, it is also the reality for many people and cultures today. While HIV prevention interventions should not seek to promote gender stereotypes, it is important to meet men where they are. Awareness and prevention campaigns may very well find a higher response rate among some men if those campaigns focus not just on personal risk and health, but on the perceived larger needs of the family unit.

Sexual violence/Power dynamics

Men are overwhelmingly the most common perpetrators of sexual violence. This is true for anonymous assault, in cases of casual sex, and in ongoing relationships.

Men are also more often in greater control regarding condom usage with their female partners. While some female-controlled protective options are available, the male condom is still the most common and feasible preventive method for anal or vaginal intercourse.

Men should be encouraged to understand issues of power and violence, to identify the roots of these power-based dynamics and, where applicable, to deal with triggers to violence and other risk behaviors.

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Sexually Transmitted Infections

While there is not necessarily a “community” of heterosexual men with sexually transmitted infections, this is a population with a clear demonstration of risk behavior. Health care providers and support groups for people with specific conditions (such as herpes or hepatitis) should become active players in disseminating HIV information and prevention education.

HIV stigma/awareness

Many men, particularly men who identify as heterosexual and who are not injection drug users, still see HIV as a “gay” disease. Previously mentioned recommendations in this document address the value of increasing awareness around risk. Another strategy that

has shown some promise with this population is the incorporation of HIV education into a general health-focused context. Studies of young heterosexual men have shown a higher level of receptivity to sexual health models as compared to disease prevention models. By teaching men to take care of themselves and their partners, we are inherently addressing prevention -- of pregnancy and of sexually transmitted infections including HIV.

Peers

Part of the “gay disease” stigma surrounding HIV for heterosexually-identified men is the lack of peer education for this group. As with any population, the involvement of peers is a key to effective programming. Wherever possible, men who have sex with women should be consulted in program design, and recruited and trained to deliver interventions to other men within this population.

END OF SECTION 6:
PEOPLE AT INCREASED RISK THROUGH HETEROSEXUAL TRANSMISSION

SECTION 7 : INJECTION DRUG USERS (IDU)

Related information elsewhere in the Comprehensive Plan:
Appendix 1: Epidemiological Profile
Appendix 4: IDU Needs Assessment Materials and Methods
Section 2: Community Services Assessment
Section 8: Priority Interventions

Introduction

The presence of injection drug use is at odds with the bucolic images of Vermont frequently held by both Vermonters and outsiders. There is tremendous denial about the realities of both injection drug use and related HIV transmission in our rural and small-town culture. The common image of injection drug use as an exclusively urban, inner-city phenomenon still prevails. This difficulty in acknowledging the problem is but one of the many barriers to effectively dealing with the interrelated issues of injection drug use and HIV transmission in Vermont.

Seventeen percent (17%) of the cumulative reported diagnoses of AIDS in the state have occurred among users of injection drugs, and 14% of people known to be living with HIV/AIDS in Vermont are attributed as injection drug users, with an additional 5% attributed as MSM/IDU (Men who have Sex with Men who are also Injection Drug Users).

Unlike other populations affected by HIV, there is no political constituency demanding services for users. And while organized groups of current users of injection drugs have formed in some large cities, issues of legality and stigma are significant barriers to this kind of organizing, particularly in a rural and small-town environment. Even without those barriers, the reality of addiction is that many or most users of injection drugs live chaotic lives in which survival and the need for drugs are the most powerful factors, making creation of community organizations and advocacy a difficult goal.

Rural injection drug use frequently differs from urban patterns. While a visible street scene and shooting galleries exist to a limited extent in a few larger Vermont towns and cities, it appears that a more common pattern is the existence of smaller, relatively self-contained groups of friends who use together, frequently sharing a common supply source. These groups are not, however, strictly self-contained, as members interact with other groups of users, or as they access drug suppliers outside of their own local area or their own state. These external interactions, coupled with fluid group membership, offer the opportunity for introduction of an infectious agent (such as HIV) into these circles.

In particular, Hepatitis C has been notably on the rise among injection drug users in recent years. Substance abuse treatment providers report high numbers of clients with Hepatitis C, far exceeding any awareness they may have of clients who are HIV positive. Transmission of Hepatitis C, however, is a strong surrogate marker for risk behaviors that may contribute to the spread of HIV.

As to prevention, a gap exists between many of the activities which are, anecdotally, the most widely supported HIV prevention activities for this population, and the activities for which the CPG can feasibly recommend funding.

Specifically, syringe exchange; pharmacological substance abuse treatment; and non-pharmacological substance abuse treatment are activities upon which there is near consensus among advocates as to their importance. When asked what the priorities for prevention should be, IDU advocates, and IDUs themselves name these activities more than any other. However, these are not fundable activities by the Vermont Department of Health. While the CPG makes a priority of focusing on specifically fundable prevention interventions, that focus should in no way be construed as de-emphasizing the importance of these other activities.

It remains the position of the Vermont Community Planning Group that syringe exchange programs, pharmacological substance abuse treatment, and culturally competent non-pharmacological substance abuse treatment are the cornerstones of effective HIV prevention for injection drug users. They should remain a top priority among service providers and advocates. Furthermore, the CPG urges the Vermont Department of Health to support these activities to the greatest extent possible and legally allowable.

Prevention Priorities

In addition to the Interventions named in this Comprehensive Plan (see Section 8), the CPG has identified a non-binding list of priority IDU sub-populations, as well as priority venues where interventions targeting Injection Drug Users (IDUs) should be considered. These lists are intended as informational guidance. They are not meant to exclude service providers from applying to do prevention work in other locations and with other groups of IDUs.

IDU Sub- Populations

It is the position of the Vermont Community Planning Group that ALL IDUs in Vermont are at increased risk for HIV infection and/or transmission.

A comprehensive approach should take into account two things:

- 1) Data indicates that the bulk of injection drug users in this state are Caucasian adult males.
- 2) Other populations have been, and continue to be, disproportionately impacted by both injection drug use and HIV/AIDS.

Applications for HIV prevention funding to provide HIV prevention interventions targeting any and all IDUs in Vermont should be considered. The need for targeting HIV prevention interventions to specific populations reflects disproportionate impact and socio-specific need among those populations, not a lack of need among the IDU population as a whole. Underserved sub-populations include:

- IDUs who are living with Hepatitis C
- young IDUs, and young opiate users who do not inject, or those who may be at increased risk for transitioning from non-injection use to injection use
- female IDUs and in particular, female IDUs living at or below the poverty line; who are sexual or needle-using partners of other IDUs; and/or those who are caregivers to children

Rationale (HCV+, Youth, Women)

- Indications among IDU service providers and current/recent injection drug users interviewed (2002 Needs Assessment project) that these populations are at increased risk and/or particularly disconnected from available services;
 - People who are HCV+ have at least some history of risk behavior;
 - Youth and Women can be particularly disconnected from services due to lack of risk awareness; transportation issues; childcare issues; and, for youth, an age requirement for accessing certain services, such as syringe exchange.
- IDUs who are members of communities of color
 - IDUs who are also men who have sex with men (IDU/MSM)
 - IDUs who are also homeless and/or seek services relating to a need for short- or long-term shelter
 - IDUs who are not currently in substance abuse treatment or seeking substance abuse treatment services; and/or IDUs who are not current clients of an existing harm reduction or HIV prevention program

Rationale (Communities of Color, MSM, Homeless, Not in services/treatment)

- Prioritized as a result of further IDU Needs Assessment committee discussion;
- Many of these populations have been disproportionately impacted by HIV/AIDS;
- Reaching IDUs who are not currently connected to services or treatment is an ongoing goal among service providers, particularly outreach workers.

In a small state like Vermont, it may not be feasible (or even advisable) to create targeted HIV prevention programs for injection drug users who fit each of these categories. A funding source too finely sub-divided for individual projects may result in a lack of program effectiveness overall. However, funded programs can be proactively inclusive of these populations. For example:

- print materials targeted to a specific audience (such as IDU/MSM; young IDUs; IDUs of color; etc.);
- use of inclusive language in the delivery of interventions (specifically, language that does not assume a certain HIV status, sexual orientation, racial background, personal ability, etc.);
- program staff that is socio-demographically reflective of specific populations (e.g., young outreach workers; counselors of varying racial/ethnic backgrounds; etc.)

These are just a few examples of the ways in which programs can, and should, be cognizant of the diversity within their target population.

The CPG recommends a balanced approach to serving the needs of the IDU population in Vermont, which is (to the extent possible), responsive to common factors among IDUs as well as the specific life circumstances among individuals and groups within that population.

Venues

Based on the 2002 needs assessment process, which involved interviews with injection drug users as well as service providers who work with them, the IDU Needs Assessment Committee developed a list of venues that might be particularly appropriate for reaching IDU in Vermont with HIV prevention services. While the primary activities that take place in some of these venues may not be fundable with federal prevention dollars, the CPG recommends that service providers consider ways in which they might leverage the opportunities presented by these venues for providing other interventions.

Note: This list is intended as informational guidance. It is not meant to exclude service providers from applying to do prevention work in other locations and with other groups of IDUs.

VENUE	DESCRIPTION/ DETAIL
Syringe Exchange-based Interventions	Activities to increase access to, awareness of, and utilization of Syringe Exchange Programs <i>(excluding actual exchange of injection equipment)</i>
	Activities delivered at, through, or in conjunction with, Syringe Exchange Programs <i>(excluding actual exchange of injection equipment)</i>
Pharmacological (e.g., Methadone, Buprenorphine) Substance Abuse Treatment-based Interventions	Activities to increase access to, awareness of, and utilization of available pharmacological substance abuse treatment <i>(excluding actual delivery of pharmacological treatment)</i>
	Activities delivered at, through, or in conjunction with pharmacological substance abuse treatment facilities <i>(excluding actual delivery of pharmacological treatment)</i>
Non-Pharmacological Substance Abuse Treatment-based Interventions	Activities to increase linkages to, awareness of, and utilization of available substance abuse treatment services <i>(excluding actual delivery of substance abuse treatment services)</i>
	Activities delivered at, through, or in conjunction with substance abuse treatment facilities <i>(excluding actual delivery of substance abuse treatment services)</i>
Corrections/Probation & Parole-based Interventions	Activities targeting IDUs in Correctional facilities and through the Probation and Parole system/services

Rationale

(Venues: Syringe Exchange Programs, Pharmacological Substance Abuse Treatment Programs, Non-Pharmacological Substance Abuse Treatment Facilities)

- Consensus among providers/users and CPG that these venues represent rare opportunities for reaching IDUs in relatively large numbers, on a regular basis.
- Many who use these services are, in doing so, proactively working to reduce their HIV risk and/or substance use-related risk.
- Word of mouth: IDUs who are reached through these venues may then make referrals and/or pass on information to other IDUs in the community who are not currently seeking services, a population that is difficult and sometimes impossible for service providers to reach in other ways.

Rationale:

Venue: Corrections/Probation and Parole

- Known high-risk group;
- Reachable population, whether individuals are currently incarcerated or part of Community Corrections (which includes the intensive substance abuse program);
- Environment can be conducive to providing specialized HIV prevention services, geared to the incarcerated;
- Indications from Vermont Department of Corrections staff that there is broad support for increased HIV prevention efforts; and that reaching groups of individuals involved in the corrections system is quite feasible.

Related Information and Recommendations

Cultural competency for IDUs in the delivery of interventions

Injection drug users continue to suffer, in their daily lives and as an at-risk population in general, from a lack of understanding in the larger population. “Addictophobia” and a pervasive view of injection drug use/opiate dependence as a criminal (versus a public health) issue can increase the barriers to effective HIV prevention. Many IDU and HIV prevention advocates rightfully make it a part of their work to increase compassion and understanding among the general population.

It is also important that the programs serving IDUs, and the people staffing those programs, are aware of what it means to be a needle user (and/or opiate dependent). This kind of cultural competency encourages service utilization as well as effectiveness.

Some key elements of cultural competency for users of injection drugs include:

- a compassionate and nonjudgmental approach to prevention and drug dependence;
- consumer input whenever possible, for program development and execution;
- inclusion of current and/or former users as service providers;
- providers who reflect the target population socio-demographically;
- an ability to make referrals for services targeted to specific populations;
- client-centered program design, accounting for:
 - the role of stigma (related to injection drug use as well as HIV infection);
 - the importance of confidentiality, and the difficulty in maintaining it in a rural environment;
 - other barriers to service utilization
- a view of drug use and addiction as a public health (as opposed to criminal) issue;
- addressing barriers associated with a rural environment (including but not limited to the above-mentioned challenges of maintaining confidentiality in the delivery of service).

Funding Issues

In many ways, HIV prevention in Vermont is shaped by the availability of funding – both the amount of funding available for prevention activities, and the restrictions placed on available funds. The primary focus of the Vermont Community Planning Group is on the allocation of federal HIV prevention dollars, as channeled through the Vermont Department of Health. At the same time, the CPG intends to continue exploring ways in which funding issues impact HIV prevention, and ways in which specific funding-related changes might improve an overall HIV prevention effort in Vermont. These include:

- The availability of state prevention dollars

While the state of Vermont has allocated funds for HIV care and services for many years, the Vermont legislature has never provided funding specifically for HIV prevention in this state. In light of 2002 budget cutbacks in Vermont (of approximately \$39M), the CPG recognizes that this may not be the time to feasibly expect an increased commitment from the state to fund HIV prevention.

However, it remains true that the allocation of state HIV prevention funds sometime in the future could distinctly improve local efforts at meeting the needs of at-risk populations. This is true on two levels: increased funds

could mean additional and farther-reaching programs; and could also potentially mean available funding for activities currently prohibited with federal HIV prevention dollars, such as syringe exchange.

The CPG encourages HIV/AIDS advocates as well as the Vermont legislature to explore future possibilities for making available state funds for HIV prevention activities.

- Cash stipends

Mixed opinions surround the notion of providing cash stipends to HIV prevention program participants. Research indicates that cash stipends (versus other incentives, such as gift certificates) are the most effective means for actively involving IDUs in certain prevention activities. These findings are at odds with the reluctance by some to endorse a system whereby a potential means for purchasing illegal substances is given to those who may be suffering from addiction or dependence on those substances.

One of the newest emerging interventions for working with IDUs is PDI (Peer Driven Intervention). The notable successes with PDI around the country have all involved the use of cash stipends to encourage IDUs to participate in an initial interview and subsequently, to educate their peers about HIV/AIDS. Whether or not this program, and others, can feasibly be undertaken using a substitute incentive besides cash is unknown.

Most of the HIV prevention activities recommended by the CPG as priorities do not involve stipending participants at all. However, where incentives do come into play, the CPG remains interested in exploring ways in which this issue might be resolved – either through a feasible and effective substitution for the use of financial remuneration; and/or through further study of this issue and dialogue among all interested parties.

- Syringe Exchange and Pharmacological Substance Abuse Treatment

As mentioned throughout this document, syringe exchange and pharmacological substance abuse treatment (i.e., methadone; buprenorphine) are two of the most widely regarded HIV prevention activities among IDU advocates and HIV prevention experts. The CPG maintains that these activities can and should be an inherent part of any comprehensive approach to meeting the HIV prevention needs of an IDU population. The CPG also recognizes that federal funds are prohibited for use on either of these activities.

The CPG strongly encourages the Vermont Department of Health to support these activities in any way that it may legally do so; and that

venues where these activities take place be used, as feasible, for the delivery of other HIV prevention activities (for example, promoting available individual and group counseling, HIV testing, etc., to those who participate in syringe exchange or methadone treatment).

The CPG also recommends that IDU and HIV prevention advocates continue to explore ways of making these interventions as widely available in Vermont as possible, including advocating for increased funding from any and all sources.

It should also be noted that funding for these activities is one of several interconnected issues, which can also include institutional capacity; social norms; and community resistance. In other words, making available funds for these activities is just one of several things that must be done before they can be implemented, or increased.

- Capacity Building

Another key question the CPG faces are the ways in which the capacity for IDU-targeted services of any kind can be increased. It is not within the scope of the CPG's work to actually work with providers to increase their ability to work with IDUs; or to create new resources in the community. However, the CPG does have a vested interest in supporting this kind of work.

In an environment of extremely limited (and potentially shrinking) prevention dollars, the CPG would like to see additional funding streams, including perhaps one-time federal supplemental funding, directed toward improving the capacity of existing and potential providers to perform HIV prevention services. As the HIV/AIDS epidemic changes and evolves, resources should be allocated to ensure that local HIV prevention efforts evolve with it.

Stigma and the difficulty of doing this work

The stigma surrounding injection drug use and addiction are intertwined in any effort at effective HIV prevention for IDUs. Part of what happens as a result of this stigma is a "facelessness" to the population. Injection drug use is often viewed as "someone else's problem," and the number of active users, private citizens, or legislators who are either able or willing to advocate for this population is small.

Contrary to commonly held beliefs, injection drug use crosses all socio-demographic boundaries in Vermont. IDUs are a population of all classes, races, genders, sexual identities, etc. The growing public awareness of heroin usage in Vermont has not necessarily increased the level of public agreement about how these issues should be addressed.

Stigma is also a barrier when it comes to bringing an IDU voice to the community planning process. Many active users are understandably reluctant to self-identify, especially in a public process like community planning. Our 2002 needs assessment interview project helped us gather more first-hand information than we have previously had to work with. We hope to continue increasing the depth of participation by this population in the future.

The importance of harm reduction- based programs

Harm reduction examines the behaviors and attitudes of the individual to offer ways to decrease the negative consequences of the targeted behavior. In a harm reduction model, complete abstinence from risky behaviors should not be the only objective of prevention services because it excludes a large proportion of people. Instead, complete abstinence from risk behaviors should be understood as a possible goal in a series of harm reduction objectives. Individuals are engaged to help them identify the steps they need, steps they are ready and able to make toward reducing their risk for HIV infection, and individuals are rewarded for their success and encouraged in their attempts. The most effective way to help people minimize their risk behaviors is to provide attractive, user-friendly services that empower them to reduce their risk.

The CPG maintains its commitment that harm-reduction-based strategies must be part of HIV prevention for users of injection drugs.

In 2002, the CPG's IDU needs assessment project yielded strong anecdotal evidence of broad-based support for the inclusion of harm reduction-based strategies in human services. We interviewed 14 service providers in Vermont working with users of injection drugs. They included mental health, substance abuse treatment, corrections, and HIV prevention providers. All of them expressed support for harm reduction-based strategies when working with injection drug users. This unanimous support was echoed at a 2002 meeting, initiated by the CPG, to discuss HIV prevention issues with representatives of various state agencies, including mental health, the Office of Alcohol and Drug Abuse Programs, Department of Corrections, and Department of Education.

This is not to say that harm reduction-based approaches have uniform support among every individual providing services to this population in Vermont. Sometimes these mixed opinions can occur within the same organization, sending mixed messages to those who are receiving services. For example, one substance abuse treatment provider described an antagonism between those staff who make referrals to syringe exchange programs, and those who view such referrals as antithetical to their work.

It is not realistic to expect all service providers to agree philosophically on a single approach to prevention. However, the prevailing research, as well as the experience of those interviewed in the 2002 Needs Assessment, indicate that

abstinence-only based approaches should never exist to the exclusion of harm-reduction-based approaches, which recognize the role of relapse in the recovery process. All users of injection drugs who access services in Vermont, and moreover, all recipients of HIV prevention services in this state, should be assisted in making informed decisions about the full range of available services and treatment modalities.

The state of Syringe Exchange and Pharmacological Substance Abuse Treatment in Vermont

The implementation of syringe exchange, and pharmacologically-based opiate addiction treatment in Vermont has been a slow process, due to a lack of consensus among Vermonters as well as Vermont legislators. The general movement, however, has been toward providing services in Vermont, albeit incrementally.

Syringe Exchange Programs

Vermont now has three syringe exchange programs in operation. The newest program, in St. Johnsbury, began operation in the summer of 2002. Existing programs continue in Burlington and Brattleboro. Because of limitations on use of federally provided funds, these programs are independently funded.

The CPG strongly supports a thoughtful, evidence-based expansion of syringe exchange in Vermont. All reasonable methods should be considered to help serve the needs of an already difficult-to-reach population in a rural environment. The CPG also encourages the Vermont Department of Health to continue as a partner in this process, examining feasible options and supporting these efforts in whatever capacity it may legally do so.

Pharmacological Treatment

Methadone

Vermont's first methadone clinic serving people who are opiate dependent began operation in the Fall of 2002. It is located in Burlington and is the only on-site methadone clinic in the state.

In 2004, a contract was awarded by the Office of Alcohol and Drug Abuse Programs for implementation of mobile methadone provision in Vermont's Northeast Kingdom (Orleans, Essex, and Caledonia Counties). This service is expected to begin in 2005.

Methadone is otherwise available in Vermont under limited circumstances only. Healthcare providers may prescribe it for chronic pain but not for

opiate dependence. The exception to this is among opiate dependent pregnant women, for whom methadone is made available through at least one health care facility. It is also available as part of one short-term detoxification program in southern Vermont.

Buprenorphine

Opioid dependence treatment using buprenorphine is available through the University of Vermont Substance Abuse Treatment Center, and through a limited number of certified private healthcare providers in Vermont, who may offer this service to no more than 30 clients each. There is a widely perceived lack of such providers and of available buprenorphine treatment in general. The Vermont Community Planning Group urges the lifting of any caps on buprenorphine treatment in the state, such that the supply for this service can more feasibly meet the demand.

Given the limitations on federal funding and the absence of Vermont state HIV prevention funds, it is beyond the scope of the CPG to recommend direct funding for syringe exchange or pharmacological treatment. However, the CPG strongly endorses any efforts by other parties to increase the availability of both syringe exchange and pharmacological treatment as part of an overall, comprehensive approach to meet the HIV prevention needs of injection drug users in Vermont.

Hepatitis C

As needle and heroin usage increases in Vermont, so will the transmission of HIV and even more so, Hepatitis C (HCV). Anecdotal reporting by Vermont health care workers, IDU service providers, and active needle users, bears out much of the current national dialogue: that among injection drug users, HCV is prevalent, and is of greater personal concern to current users than HIV. The Community Planning Group supports the incorporation of hepatitis prevention efforts with existing HIV prevention efforts targeting users of injection drugs in Vermont. This effort is already underway in many places. Many service providers recognize the link between HIV and HCV prevention, including the fact that for many needle users, HCV is not only a more prevalent topic, but it can be more easily introduced and may act as a means of bridging to the subject of HIV/AIDS.

- END OF SECTION 7 : INJECTION DRUG USERS (IDU) -

SECTION 8 : INTERVENTIONS

In this section:

- *Elements of a Successful HIV Prevention Program*
- *Behavioral Theories*
- *Interventions with Shown Effectiveness:*
 - *Diffusion of Effective Behavioral Interventions for HIV Prevention (DEBIs)*
 - *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*
 - *Prevention For Positives – Interventions*
- *HIV Prevention Interventions Categories*
- *Counseling, Testing, and Referral Definitions*

In 2004, the Vermont Community Planning Group adopted three lists of interventions for use in Vermont:

- 1) DEBIs (Diffusion of Effective Behavioral Interventions for HIV Prevention)
- 2) Compendium of Effective Interventions
- 3) A list of programs with demonstrated effectiveness for HIV prevention targeting people who are living with HIV/AIDS, a/k/a, Prevention with Positives.

Each of these lists is detailed further down in this section of the Comprehensive Plan.

A NOTE ON RURAL - SPECIFIC LIMITATIONS

Many of the interventions and prevention programs named on these lists were developed in, and for, an urban environment. One of the real challenges of implementing effective, science-based HIV prevention in Vermont is in bringing those urban-based models into a largely rural state such as ours.

The Vermont CPG strongly encourages providers to look closely at these intervention programs in terms of feasibility, and where possible, to adapt the named interventions in such a way as to maximize their chances for success with the intended audience.

Factors to consider include:

- Vermont's small population size in general;
- The relatively small size of target populations and sub-populations here;
- Limited resources (including funding, staffing, media outlets, gathering spaces)
- Rural isolation and disparate populations;
- Lack of available transportation;
- Vermont's fluctuating weather and the limitations that go with it.

Elements of a Successful HIV Prevention Program

People at increased risk for HIV infection and/or transmission must be at the heart of HIV prevention program design. Programs must meet the real needs of those they seek to serve. Accordingly, certain common elements should apply to any HIV prevention effort, whether it is a direct implementation of a prescribed curriculum, or a well-considered and science-based adaptation of an existing program. Those elements include:

Behavior Change Counseling

Sexual and needle using behaviors are the most basic elements of HIV transmission. Individuals who receive HIV prevention services should be given the opportunity to address their need for the initiation, re-initiation, or maintenance of safer practices.

Skills Building

The intent of prevention interventions is to affect changes in behaviors that put people at risk for HIV. Building skills through role-playing and other interactive exercises and creating social norms for adopting healthy behaviors are critical when focusing on behavior change. Skills building generally refers to specific experiential activities aimed at helping people increase their confidence and abilities for condom usage; negotiation, refusal and communication skills; safer injection techniques; and other preventive behaviors.

Harm Reduction

A harm reduction approach acknowledges that people engage in unhealthy behaviors and seeks to reduce the harm that results from the behavior. For example, injection drug use is a behavior for which the potential for harmful effects can be reduced if the person does not share needles; therefore, an intervention that promotes the use of a new syringe for every injection is based on harm reduction principles.

Peer Involvement

Any targeted program should be designed in consultation with, and to the extent possible, implemented by members of the population for whom the program is intended. Programs should be responsive to community needs. Staff and volunteers should be knowledgeable and sensitive toward the issues their target population faces, including issues directly and indirectly related to HIV/AIDS.

Cultural Competency and Appropriateness

Cultural competency includes but is not limited to issues of race, ethnicity, language and sexual orientation. The target population's norms, perceptions and practices should have a direct relationship to program design. These factors should be respected as community parameters and not treated as obstacles to preconceived notions of what a program should be.

Examples include delivering interventions in the language the target population is most comfortable speaking and hiring members of the target population to deliver interventions when possible.

Defining the Target Population

In general, the more well-defined the target population the more effective and cost-effective programs are. Interventions that target the “general population” or other broadly defined groups are not as relevant in this era of HIV prevention in which there are generally high levels of knowledge and awareness about HIV/AIDS. Target populations can be defined by behavioral risk, gender, age, sexual orientation, ethnic or cultural identity, etc., or a combination of these factors.

Holistic Services

HIV cannot be addressed in a vacuum; it must be addressed within the context of people’s own lives. HIV prevention should be just one component of a set of services addressing multiple issues relevant to clients and community members. Social services that should be prioritized for coordination with prevention services include, but are not limited to: substance abuse treatment, immigration services, legal services, mental health and primary health care services, shelters for homeless, shelters for battered women and children, rape crisis counseling, child protective services, suicide prevention, job training and placement, youth and runaway services, family planning, STD care and prevention, and services for people with physical, emotional, and/or learning disabilities.

While HIV prevention programs do not necessarily need to address all these issues directly, providers should be able to make appropriate referrals and perform follow-up to determine if those referrals were useful to the client. The ability to respond to a variety of issues, including the ability to make appropriate referrals, is key to a comprehensive HIV prevention program.

Multiple Approaches

HIV prevention strategies and interventions are more likely to reach target populations if a variety of approaches are used. The most successful prevention programs use a combination of theories, strategies, and interventions linked together to create one cohesive program. Providers may achieve this goal within their own programs or collaborate with other agencies that serve the same target population. In addition, the use of multiple communication methods and the design of consistent messages that address the issue from more than one perspective are likely to contribute to the effectiveness of programs.

Prevention Messages

The content of interventions should be dictated by findings from a needs assessment, either formal or informal, and should address issues that are current and relevant for the target population. For example, a needs assessment might reveal that a belief that certain treatments decrease infectiousness is leading to increased unsafe sex in a

particular population; therefore, an intervention for this population would disseminate prevention messages that focus on this issue.

In addition, prevention messages should be concise, appropriate to the target population, and delivered with frequency over an extended period of time for maximum effect. (However, attention to “saturation” is important; needs assessments can help determine when it is time to change a prevention message or give it a “new look.”)

Recruitment and Retention

Recruitment and retention of participants in HIV prevention programs can be challenging. Providing incentives such as food, food vouchers, transportation tokens, t-shirts, or condoms, can be useful for some target populations. Likewise, attention to recruitment and retention of staff and volunteers is critical for the continuity of programs, which contributes to agency credibility and helps promote community trust.

Risk Reduction

HIV prevention efforts should aim to reduce people’s risk, allowing for both abstinence and non-abstinence. Risk reduction does not necessarily aim to eliminate risk altogether. Abstinence is one kind of risk reduction. Other examples include bleaching used needles; using condoms for anal, oral or vaginal sex; and opting for non-penetrative sexual activities.

Special Needs

Some target populations, or subgroups within a population, can be very difficult to access. Providers should use creative means to reach these groups. Groups that often get missed with conventional HIV prevention efforts include people who are visually or hearing impaired, people with developmental disabilities, people who do not read, people who speak English as a second language, and people who speak non-English languages.

Combating Stigma

Stigma is a barrier to better HIV prevention in many ways. HIV and AIDS are highly stigmatized conditions, with widely reported evidence of discrimination against people who are living with the virus. The behaviors that can increase HIV risk are also heavily stigmatized in our culture – namely, injection drug use and sex, particularly sex between two men.

There is also a burden of stigma upon many of the populations experiencing a disproportionate impact in the epidemic. It takes the form of sexism against women, addicto-phobia against people with substance addictions, homophobia against gay and bisexual men, and racism against communities of color. All of these are intrinsically tied to society’s perception of these groups and the subsequent willingness by society to respond in a compassionate manner to HIV infected individuals and impacted communities. Fighting stigma on any and all of these levels is a legitimate HIV prevention activity.

Frank talk about sex and/ or drug use

HIV infection is the result of specific risk behaviors. Effective prevention depends on an ability to address those behaviors. Frank discussion of sexual and drug using behaviors may or may not include use of the vernacular, as appropriate to the group or community. However, it is necessary to honestly describe these behaviors and to engage people at increased risk in meaningful discussion about how the virus is transmitted and ways in which people can put themselves at risk.

Behavioral Theories

HIV prevention interventions and programs should be designed with behavioral change and/or maintenance as a goal. Sound approaches to behavioral change include an understanding of behavioral theory(s). This list contains several major theories. One or more of these theories, or other established theoretical models, should be taken into account at the earliest stages of HIV prevention program design.

Health Belief Model (Rosenstock et al, 1994) proposes that an individual's actions are based on beliefs. It identifies key elements of decision making such as the person's perception of susceptibility, perceived severity of the illness, and the perceived barriers to prevention.

Theory of Reasoned Action (Fishbein, 1989) sees intention as the main influence on behavior. Intentions are a combination of personal attitudes toward the behavior as well as the opinions of peers, both heavily influenced by the social milieu.

Social Cognitive Theory (Bandura, 1994) (**also: Social Learning Theory**) views learning as a social process influenced by interactions with other people. In Social Cognitive Theory physical and social environments are influential in reinforcing and shaping the beliefs that determine behavior. A change in any of the three components- behavior, physical or social environments-influences the other two. Self-efficacy, an essential component of the theory, is the person's belief that s/he is capable of performing the new behavior in the proposed situation.

Diffusion of Innovation (Rogers, 1983) helps understand how new ideas or behaviors are introduced and become accepted by a community. People in the same community adopt new behaviors at different rates and respond to different methods of intervention.

Stages of Behavior Change Model (Prochaska et al., 1992) explains the process of behavior change, from not being aware of the negative effects of a behavior, to maintaining safer behaviors. The five stages are: Precontemplation, Contemplation, Preparation, Action and Maintenance. Different stages exist in the same population. People do not necessarily pass through stages sequentially and may repeat stages.

Harm Reduction (Brette, 1991) accepts that while harmful behaviors exist, the main goal is to reduce their negative effects. Harm Reduction examines behaviors and

attitudes of the individual to offer ways to decrease the negative consequences of the targeted behavior.

Empowerment Education Theory (Wallerstein, 1992), based on Paulo Freire's popular education model, engages groups to identify and discuss problems. Once the issue is fully understood by community members, solutions are jointly proposed, agreed, and acted upon. This seeks to promote health by increasing people's feelings of power and control over their lives.

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Interventions with Shown Effectiveness:

The following three lists of interventions are described as they were published and/or originally implemented. The original target audience for these interventions, and the particulars of intervention delivery may or may not be the only way to approach these programs in Vermont.

As mentioned above, the Vermont CPG strongly encourages service providers in Vermont to examine each of these programs and interventions closely, with an eye on implementation in our state, and to use a science-based HIV prevention theory (described above, and elsewhere) to adapt interventions for Vermont in ways that will maximize their chances for success.

Diffusion of Effective Behavioral Interventions for HIV Prevention (DEBIs)

More information is available on all of these programs at <http://effectiveinterventions.org>. The list is published by the Academy for Educational Development (AED).

Community-Level Interventions seek to change attitudes, norms and values, as well as social and environmental context of risk behaviors of an entire community/target population.

INTERVENTION/ PROGRAM	ORIGINAL INTENDED AUDIENCE	DESCRIPTION
The MPowerment Project	MSM <i>Young gay and bisexual men (18-29)</i>	An ongoing project (ideally with its own physical space), with activities including formal outreach; peer-led group discussion and skills building sessions; informal outreach; ongoing publicity campaign.
Community PROMISE	Any community or population	Program relies on role model stories and peers from the target community. Includes community assessment, followed by recruitment/training of peers, who gather stories from community members (prevention challenges and successes), and disseminate those stories, along with risk reduction supplies, in the community.
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INTERVENTION/ PROGRAM	ORIGINAL INTENDED AUDIENCE	DESCRIPTION
Popular Opinion Leader (POL)	MSM	Recruitment of well-regarded (popular) community members for training and subsequent dissemination of risk reduction endorsement messages within their own social networks. Attempts to re-shape community norms around preventive behaviors.
Real AIDS Prevention Project (RAPP)	Heterosexual <i>Sexually active women and their male partners</i>	Strives to increase consistent condom use; and to change community safer sex norms through 1) community assessment; 2) getting the community involved in a combination of risk reduction-oriented activities
Teens Linked to Care	PWA/Youth <i>Young people 13-29, living with HIV</i>	Ongoing group sessions, focusing on social support, skills development and practice, socializing, goal-setting for health.
VOICES/VOCES	People of Color <i>African American and Latino adult men and women clinic clients</i>	Gender- and ethnic-specific one-time group sessions for clinic patients, focusing on prevention strategies. Also info on HIV risk behavior and prevention; culturally-specific videos; facilitated group discussion.

Group- L evel Interventions seek to change individual behavior within the context of a group setting.

INTERVENTION/ PROGRAM	ORIGINAL INTENDED AUDIENCE	DESCRIPTION
Healthy Relationships	PWA <i>Men and women living with HIV/AIDS</i>	5-session small group intervention, focusing on developing skills and building self-efficacy through modeling behaviors and practicing new skills
Holistic Harm Reduction Program	PWA/IDU <i>HIV-positive injection drug users</i>	12-session, manual-guided group level program to reduce harm, promote health and improve quality of life.

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INTERVENTION/ PROGRAM	ORIGINAL INTENDED AUDIENCE	DESCRIPTION
Man Men, Many Voices	MSM <i>Gay men of color; also men on the 'down low' with or without female partners</i>	Six- or seven-session peer-facilitated group level STD/HIV prevention intervention. Addresses behavioral influencing factors specific to gay men of color.
Safety Counts	IDU <i>Individuals who are currently using drugs, including injectors and non-injectors</i>	A behaviorally-focused seven-session group-level intervention, including structured and unstructured activities. The focus is reduction of high-risk drug-use and sexual behaviors; also on HIV testing.
The SISTA Project	Women of color <i>Sexually active African-American women</i>	Five two-hour sessions delivered by peer facilitators. Sessions are gender- and culturally-relevant, and include behavioral skills practice, group discussion, lecture, role play, video, and take-home exercises.
Street Smart	Youth <i>Runaway and homeless youth, 11-18</i>	Program includes eight facilitated group sessions, one individual counseling session, and one visit to a community-based organization that provides healthcare. Focus includes HIV/AIDS, STD, and pregnancy prevention; coping and negotiation skills; risk- and drug-use reduction skills; role play; video production.

Compendium of HIV Prevention Interventions with Evidence of Effectiveness

This Compendium is published by the Centers for Disease Control and Prevention (CDC). More information on all of the named programs and interventions is available at <http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm>.

INTERVENTION/ PROGRAM	ORIGINAL INTENDED AUDIENCE	DESCRIPTION
AIDS Community Demonstration Project	All Populations	Included in DEBIs (see Community PROMISE, above)
AIDS/Drug Injection Prevention	IDU	4-session group level intervention; piloted with heroin sniffers, to reduce progression to injection
Skills Building	Female IDU	5-session group level intervention for female methadone patients. HIV/AIDS info; condom use; communication skills. Incentives for participation
Intensive AIDS Education in Jail	IDU and/or Youth in correctional settings	4-session group level intervention. Problem solving. HIV/AIDS info/prevention. Incentives for participation.
Informational and Enhanced AIDS Education	IDU	Two or six 1-hour sessions (regular and enhanced program); comparison of effectiveness between the two. Focus on risk awareness, risk reduction, skills building, discussion.
Condom Skills Education	Heterosexual	One-time 30-minute group level intervention focusing on condom use and skills building.
Group Discussion Condom Promotion	Heterosexual	One-time session delivered to STD clinic patients. Video; discussion of prevention methods; role-playing; question and answer; condom distribution.
Social Skills Training	Heterosexual	Five-session group level intervention. Focus on gender and ethnic pride; personal responsibility; video; communication skills; role play; prevention skills.
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INTERVENTION/ PROGRAM	ORIGINAL INTENDED AUDIENCE	DESCRIPTION
Reducing AIDS Risk Activities	Heterosexual	Four-session group level intervention in clinics serving pregnant women. Video; skills building and communication; assertiveness. Incentives offered.
Project RESPECT	Heterosexual	Enhanced and Brief sessions – four or two-session intervention. Focus on risk reduction; condom use; etc.
Cognitive-Behavioral Skills Training Group	Heterosexual	Four weekly group sessions for high-risk women. Focus on risk behavior, misconceptions, risk reduction. Exercises; skills building.
Women and Infants Demonstration Projects (WIDP)	Heterosexual	Community-level intervention aimed to modify community norms, attitudes and behaviors about condom use. Provides models of successful risk reduction strategies within the peer group. Includes media campaign; outreach; and community mobilization.
VOICES/VOCES	Heterosexual	Included in DEBIs (above)
HIV Education, Testing, and Counseling	Heterosexual	Counseling session and HIV blood test.
Mpowerment Project	MSM	Included in DEBIs (above)
Behavioral Self-Management and Assertion Skills	MSM	12-session group level intervention. Risk reduction; behavioral self-management; assertion skills; relationship skills and social support.
Popular Opinion Leader (POL)	MSM	Included in DEBIs (above)
Small Group Lecture Plus Skills Training	MSM	Two-session group level intervention, one focused on general HIV/AIDS information (transmission, prevention) and one focused on prevention skills building.
Be Proud! Be Responsible!	Youth	One five-hour session. HIV/AIDS information (sex and drug-related behaviors); video; games; exercises.
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INTERVENTION/ PROGRAM	ORIGINAL INTENDED AUDIENCE	DESCRIPTION
Reducing the Risk	Youth	School-based, fifteen-session group intervention (part of a health curriculum). risk reduction; social and communication skills; postponement; role play; decision making.
Get Real about AIDS	Youth	School-based fifteen-session curriculum: HIV knowledge; risk awareness; risk behavior and reduction; skills building around recognizing and managing risky situations.
StreetSmart	Youth	Ten group sessions and one individual counseling session. HIV knowledge; social skills; access to resources; personal beliefs and individual barriers to prevention. Incentives offered.
Focus on Kids	Youth	Targets pre- and early-adolescents in their existing friendship groups. Eight session, including one day-long retreat.
Becoming a Responsible Teen (BART)	Youth	Eight group sessions, focused on HIV/AIDS information and skills building; decision making; social support and empowerment. Incentives offered.

Prevention For Positives - Interventions

In addition to the above-named interventions, the following programs were approved by the CPG for implementation with people living with HIV/AIDS (a/k/a, Prevention with Positives).

For more information on all of the named interventions, see Appendix 2 to this Comprehensive Plan.

While all of these programs have some history of demonstrated effectiveness in their original format, the Vermont CPG and the Vermont Prevention For Positives work group have noted their reservations, sometimes strong reservations, where they exist for each of the following. Rather than ruling out any given program, which might be successfully adapted for use here, the CPG has chosen to include the full list of interventions that were considered.

Program planners should take these reservations into account, along with general issues of program feasibility, when considering implementation of any of the following programs.

INTERVENTION <i>sometimes named for the organization from which it originated</i>	DESCRIPTION	RECOMMENDATION(S)
Tarzana HIV Service, Los Angeles	Individual Level Intervention for recently diagnosed individuals (known status less than 2 years) in substance abuse treatment who are also homeless.	Recommended with reservations: Issues of feasibility and fundability should be taken into account.
Brief Motivational Interviewing	Individual Level Intervention for all people with HIV	Recommended. Vermont would need to locate training materials to help agencies implement this intervention.
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INTERVENTION	DESCRIPTION	RECOMMENDATION(S)
HIV Prevention Education and Risk Reduction (Wisconsin)	Individual Level Intervention; Prevention Case Management; Health Communication/ Public Information; Counseling and Testing; Outreach; Partner Counseling and Referral. For people with HIV in high sero-prevalence areas, plus people who have not responded to less intensive HIV interventions.	Recommended with reservations: The following should be taken into account: the needs of clients also receiving services case management; who would deliver PCM and how that would affect the service?; intervention should not be limited to certain risk factors.
HIV Stops with Me	Community Level Intervention; Health Communication/Public Information; Outreach; Counseling and Testing. Social marketing stressing empowerment. For a sub-group of people living with HIV: gay/bisexual men, transgendered folks, youth 13-24, and women of color residing in housing developments.	Recommended with reservations: Spokesmodels should be representatives of target group; viewing patterns of all of the target populations should be addressed; ads should be designed with specific attention to demographic, cultural and geographic consideration, and also with emphasis on adding a referral message to any campaign that is developed.
Teens Linked to Care	Group Level Intervention for people with HIV, specifically ages 13-29	Recommended with strong reservations: This intervention is resource-intensive and time consuming. The number of sessions may have to be limited, as compared to the 24-36 noted in the program description.
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INTERVENTION	DESCRIPTION	RECOMMENDATION(S)
Holistic Harm Reduction Program	Group Level Intervention. Twelve sessions for people with HIV, specifically IDU.	Recommended with strong reservations: Funding could be difficult, as could getting enough individuals in a group. Facilitation training would be essential, and questions of where this program could feasibly take place should be considered.
Los Angeles Clinic-Affiliated Intervention	Group Level Intervention for people with HIV, specifically MSM	Recommended with reservations: Follow-up could be difficult in Vermont; incentives for participation may need to be added; and providers should consider whether to offer this regionally or statewide.
Stop AIDS Project, San Francisco	Social events, group risk reduction, social supports for people living with HIV, specifically gay/bi men	Recommended with reservations: Could the target population be expanded without losing the intent of the program? Could this become a component of a larger program?
Positive Images, Los Angeles	Individual Level Intervention; Group Level Intervention; Counseling and Testing; and Outreach. The [original intended] audience includes high risk and people of color in public sex venues/ environments.	Recommended with strong reservations: This program would need very specific adaptation for usage in Vermont. Options of internet-based outreach should be considered, along with other ways of reaching MSM, communities of color, and any other populations reached here. The ramifications of public sex environment (PSE) outreach should also be carefully considered.
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INTERVENTION	DESCRIPTION	RECOMMENDATION(S)
Prevention in Medical Care Settings	<p>Individual Level Intervention; Prevention Case Management; Health Communication/Public Information; Counseling and Testing; Partner Counseling and Referral Services.</p> <p>For people living with HIV, specifically those in HIV Specialty Healthcare</p>	<p>Recommended with strong reservations: It is important to maintain a client-centered message and program delivery in the clinical setting; specific training for medical providers delivering these interventions would also be important. In that respect, the clinical setting may be prohibitive.</p>
Healthy Relationships	<p>Group Level Intervention for all people with HIV</p>	<p>Recommended with reservations: It would be helpful if ready-made videos could be available, rather than asking programs to create their own. The program also calls for a full-time mental health counselor, which may be prohibitive. This program may be more feasible in a retreat context.</p>
Power Program Los Angeles	<p>Prevention Case Management for people with HIV, and specifically a sub-group of people living with HIV for more than 2 years.</p>	<p>Recommended with reservations: Concerns centered on staff requirements – necessary training for PCM, along with the barrier that mental health “treatment” requirements can be to clients.</p>
HTPP HIV Transmission Prevention Project	<p>Prevention Case Management for people with HIV, and specifically a sub-group of people living with HIV for more than 2 years.</p>	<p>Recommended with reservations: Concerns centered on staff requirements – necessary training for PCM, along with the barrier that mental health “treatment” requirements can be to clients.</p>
<p>- continued next page -</p>		

INTERVENTION	DESCRIPTION	RECOMMENDATION(S)
Peer Based Intervention to Promote Condom and Contraceptive Use Among HIV Positive and At-Risk Women	Peer-based Individual Level Intervention and Prevention Case Management for a sub-group of people living with HIV, specifically women living with HIV.	Recommended without reservation
Project Connect	Prevention Case Management; Counseling and Testing for a sub-group of people living with HIV, specifically incarcerated African American women.	Recommended with reservation: This intervention should be implemented with short-term detainees in Vermont.

HIV Prevention Interventions Categories

The interventions named on the previous pages of this section all involve the delivery of various types of services. Those services generally fall into one of seven (7) categories that the Vermont CPG recognizes for HIV/AIDS prevention.

These categories are particularly important in a state like Vermont where adaptation of existing intervention curricula may be necessary to meet the needs of a small, disparate and/or rural target population. HIV prevention activities in Vermont, whether they involve the delivery of a pre-defined curricula, or an adaptation of an existing program, should fall into one or more of the following categories:

1) Health Education/Risk Reduction (HE/RR)

Health Education and Risk Reduction (HE/RR) counseling, also known as prevention counseling, is provided to clients with a skills development component. HE/RR should assist clients in making plans to change individual behavior and ongoing appraisals of their own behavior. HE/RR should always include a skills building activity. These interventions also facilitate linkages to services in both clinical and community settings in support of behaviors and practices that prevent transmission of HIV, and help clients make plans to obtain these services.

Definition excludes:

- Outreach: which takes place where the participants congregate, and does not include skills building
- "One shot" presentations or lectures which do not aim to develop prevention skills
- Prevention Case Management: which is ongoing over time and has a social support component

2) Prevention Case Management (PCM)

Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk reduction behaviors by clients with multiple, complex problems (social, economic and behavioral) and risk reduction needs. It is a hybrid of HIV risk reduction counseling and traditional case management that provides intensive, ongoing and individualized prevention counseling, support and services brokerage.

Important components of the definition:

- Client-centered HIV prevention combining risk reduction counseling and traditional case management
- Intensive, ongoing (over the months and years) and individualized prevention counseling and support

Definition excludes:

- HE/RR counseling to individuals which is intense but not ongoing

3) HIV Counseling, Oral Testing, and Referral Services

The voluntary process of client-centered, interactive information sharing in which an individual is made aware of the basic information about HIV/AIDS, testing procedures, how to prevent the transmission and acquisition of HIV infection, and given tailored support on how to adapt this information to their life.

Oral testing services are sometimes offered in conjunction with outreach among hard to reach populations, and uses oral fluid as sampling method.

Important components of the definition

- Pre- and post-test counseling
- HIV testing using oral fluid in the service provider's facility or in the communities at high risk
- Referrals to other Prevention and Care Services (including Partner Counseling and Referral Services)

Definition excludes

- Blood-based Counseling and Testing services

4) HIV Counseling, Blood Testing, and Referral Services

The voluntary process of client-centered, interactive information sharing in which an individual is made aware of the basis information about HIV/AIDS, testing procedures, how to prevent the transmission and acquisition of HIV infection, and given tailored support on how to adapt this information to their life. HIV/Antibody testing involves taking a blood sample in a clinical setting and/or by a state-certified phlebotomist.

Important components of the definition:

- Pre- and post-test counseling
- Blood sampling
- Referrals to other Prevention and Care Services (including Partner Counseling and Referral Services)

Definition excludes:

- Oral fluid-based HIV Counseling and Testing services

5) Outreach

HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility or safety kits, and educational materials.

Important components of the definition:

Individual or group level HIV/AIDS education provided by peer or non-peer educators, face-to-face in the clients' neighborhoods or areas where clients congregate. Usually involves the distribution of prevention material.

Definition excludes:

- Interactions that include skills building activities

6) Health Communication / Public Information

The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection on how to obtain specific services.

- **Electronic media:** means by which information is electronically conveyed to large groups of people, including radio, television, public service announcements, news broadcasts, infomercials, internet, etc/, which reach a large-scale (city, region, or statewide) audience.
- **Print media:** these formats also reach a large-scale or nationwide audience, including any printed material such as newspapers, newsletters, magazines, pamphlets, and "environmental media" such as posters and transportation signage.
- **Hotline:** telephone services (local or toll-free) offering up-to-date information and referral to local services, e.g., counseling/testing and support groups.
- **Clearinghouse:** interactive electronic outreach systems using telephones, mail and the internet to provide a responsive information service to the general public as well as high-risk populations.
- **Presentation/ Lectures:** these are information-only activities conducted in group settings, and are often called "one-shot" education interventions.

Important components of the definition:

- Group level intervention without prevention skills development; i.e. lecture, one shot presentation.

- Delivery of planned prevention messages targeting general population to support risk reduction, provide information, increase awareness, or build support for safe behavior.
- HC/PI may take the form of electronic and print media, a hotline, a clearinghouse and/or a one-shot presentation/lecture

Definition excludes:

- HE/RR for a group which has a skills development component

7) Other interventions

Interventions not described in the previous categories. They include the Community Level Interventions, i.e.: community mobilization, social marketing campaign, community-wide intervention, policy intervention, structural intervention and mentoring programs.

Community Level Interventions (CLI)

A CLI is designed to reach a defined community (geographic or individual subgroup based on behavioral or sociodemographic characteristics) to increase community support of the behaviors known to reduce the risk for HIV infection and transmission. CLI implies working with social norms or shared beliefs and values held by members of the community. It aims to reduce risky behaviors by changing attitudes, norms and practices through community mobilization and organization, and through community-wide events

- **Community mobilization** – The process by which community citizens take an active role in defining, prioritizing and addressing issues in their community. This process focuses on identifying and activating the skills and resources of residents and organizations while developing linkages and relationships within and beyond the community for the purpose of expanding the current scope and effectiveness of HIV/STD prevention.
- **Structural intervention** – Designed to remove barriers and incorporate facilitators of an individual's HIV prevention behaviors. These barriers or facilitators include physical, social, cultural, organizational, community, economic, legal or policy circumstances or actions that directly or indirectly affect an individual's ability to avoid exposure to HIV.

Counseling, Testing, and Referral Definitions

Anonymous: Client-identifying information is not linked to test results.

Client- centered: Tailored to the behaviors, circumstances and special needs of an individual.

Confidential: Client-identifying information is linked to test result; test result is part of a standard medical record.

Consent: Indicates the client has understood and agreed to the specifications surrounding an HIV test.

Cultural competence: Culturally and appropriate manner of providing services.

Informed: Information about HIV and testing procedures are given to the client to help them make an informed choice about whether or not they wish to be tested.

Oral: As performed with the OraSure HIV-1 testing kit.

Pre- Test Counseling: Includes risk reduction counseling, acquisition of informed consent, performance of HIV test, referrals to appropriate resources.

Post- Test Counseling: Includes risk reduction counseling, receipt of test result, referrals to appropriate resources.

Voluntary: Client decides whether or not they wish to have an HIV test.

SECTION 9 : VERMONT DEPARTMENT OF HEALTH ACTIVITIES

In this section:

- Section 9A: Community Planning
- Section 9B: Partner Counseling and Referral Services
- Section 9C: Capacity Building
- Section 9D: Counseling and Testing
- Section 9E: Surveillance and Research
- Section 9F: Health Education/Risk Reduction (HE/RR)
- Section 9G: Evaluation/PEMS
- Section 9H: Collaboration and Coordination
- Section 9I: Quality Assurance
- Section 9J: Perinatal Transmission

Section 9 A: Community Planning

2004 Community Planning Group Process

At present, the CPG consists of 18 members, including 2 non-voting members who are State employees. In preparation for current appointments that began in October of 2003, applications were circulated widely to HIV prevention provider organizations, peer-based HIV advocacy groups and professionals from various disciplines. Selected members were appointed to staggered two-year terms to facilitate continuity of membership. In the Fall of 2003, two Community Co-Chairs were elected by the CPG; and the Health Department Co-Chair position continues to be held by the HIV/AIDS Program Director.

Four CPG committees convened this year:

Steering: Steering Committee, comprised of the CPG co-chairs and other committee chairs, meets monthly to formulate agendas for upcoming meetings, develop strategic work plans, facilitate communication among the membership, and to address any other related CPG business.

Membership: The Membership Committee meets on an as-needed basis, to plan and implement the creation of a CPG membership application; the recruitment of new members; the screening of new membership applications; and the planning of the new member orientation, which will take place this year in October.

Policies and Procedures: The Policies and Procedures Committee has continued its work, updating existing policies and procedures to govern the CPG's process. A new Policies and Procedures manual is expected to be

finished and available to the members by the end of 2004. It will also be made available through the CPG's website at <http://www.nvtredcross.org/cpg>.

Heterosexual: This committee was formed recently, and will continue its work in the coming year, examining the HIV prevention needs of people at increased risk through heterosexual contact; deciding upon a specific direction within that goal; and implementing a needs assessment process for this target population, or for some sub-population(s).

In addition to the regular CPG committees in 2004, there was also a Prevention for Positives work group, comprised of CPG members, other community members and consumers, and service providers from around the state. This group focused on the prevention needs of people living with HIV/AIDS in Vermont, and also reviewed potential HIV prevention interventions for this population. The work group's final recommendations were passed onto the CPG and became the basis of Section 4 of this Comprehensive Plan: Prevention For Positives.

All CPG committee meetings were typically held by conference call, to facilitate participation among members around the state. The full CPG met in person monthly, with additional special meetings scheduled as necessary. Full CPG meetings were held in geographically central locations to reduce barriers to participation. Members who are not state employees or employees of an agency receiving federal HIV prevention funding were eligible for stipends and travel expense reimbursement

2004 CPG Membership and Participation

The CPG strives to reflect the epidemic in its membership. In 2004, five of the CPG's 18 members were MSM. Two members were either current or former users of injection drugs. Two members were African American, and another two were Native American. In terms of gender, the CPG membership included eight females, nine males, and one transgender person. At least four members were people living with HIV/AIDS.

An overview of 2004 CPG membership demographics appears on the following page.

2004 CPG Membership

	County	New/ Return	Term Expires	Target Pop.	Gov't Vote	Grantee Provider	Ailly	MSM	IDU	Hetero	Ailly	Gender	Race Ethnicity	Age	Youth	People of Color	Woman	PLWA/HIV
1	Caledonia	Returning	2004				X				X	F	W	15	X			
2	Washington	Returning	2005	X				X				F	W	50+			X	
3	Chittenden	Returning	2005	X				X				M	W	40+				X
4	Calendonia	New	2006	X						X		F	W	40+			X	X
5	Bennington	Returning	2004	X				X				M	W	30+				
6	Chittenden	New	2005			X	X				X	T	W	25+	X			
7	Windsor	New	2006			X	X				X	F	W	40+				
8	Orleans	Returning	2005	X					X			M	NA	50+				X
9	Orleans	Returning	2004				X				X	M	NA	20	X			
10	Caledonia	Returning	2004	X						X		F	W	40+			X	X
11	Chittenden	New	2005	X		X		X				M	W	25+	X			
12	Chittenden	Returning	2005			X	X				X	M	AA	50+				X
13	Windsor	Returning	2005	X				X				M	W	50+	X			
14	Windsor	Returning	2004				X				X	F	W	25+	X			
15	Orange	Returning	2004	X				X				M	W	30+				
16	Chittenden	Returning	2005			X	X				X	F	AA	25+	X		X	
17	Chittenden	Gov't.			X							F	W	30+				
18	Caledonia	New	2006	X						X		M	W	40+				X
				10	1	5	7	5	2	3	7	8 F 9 M 1 T	14W 2AA 2N	(2)<24(4)25 330(5)40	7	3	4	4

CPG Future Goals and Areas of Concentration

The Community Planning Group has identified the following areas for further discussion and/or concentration in the coming four-year work cycle.

Needs Assessment:

- Incarcerated populations
- Sex workers/people who trade sex for resources
- Communities of Color
- People who are intermittent/casual drug injectors
- MSM/IDU; also MSM who are Crystal Methamphetamine users
- People who are Transgender
- All sub-populations within our existing definition of People at increased risk through Heterosexual Transmission.
- Youth who are substance users, including alcohol

Examining specific issues related to HIV prevention:

- Alcohol-related risk, across all populations
- Geographically specific HIV prevention issues in Vermont. Which areas, and which populations in specific areas, are underserved?
- The intersection of Prevention for Positives efforts and prevention efforts targeting at-risk populations. In what ways should these programs be distinct? In what ways should they be cooperative?
- HIV and Hepatitis coinfection. Create recommendations for prevention efforts that address this issue.

Planning and Prioritizing:

- Long-range planning for the CPG (i.e., 5-10 year projections)
- Move toward a more targeted list of priority populations (and moreover, address the disparity between the small amount of prevention funding available in Vermont and the relatively large number of people we are currently trying to reach with prevention services)
- Continue to collaborate with the HIV/AIDS Services Advisory Council (HASAC); continue to seek appropriate linkages between HIV prevention and care services.
- Evaluation of HIV prevention program effectiveness – determining the CPG's options in this regard.

Section 9 B : **Partner Counseling and Referral Services (PCRS)**

The Vermont CPG concurs that PCRS in Vermont should continue to be planned and implemented by Vermont Department of Health (VDH) staff, as has been the case thus far. Plans for improving PCRS in Vermont were provided to the CPG by VDH as follows:

1) Vermont Department of Health personnel will attend a formal CDC-sponsored training in December 2004

2) PCRS implementation is anticipated in early 2005. Plans are to begin implementation with private physicians/providers who are diagnosing newly infected individuals (including those with AIDS).

VDH will integrate PCRS information into a training already in development between VDH and key HIV medical providers. There will also be a one-page overview of PCRS and its availability in a quarterly newsletter sent by VDH to all medical providers statewide, by June 2005

3) Concomitant with implementing PCRS among private providers, VDH will work with ASOs to develop their capacity to implement PCRS activities in a way that is skills-based, practical, and will protect the confidentiality (and anonymity) of the HIV-infected person. ASOs will be limited to the partner elicitation component of PCRS; VDH will manage the partner notification.

4) VDH will also investigate the possibility of implementing PCRS activities in high prevalence settings such as corrections.

5) VDH will develop guidelines around PCRS implementation among prevalent cases of HIV/AIDS (i.e., HIV/AIDS cases that were diagnosed before the implementation of HIV reporting in Vermont).

Note: PCRS activities can be implemented without requiring names since Vermont does not have a named system for HIV reporting.

Other plans regarding PCRS in Vermont include the following:

- Promote PCRS within Vermont's CTR system by providing current testers with an overview of PCRS, and by integrating PCRS information into CTR training curricula.
- Maintain information in the Vermont Consent Form for Confidential and Anonymous Testing in regards to the availability of PCRS.
- Create a client brochure for PCRS, available to anyone visiting a medical or non-medical setting who is interested in learning more about PCRS.

Section 9 C: Capacity Building

The following overview of capacity building plans in the coming four-year work cycle was presented to the CPG by the Vermont Department of Health in April 2004, and subsequently approved the CPG for inclusion here.

Capacity building around HIV Prevention in Vermont will include:

- Training – workshops, conferences (in-state and out of state), courses, public speakers
- Cross-training and collaboration – between grantees and VDH, among grantees, between grantees and other health or human service providers, between VDH and other states' HIV/STD programs
- Technical Assistance – includes both in-state and out of state providers, national organizations, CDC, NIH, other governmental organizations
- National Conferences and regional meetings – National HIV Prevention Leadership Summit, U.S. Conference on AIDS, National HIV Prevention Conference (biannual), regional STD conferences
- Distance learning opportunities – phone conferencing, satellite broadcasts, Web-casts and video conferencing

Target audiences for HIV Prevention capacity building include:

- CPG
- VDH grantee staff and volunteers
- VDH staff
- Other health or human service providers
- Communities at risk and the larger community

Resources directed toward HIV Prevention capacity building come from:

- Vermont's CDC HIV Prevention grant
- CDC's training and technical assistance
- CDC and/or other state's distance learning efforts (satellite and Web-casts)
- New England AIDS Education Training Center (AETC)
- Other state government agencies or departments (Alcohol and Drug Abuse Programs, etc.)
- Expertise/experience at Vermont CBO's, ASO's, and communities

Capacity building needs are determined through:

- CPG surveys, evaluations
- Prevention grantee provider surveys, dialogue with grant monitors and training evaluations
- CDC initiatives and directives
- Analysis of other data collection

Key areas of HIV Prevention capacity development include:

1. HIV Prevention Community Planning Group
 - a) CPG Orientation
 - b) Introduction to the CPG Guidance
 - c) Vermont Epidemiological Profile Presentation
 - d) Vermont Counseling and Testing System Update
 - e) Community Planning Leadership Summit
 - f) Prevention for HIV Infected Persons – Report on Guideline Development
 - g) CPG Priority Setting Technical Assistance

2. HIV Prevention Counseling, Testing and Referral (CTR)
 - a) Anonymous Oral Testing Training
 - b) Anonymous Blood Testing Training
 - c) Fundamentals of HIV Prevention Counseling and Testing Training of Trainers
 - d) Routine HIV Testing in High Prevalence Medical Settings Training
 - e) Updated CTR Reporting Tool and Prevention Evaluation Monitoring System (PEMS) Training
 - f) Introduction to the Updated CTR Reporting Tool (bubble form) Workshop
 - g) Making Referrals Work Training

3. Partner counseling and Referral Services (PCRS)
 - a) CDC Sponsored PCRS Training of Trainers
 - b) Utilizing the VDH PCRS System Training for Current CTR Providers

4. Prevention for HIV Infected Persons
 - a) Prevention for HIV Infected Persons – Guideline Development Meetings
 - b) Prevention for HIV Infected Persons – VDH Staff Training
 - c) Prevention for HIV Infected Persons – Grantee Staff Training

5. Health Education and Risk Reduction (HERR)
 - a) American Red Cross Basic HIV Program Training
 - b) Annual HIV/AIDS Updates
 - c) Annual HIV/AIDS Public Nurse HIV Designee Updates
 - d) Outcome Monitoring – Initial Results and Program Improvement
 - e) US Conference on AIDS
 - f) Intervention Design Trainings
 - g) National HIV Prevention Conference
 - h) Effective Outreach Training for VDH Staff
 - i) Effective Outreach Training for Grantee Staff
 - j) Making Referrals Work Training for VDH Staff
 - k) Making Referrals Work Training for Grantee Staff

6. Public Information Programs

- a) VDH HIV/AIDS Hotline Training for VDH Staff
- b) National HIV Testing Day Orientation / Public Health Nurse HIV Designees
- c) World AIDS Day Orientation for Public Health Nurse HIV Designees

7. Perinatal Transmission Prevention

- a) Medical Providers Offering Perinatal Care Training
- b) Perinatal HIV Screening Programs for Community Public Health Staff and Public Health Nurses

8. Quality Assurance

- a) Quality Assurance Standards Guideline Development Meetings
- b) Quality Assurance Standards Implementation Training for VDH Staff
- c) Quality Assurance Standards Implementation Training for Grantee Staff

9. Evaluation

- a) Evaluation Training for VDH Staff
- b) Evaluation Training for Grantee Staff
- c) Evaluation Tools for Outcome Monitoring Training
- d) Prevention Evaluation Monitoring System (PEMS) Training for VDH Staff
- e) Prevention Evaluation Monitoring System (PEMS) Training for Grantee Staff

10. Capacity Building Activities

- a) Cultural Competency Training for Grantee Staff
- b) Cultural Competency Training for VDH Staff

11. STD Prevention Activities

- a) STD/HIV Updates

12. Collaboration and Coordination with Other Related Programs (non-governmental)

- a) HIV Risk Assessment for Medical Providers Training
- b) Making Referrals Work Training for Mental Health Service Providers

13. HIV/AIDS Epidemiological and Behavioral Surveillance

- a) Orientation to the Epidemiological Profile for VDH Staff
- b) Orientation to the Epidemiological Profile for HASAC
- c) National CDC-Sponsored Evaluation Training for VDH Staff

14. Prevention Case Management

- a) Prevention Case Management Training for VDH Staff
- b) Prevention Case Management Training for Grantee Staff

Section 9 D: **Counseling, Testing and Referral Services**

An overview of HIV Counseling and Testing in Vermont, including future directions for counseling and testing in the state, was presented by Vermont Department of Health to the CPG in April, 2004, and subsequently approved by the CPG for inclusion here:

Vermont's Counseling, Testing and Referral Program (CTR) presently includes a total of 40 locations statewide. These sites are a combination of AIDS Service Organizations, publicly-funded health clinics, hospitals, private medical providers, family planning clinics, minority-based community organizations, youth-based community organizations, drug treatment facilities, and correctional facilities. Of these 40 sites, 17 offer free anonymous oral testing, 14 offer free anonymous blood testing, and 13 offer free confidential blood testing. The anonymous oral sites are customized to reach those most at risk in non-medical and outreach settings.

In 1998, Vermont tested a total of 898 individuals and identified one HIV-positive person. In 2002, Vermont tested more than 2,400 individuals and identified 18 previously unidentified HIV infections. While Vermont remains a low-prevalence state for HIV, it is anticipated by the Department of Health that numbers will continue to increase for both testing and the detection of HIV within our communities.

Improving efforts to identify newly infected persons

- Increase availability of free anonymous tests: Add two oral and/or rapid test sites yearly, increasing the number testing sites by ten by 2008
- Increase the number of trained counselors who perform anonymous oral testing outside of medical settings: Hold a minimum of 2 trainings yearly to attain a maximum of 24 new counselors per year.
- Increase the number of trained counselors who perform anonymous blood testing within medical settings: Hold one training per year to reach nurses, physician's assistants, and physicians.
- Train 1-2 individuals per year to teach the CDC Fundamentals of HIV Prevention curriculum.
- Hold three trainings by the end of 2005 of medical providers in HIV risk assessment and symptom recognition.

- Provide two trainings to medical providers from high-prevalence medical settings as well as the Vermont Department of Corrections, around the need for routine HIV-antibody testing in their medical settings.
- Increase the availability of anonymous testing in correctional facilities: Have anonymous testing available in all 10 of Vermont's correctional facilities by 2006, with the addition of providers able to offer testing.
- Increase Partner Counseling and Referral Services, as outlined above.

Improving Provision of Test Results

In 2000 when national post-test counseling rates for HIV-positive results were at an average of 58.2%, Vermont's rate was 100%. Similarly, Vermont's post-test counseling rate for HIV-negative test results was 90%. In 2002, the rates were 95.5% and 87.5%, respectively.

Plans for maintaining these rates are as follows:

- Increase the number of anonymous test sites available to individuals statewide, in geographically diverse areas.
- Emphasize high-quality training for counselors, including many opportunities to practice role-playing for pre- and post-test counseling sessions, and placing an emphasis with clients on the importance of returning for test results.

Providing and Tracking the Completion of Referrals for Persons with Positive Test Results

Until this time, Vermont has not tracked referrals in its system. Given the rural nature and low prevalence of HIV here, the Department of Health plans to examine ways in which other states have addressed this issue. Plans at this time include:

- Develop a conversion system for anonymous HIV positive test results by which the anonymous test result becomes a confidential test result. Issues of implementation, feasibility, and confidentiality must be examined and addressed before this can take place.
- Explore possibilities of developing an inter-agency referral tracking system.
- Explore new opportunities for referral tracking using PEMS and CTS data collection forms.

Working with Medical Care Entities to Encourage and Support Routine HIV Screening in High Prevalence Settings

- Provide trainings to medical providers from high-prevalence medical settings as well as the Vermont Department of Corrections, around the need for routine HIV-antibody testing in their medical settings.
- Communicate with other medical entities that possibly see high-risk individuals: veterans' hospitals, refugee health clinics, and others.
- Encourage routine risk assessment at medical facilities who largely see low-risk clients.

Supporting Providers of CTR Services

- Certify oral testing counselors only following a successful five-day training and pre-test counseling role-play evaluation.
- Provide annual training for CTR providers in medical settings who perform blood testing.
- Provide training to medical providers from high-prevalence medical settings around the need for routine HIV-antibody testing.
- Provide training to medical providers from low-prevalence medical settings around the need to HIV risk assessment and symptom recognition.
- Hold quarterly conference calls with all CTR providers, to inform them of new guidelines and recommendations, changes to procedures, etc. It is also an opportunity for providers to exchange information, offer support, and share learning experiences.
- Continue to offer each counselor one-on-one support, to answer questions and concerns, thus making CTR services more effective for both the CTR provider and his/her clients.
- Hold three trainings concerning the updated CTR reporting tool (bubble form) and how to correctly administer it.
- Create a media campaign, comprised of posters and pamphlets, directed at pregnant women, with the goal of increasing the number of women who choose to receive HIV CTR services as part of their family planning services, and to help physicians and clients share the responsibility of universal voluntary CTR for pregnant clients.

Section 9 E: Surveillance and Research

HIV/ AIDS Surveillance

HIV/AIDS surveillance is the process of collecting, analyzing, and interpreting data on individuals infected with HIV and/or who have an AIDS diagnosis. These data are used to plan and evaluate treatment and support programs for people in Vermont living with HIV and AIDS. Surveillance data also assist in the development of programs to prevent infection with HIV. AIDS surveillance has continued since 1982, with names of cases reported confidentially. In March 2000, the HIV surveillance system was implemented using a coded unique identifier system. Recent treatment advances have slowed the progression of HIV to AIDS and as a result, people are living longer with HIV. The HIV surveillance system was implemented because AIDS data alone cannot offer a reliable estimate of the HIV epidemic.

Any physician, nurse, or other institution required to report results of HIV tests must have written policies in place to ensure the confidentiality of the information. The Vermont Department of Health ensures the security and confidentiality of HIV/AIDS data and meets strict security requirements outlined by the Centers for Disease Control and Prevention (CDC).

Surveillance/ Research Activities - Ongoing

Vermont's small population, low incidence, and rural nature often limit our state's eligibility for participation in larger-scale studies. However, the Vermont Department of Health is committed to additional research that may further our understanding of HIV prevention, and specifically, HIV prevention in Vermont, and looks forward to participating in these studies when invited to do so.

The following research activities are ongoing.

Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS collects state-level data on personal health behaviors using a standard core questionnaire so that data can be compared across states. It is a population-based random digit-dialed telephone survey of adults. A sexual behavior module was added to the survey in 1994, 1995, 1996, 1998 and 2000. In this module, adults (ages 18-49) were asked about their number of sexual partners, condom use, and treatment for STDs.

Youth Risk Behavior Survey (YRBS)

The Vermont YRBS collects information on health-risk behaviors among youth and young adults in each of the following categories: behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use;

sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; unhealthy dietary behaviors; and physical inactivity. The survey has been conducted among a representative sample of Vermont students in grades 8-12 every two years since 1985.

Sexually Transmitted Disease (STD) Surveillance

Chlamydia trachomatis infection, gonorrhea, and syphilis are reportable under Vermont's Communicable Disease Regulations. Demographic information is entered into the NETSS system and transmitted to the CDC (without identifiers) on a weekly basis.

Drug Treatment Surveillance

The Alcohol and Drug Abuse Program (ADAP) of Vermont Department of Health maintains substance abuse treatment admissions from facilities that receive State funding. The data offer another way to indirectly measure the prevalence of injection drug use in Vermont. The admissions data may not represent unduplicated individuals, but rather they may represent multiple admissions within a calendar year for an individual.

HIV Counseling and Testing Data

The HIV Counseling and Testing System (CTS) was originally developed in 1988 to collect data on the population receiving counseling and testing services. The data are used to guide the development of HIV prevention programs and to estimate the need for early intervention service for persons with HIV infection. Demographic and behavioral data as well as HIV test results are reported to the Vermont Department of health by each of the state's testing sites. Data are entered into CTS software provide by the CDC and are transmitted to the CDC on a monthly basis. Data cannot distinguish multiple tests on the same individual and cannot be used to estimate statewide HIV seroprevalence.

Ryan White CARE Act Data

In 2002 the Vermont Department of Health HIV/AIDS Program established a standardized unique identifier reporting system with the state- and federally-funded AIDS Service Organizations and the Comprehensive Care Clinics in Vermont, in order to reduce duplication of services and to determine the number of people receiving services from these organizations. The HIV/AIDS Program reports on HIV-positive client utilization of Ryan White Title II services by service category. The data include individuals who are HIV-positive, as well as individuals who are not infected but who are directly impacted by immediate family members living with the virus. Unique identifiers are not reported for HIV-negative individuals.

The HIV/AIDS Program also uses unique identifiers reported to the Title II Coordinator to determine the number of individuals receiving case management services, where these services are received, and the percentage of duplication of services occurring across agencies.

Section 9 F: Health Education/ Risk Reduction (HE/RR)

The Vermont Department of Health (VDH) HIV/AIDS Program has taken several steps to ensure that HIV prevention grantees provide interventions based on scientific theory, program theory, and/or evidence of effectiveness. Existing and prospective grantees received information and training in 2004 on the DEBIs (Diffusion of Effective Behavioral Interventions for HIV Prevention) and CDC's Compendium of Effective Interventions. Grantee organization capacity to deliver interventions from DEBI and the Compendium was also discussed.

The use of scientific theory, and programs with evidence of effectiveness was further developed in Prevention with Positives meetings with grantees and community stakeholders. The VDH HIV/AIDS Program hosted a series of monthly meetings on Prevention with HIV Positives from December 2003 – April 2004 with grantees and people living with the virus. This Prevention with Positives Workgroup was an informal sub-committee to the Vermont CPG. They reviewed 14 evidence-based interventions for Positives taken from the Compendium, DEBI and PHIPP and made feasibility recommendations to the CPG. These interventions and recommendations are detailed in Section 8 of this Comprehensive Plan.

In 2004 the Vermont CPG approved all DEBI and Compendium interventions for use in Vermont. (These interventions are also detailed in Section 8 of this Comprehensive Plan.) Based on that CPG recommendation, the Vermont Department of Health's HIV Prevention RFP for 2005-2007 lists the DEBI and Compendium interventions as options for use by organizations submitting proposals. However, because both DEBI and Compendium interventions are largely developed for and tested within urban areas, it has been important to allow flexibility about which interventions are allowable in rural Vermont. For this reason, VDH did not require grantees to implement DEBI, and allowed other evidence-based and theory-based HIV Prevention interventions to be used.

It is anticipated that the majority of grantees in the coming three-year cycle will be using DEBI and/or Compendium projects, for which protocols are already developed. Organizations that are funded for interventions that do not fall within the DEBI or Compendium will be required to write intervention curricula and protocols that are appropriate to the behavior change theory or evidence-based intervention from which they are derived.

Section 9 G: Evaluation/ PEMS

The Center for Disease Control and Prevention (CDC) has been working to implement a new system that will help evaluate HIV Prevention programs. This system is called the Prevention Evaluation Monitoring System (PEMS).

When draft data variables were released by CDC, the Vermont Department of Health HIV/AIDS Program convened HIV Prevention grantees in order to review these draft variables and to provide comment to the CDC. Concerns that were stated during this comment period are also concerns shared by the Vermont Community Group. They include:

- Data system security and a lack of clarity around how client-related information will be shared via computer.
- The challenge of maintaining anonymity in a rural state like Vermont, where unique identifiers can be very identifying.
- Some of the client data is personal – including information about the number of sexual partners, the frequency of sex without a condom, HIV status, etc. Client discomfort with sharing this information may inhibit some from accessing good programs and necessary services.
- Clients may also be reluctant to provide the information necessary to create a unique identifier, and may have questions about what CDC will do with this information. This, too, could keep people away from good programs.
- Clients may not wish to be tracked when receiving and following up on referrals. There is a lack of clarity at the community level about who will be getting and using this information, and there is no way to guarantee clients that the information will be used in an honest way.
- The amount of time required to collect all variables will cut into the amount of time providers will have with clients for the actual interventions themselves. Clients may not be willing to spend the extra time required to do both.

The CDC has not yet released final data variables. However, they have conveyed that some of the individual client data variables will not be required in low-prevalence jurisdictions such as Vermont. Once the variables are released, the HIV/AIDS Program will share them with prospective HIV Prevention grantees. Recently, CDC expressed that the rules regarding safeguarding of PEMS information will be similar to, or stricter than, Surveillance data.

Concerns raised during the initial discussions about PEMS continue to be of issue to the HIV/AIDS Program, HIV Prevention grantees' staff, and to the Vermont Community

Planning Group. The CPG will continue to monitor these issues as PEMS implementation begins in 2005 and beyond.

How the Vermont HIV/AIDS Program will proceed with PEMS:

- In early 2005 the HIV/AIDS program will convene HIV Prevention grantees to help decide on an appropriate unique identifier for prevention clients. The Vermont Department of Health has committed to collect unique identifiers, and NOT names.
- The HIV/AIDS Program plans to offer training on referral tracking in 2005.
- Implementation of PEMS is expected to move forward according to the existing PEMS timeline.

Section 9 H: Collaboration and Coordination

Collaboration among Vermont Department of Health programs, as well as between the Vermont Department of Health and other organizations that serve people at increased risk for HIV transmission, is key to the success of our state's HIV prevention efforts.

Internal collaboration at the Department of Health has included, and should continue to include, coordination of Counseling and Testing; Partner Counseling and Referral; and both the Prevention and Care Early Intervention Programs.

External collaboration, as well, should continue. In the past year, the Vermont Department of Health HIV/AIDS Program has collaborated with the agencies listed below, and anticipates that it will continue these collaborations in the future:

- The American Red Cross of Northern Vermont provides administrative services for Community Planning Group meetings on behalf of the HIV Program. These services include meeting organization, provision of mileage reimbursement, participant stipends, taking of meeting notes. The American Red Cross also provides three levels of HIV-related trainings to HIV Program prevention grantees to increase basic factual information about transmission, prevention and treatment of HIV.
- The Comprehensive Care Clinics, through a partnership with the AIDS Education Training Center (AETC), provides training on HIV/AIDS-related information to other Agency of Human Services programs such as Vocational Rehabilitation and Social Rehabilitation Services. Furthermore, the Comprehensive Care Clinics collaborate with the HIV Program to provide HIV-related training to incoming counselors as part of our CTR training. Objectives of these trainings include an increase in knowledge regarding

- serostatus awareness and the treatment and care systems for HIV. The HIV Program also collaborated with the Comprehensive Care Clinics in a research project designed to inform OB/GYNs about the need to conduct risk screening for HIV of all pregnant clients. This project allowed for oral testing to be provided to clients free of charge.
- The Vermont Department of Education works with the HIV Program to make training on HIV available to school staff members who deliver health curriculums, including school nurses. Also, an HIV prevention staff member sits on the DOE materials review panel for HIV and a DOE staff member sits on the HIV Program materials review panel. This exchange provides both organizations with a greater level of insight and expertise.
 - The Vermont Department of Health STD Program collaborates with the HIV Program in numerous ways. Both of Vermont's STD staff members are available to provide HIV PCRS on an as-requested basis. This collaboration will increase in 2005 following formal training in PCRS. A member of the STD Program sits on the HIV Community Planning Group as a non-voting member to share her expertise of STDs and populations at risk for infection. A member of the STD Program performs HIV testing to individuals who seek testing outside of an organizational setting. Furthermore, both STD Program staff members help to answer HIV hotline calls. As HIV is a sexually transmitted disease, this collaboration greatly helps the HIV Program to keep a broad focus when looking at factors that lead to increased risk of HIV infection. The wealth of knowledge and experience of Vermont's STD Program members is an invaluable entity to the HIV Program.
 - The University of Vermont's Dr. Sondra Solomon, a clinical psychologist, supports the Community Planning Group by sharing a research perspective, and by helping members to gain a greater understanding of how to use data. Dr. Solomon also helps the HIV Program by sitting on the HIV Prevention External Review panel and by providing training to incoming HIV testers on cultural competency. The HIV Program works as a conduit between Dr. Solomon and the HIV Surveillance branch for data collection needs. The HIV Program also hires a psychology graduate student who works in Dr. Solomon's HIV Stigma Laboratory to help with various evaluation needs. Furthermore, the HIV Program supports Dr. Solomon's research on HIV stigma in rural communities.
 - The Vermont Department of Health Alcohol and Drug Abuse Program (ADAP) supports the HIV/AIDS Program's work around creation of needle exchange guidelines and proposals. ADAP also supports the HIV Program's external review of prevention proposals. The HIV Program supports the ADAP's mobile methadone proposals. These collaborations allow for a sharing of resources to better reach substance users at increased risk for HIV infection.

As a result of a recent reorganization of the Agency of Human Services in Vermont, ADAP now has its own deputy commissioner within the health department. This has allowed VDH to begin discussions about how to better collaborate in regards to HIV prevention programming for injection drug users and make HIV testing available in fixed sites and in mobile methadone treatment facilities.

- The Vermont Office of Minority Health (OMH) has one stream of funding which is for HIV prevention capacity-building among organizations that reach minority populations. As a result, the OMH and HIV Program fund many of the same community-based organizations for different but complimentary projects. The OMH and HIV Program support one another in the development of program work specifications, communication with community groups and strategic planning around HIV prevention for minority groups. Of special note is that the OMH is working with HIV prevention and care programs as well as HIV Surveillance programs on a needs-assessment among people of color and incarcerated populations. A report on this assessment will be available in the first quarter of 2005. Data collected from this assessment will likely effect future HIV prevention and care documents.
- Vermont Department of Corrections (DOC) collaborates with the HIV Program by supporting the work of HIV prevention grantees in corrections settings. Furthermore, the DOC supports the HIV program's needs-assessment research among people of color and incarcerated populations. The HIV program is assisting the DOC to enhance their existing medical services request for proposals to help ensure quality care and surveillance recording for people with HIV in the corrections system.
- The HIV/AIDS Services Advisory Council (HASAC) collaborates with the HIV Program by supporting coordination of quarterly meetings between the HASAC and the Community Planning Group. These meetings allow for shared training opportunities, shared data and projects that are appropriate for both care and prevention of HIV. The two groups have decided not to join into a single planning body at this time but have committed to reviewing the opportunity again in 2006.

Section 9 I: Quality Assurance

Quality Assurance is an important aspect of any ongoing, comprehensive HIV prevention effort. The Community Planning Group encourages the Vermont Department of Health to continue its expansion of quality assurance measures for all HIV prevention programs and should assure that programs are run in an efficient and effective manner that supports clients in the best way possible.

Quality assurance should include monitoring efforts, as well as the development or updating of protocols. Some areas of note for quality assurance include, but are not limited to:

- the implementation of HIV prevention interventions by Community-Based Organizations;
- Counseling Testing and Referral (both in the training of providers as well as the actual provision of services);
- risk screening and testing of pregnant women;
- Partner Counseling and Referral Services (PCRS) as those efforts are expanded in the coming years.

Section 9 J : Perinatal Transmission

With an increased focus on perinatal transmission under new CDC guidelines, the Vermont Department of Health HIV/AIDS Program should continue to collaborate with organizations that have funds with which to formally support perinatal transmission prevention.

Specific Department of Health plans in this area include

- working with the Women Infant Child (WIC) program to have health communication/public information about HIV and HIV testing available in all WIC clinics;
- reviewing 2000 Guidelines for Universal HIV Counseling and Voluntary Testing for Pregnant Women, and updating and distributing the guidelines should the need be present.

APPENDIX 1:

**EPIDEMIOLOGIC
PROFILE**

APPENDIX 2:

PREVENTION FOR POSITIVES

INTERVENTION FACT SHEETS

The pages that follow contain fact sheets and other information describing the HIV prevention interventions considered by the CPG for use in Vermont among people living with HIV/AIDS. The following interventions are included:

1. Tarzana HIV Service, Los Angeles
2. Brief Motivational Interviewing
3. HIV Prevention Education and Risk Reduction (Wisconsin)
4. HIV Stops with Me
5. Teens Linked to Care
6. Holistic Harm Reduction Program
7. Los Angeles Clinic-Affiliated Intervention
8. Stop AIDS Project, San Francisco
9. Positive Images, Los Angeles
10. Prevention in Medical Care Settings
11. Healthy Relationships
12. Power Program Los Angeles
13. HTPP HIV Transmission Prevention Project
14. Peer Based Intervention to Promote Condom and Contraceptive Use Among HIV Positive and At-Risk Women
15. Project Connect

APPENDIX 3:
MSM NEEDS ASSESSMENT
SURVEY AND
INTERVIEW GUIDE

Appendix 3A: MSM Survey Instrument

Appendix 3B: MSM Service Provider Interview Guide

SURVEY FOR MEN WHO HAVE SEX WITH MEN (MSM)

Did you know that the Vermont Department of Health allocates more than \$175,000 for HIV prevention for men who have sex with men? The Vermont HIV Prevention Community Planning Group, a community-based advisory group to the Vermont Department of Health, would like to make sure that the Department funds programming of interest to you, and that organizations serving MSM in Vermont know what your priorities are. To that end, would you be so kind as to complete this survey? **Thank you for your time.**

You are making a difference.

<p>1. What are the <u>primary</u> ways you spend your free time? →Check no more than five activities.</p>	<p>2. Which of the following do you NOT participate in but would <u>most</u> like to if it was available? →Check no more than five activities.</p>
<p> <input type="checkbox"/> Large social events (parties, dances, etc.) <input type="checkbox"/> Small social events (dinners, get-togethers, etc.) <input type="checkbox"/> Arts and cultural events (theater, music, galleries, etc.) <input type="checkbox"/> Going to a bar <input type="checkbox"/> Going out elsewhere (restaurant, café, movies, etc.) <input type="checkbox"/> Dating/Looking for a partner <input type="checkbox"/> Connecting/Cruising for Sex <input type="checkbox"/> Internet (surfing, chat rooms, etc.) <input type="checkbox"/> Telephone chat lines <input type="checkbox"/> Adult education (classes, workshops, etc.) <input type="checkbox"/> Political work/Activism <input type="checkbox"/> Volunteer work <input type="checkbox"/> Sports/Exercise <input type="checkbox"/> Outdoor activities <input type="checkbox"/> Shopping <input type="checkbox"/> Hobbies (book clubs, gardening, etc.) <input type="checkbox"/> Individual and/or Couples Counseling <input type="checkbox"/> Support groups (including 12-step groups, coming out groups, etc.) <input type="checkbox"/> Religious activities/Spiritual gatherings (church, synagogue, Radical Faeries, etc.) <input type="checkbox"/> Parenting/Mentoring (spending time with your own or other children) Other: _____ </p>	<p> <input type="checkbox"/> Large social events (parties, dances, etc.) <input type="checkbox"/> Small social events (dinners, get-togethers, etc.) <input type="checkbox"/> Arts and cultural events (theater, music, galleries, etc.) <input type="checkbox"/> Going to a bar <input type="checkbox"/> Going out elsewhere (restaurant, café, movies, etc.) <input type="checkbox"/> Dating/Looking for a partner <input type="checkbox"/> Connecting/Cruising for Sex <input type="checkbox"/> Internet (surfing, chat rooms, etc.) <input type="checkbox"/> Telephone chat lines <input type="checkbox"/> Adult education (classes, workshops, etc.) <input type="checkbox"/> Political work/Activism <input type="checkbox"/> Volunteer work <input type="checkbox"/> Sports/Exercise <input type="checkbox"/> Outdoor activities <input type="checkbox"/> Shopping <input type="checkbox"/> Hobbies (book clubs, gardening, etc.) <input type="checkbox"/> Individual and/or Couples Counseling <input type="checkbox"/> Support groups (including 12-step groups, coming out groups, etc.) <input type="checkbox"/> Religious activities/Spiritual gatherings (church, synagogue, Radical Faeries, etc.) <input type="checkbox"/> Parenting/Mentoring (spending time with your own or other children) Other: _____ </p>
<p>3. What health topics are of <u>greatest</u> interest to you? →Check no more than five topics.</p>	<p>4. How did you hear about this survey? →Check all that apply.</p>
<p> <input type="checkbox"/> Alternative therapies (acupuncture, aromatherapy, etc.) <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Diet/Nutrition <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other Sexually Transmitted Diseases <input type="checkbox"/> How to find a "GLBT-friendly" provider <input type="checkbox"/> Mental health <input type="checkbox"/> Physical fitness <input type="checkbox"/> Prostate health <input type="checkbox"/> Substance use/abuse and/or addiction <input type="checkbox"/> Other addictions (sex/love addiction, work addiction, etc.) <input type="checkbox"/> Tobacco cessation Other: _____ </p>	<p> <input type="checkbox"/> Word of mouth <input type="checkbox"/> Internet <input type="checkbox"/> Email <input type="checkbox"/> Advertisement <input type="checkbox"/> Out in the Mountains <input type="checkbox"/> Case worker <input type="checkbox"/> Community organization/agency: _____ Other: _____ </p>

PLEASE CONTINUE ON THE OTHER SIDE →

APPENDIX 3A: MSM SURVEY – pg. 2 of 2

Demographic Information (optional)

1. Would you describe yourself as (check all that apply):

- Gay
- Bisexual
- Transgender
- Heterosexual
- Queer
- Other: _____

2. Age _____

3. Highest grade completed in school:

- 8th grade or less
- Some high school
- High school graduate or GED
- Some college, Associate's degree/
Technical school training
- College graduate / Postgraduate

4. What zip code do you live in? _____

5. What is your HIV status?

- HIV+ (HIV Positive)
- HIV- (HIV Negative)
- Don't know

6. What is your household's annual income before taxes?

- <\$12,000
- \$12,000 – \$24,000
- \$24,000 – \$36,000
- \$36,000 – \$48,000
- \$Over 48,000

Number of people in household: _____

7. Which racial group or groups do you consider yourself to be in? (check all that apply):

- American Native or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White/Caucasian

8. Which ethnicity do you consider yourself to be?

- Hispanic or Latino
- Not Hispanic or Latino

Thank you for completing this survey!
We promise to use this information to serve you better.

Instructions: Please fold then tape closed. Return by mail by June 30, 2003.

A self-mailer imprint filled this space

APPENDIX 3B: MSM SERVICE PROVIDER INTERVIEW INSTRUMENT – pg. 1 of 5

Methods note: This instrument was used for phone interviews and responses were entered electronically; it was not intended as a self-administered written survey

I. PROVIDER PROFILE

I.1. Organization	
I.2. Provider’s Position	
I.3. To whom are your services available (generally)?	
I.4. Geographic service area	
I.5. Types of Services Offered to MSM	A. Crisis Services
	B. Cultural/Racial/Ethnic-specific
	C. Education
	D. Employment/Job-Related
	E. Faith-based
	F. HIV/AIDS
	G. Health
	H. Other social/human services:
	I. Political/Community Organizing/Advocacy
	J. Social/Recreational
	K. Substance Use/Abuse
	L. Other:
I.6. What are the ways you come into contact with MSM? <i>Describe your involvement/work with MSM; General description of services; not specific programming notes.</i>	
I.7. Is it part of your organization’s mission or goals to address HIV/AIDS?	
YES: How is it addressed?	
NO: How, if at all, does it come up in your work?	
I.8. What challenges or issues do you face in providing services to MSM? How can these issues be addressed?	

APPENDIX 3B: MSM PROVIDER INTERVIEW INSTRUMENT – pg. 2 of 5

I.9. What resources would help you better serve MSM?

Resources	How would the resource be used?
A. Staff/Human Resources	
B. Training/T.A.	
C. Funding	
D. Print Materials	
E. Other Materials	
F. Other (specify):	

I.10. Access of Services. I'm going to give you a list of ways in which MSM might access any of your services. I'd like to know if they access services in this way Never, Rarely, Sometimes, or Frequently.

N - never R – rarely S – sometimes F - frequently	
	A. Phone
	B. By appointment
	C. Community/Public Events
	D. Referral/Word of Mouth
	E. Outreach
	F. Website
	G. Other (specify):

II. DESCRIPTION OF MSM

II.1. To the extent that you can comment on this: In general terms, how would you describe the MSM you work with/serve?

First in terms of:

II.1a. Self-identity <i>gay, bisexual, trans, hetero, etc.</i>	
II.1b. Sociodemographic characteristics <i>age, race, ethnicity, SES, HIV status, etc.</i>	

APPENDIX 3B: MSM PROVIDER INTERVIEW INSTRUMENT – pg. 3 of 5

II.1c. Risk behaviors <i>Engaging in sexual or needle-related HIV risk, or other risk behaviors</i>	
II.1d. Other characteristics	

II.2. I'm going to give a list of categories, and would like to know if you work with (come into contact with) MSM who are in those categories.

- 0 – Not at all
- 1 – A little
- 2 – Some
- 3 – A lot
- 4 – Exclusively
- ? – Don't Know

	A. Youth (13-24)
	B. Older (55+)
	C. HIV+
	D. Men in serodiscordant relationships
	E. Men of color (Specify, if applicable)
	F. Men who are substance users and/or abusers
	G. Injection Drug Users (current or recent)
	H. Non-gay- or bisexual-identified
	I. Living at or below the poverty line
	J. Homeless/Seeking temporary shelter
	L. Incarcerated/involved with Corrections, Probation/Parole
	M. Dealing with mental illness/mental health issues
	N. Dealing with or who have a history of violence or abuse (perpetrators or survivors)
	O. Dealing with any other specific challenges (developmentally delayed, hard of hearing, visually impaired)
	P. Other groups:

COMMENTS ON ANY OF THE ABOVE:

APPENDIX 3B: MSM PROVIDER INTERVIEW INSTRUMENT – pg. 4 of 5

<p>II.3. What would you say are the major health-related issues or concerns among the MSM you serve? <i>(Including conditions and access: HIV, HCV, other STIs or conditions, mental health, addiction, substance use, access to providers, cultural competency, prostate health, cancer, heart disease, diabetes, Alzheimer’s, obesity)</i></p>	
<p>II.4. What are the major other concerns, or priorities in their lives? <i>Social, political, financial, employment, etc.</i></p>	

III. SERVICES

<p>III.1. What are the three best venues for reaching MSM with services/messages? <i>(Internet, bars, PSEs, community events, media, etc.</i></p>	
<p>III.2. How might HIV counseling and testing be increased among the population you serve? How might the barriers to testing be removed? <i>(What are the barriers to HIV testing among the MSM you serve? How might those barriers be addressed?</i></p>	
<p>III.3. Are you aware of any issues facing MSM living with HIV with regard to medical care and services? Are they receiving the care they need? Why or why not? <i>Barriers: cultural competency, distrust, transportation, denial, financial, etc.</i></p>	
<p>III.4. What services or community functions do the MSM you serve want, but aren’t receiving? What are the unmet needs? <i>(Social, medical, human services, housing, food, advocacy, etc.)</i></p>	
<p>III.5. Would you say there are specific groups of MSM who <u>are</u> being well reached with HIV prevention services? If so, who?</p>	

APPENDIX 3B: MSM PROVIDER INTERVIEW INSTRUMENT – pg. 5 of 5

III.6. Who is NOT being well reached?	
III.7. Are there specific (geographic) areas where services are most lacking, or more difficult to provide to MSM? If so, specify.	
In your service area:	
In Vermont in general:	

III.8. I'm going to ask you about a range of HIV prevention services, and several questions about each one:

- Do you provide these services?
- Do you make referrals for these services?
 - If so, to what organizations?

Service	Provide? (Y/N)	Refer? (to...)
ILI		
GLI		
CLI		
CTS		
Outreach		VENUE(S):
PCM		
Info/Hotline		
PI		
NEP		
Online/Internet		
Other		

III.9. Based on everything we've discussed, what do you think should be the priorities for implementing effective HIV prevention for MSM in your area? (<i>How could HIV prevention be more effective targeting MSM in Vermont</i>)

APPENDIX 4: IDU NEEDS ASSESSMENT

Appendix 4A: Materials and Methods

Appendix 4B: IDU Participant Interview Guide

Appendix 4C: IDU Service Provider Interview Guide

IDU Needs Assessment Project
Participant and Provider Interviews – Materials and Methods

Material

Two interview guides were used to collect data: one for IDU and one for service providers. These guides are included in Appendix 4.

Methods

1) Study design

The method selected to perform the IDU needs assessment was a qualitative method based on face-to-face interviews, or when this was not possible, phone interviews. This method was preferred over a quantitative method because of the limited data available on IDU, but also because of limited resources. All participants were reassured that the information gathered would be confidential. Verbal consent to participate was obtained from each respondent before starting the interviews.

2) Study population

Sample size, sample source, and venues

Key informants were identified among injection drug users and among IDU service providers. As a result of a collaborative effort with the health department, the CPG and the target populations, the following groups were identified at the outset of the project.

A minimum of 10 injection drug users

Key IDU informants were recruited, following the goals described below:

Age groups: 5 IDUs between 24 and 18 of age and 5 IDUs 25 and older.

Information on younger IDU (17 and less) was to be gathered from older participants and from provider interviews.

Appendix 4A: IDU Needs Assessment: Materials and Methods – pg. 2 of 3

Venues for data collection:

- 2 IDUs in Drug treatment facilities, 1 inpatient and 1 outpatient treatment facility
- 3 IDUs through syringe exchange programs/prevention case management interventions, harm reduction center
- 2 IDUs who are incarcerated
- 3 IDUs reached through outreach in street locations or other community location
- 1 IDU through an out-of-state methadone clinic

Gender: The target figures for gender were 70% male and 30% female IDUs.

Race/ethnicity: 70 to 80% Caucasian/white and 20 to 30% minorities. Priority was given to IDUs who are Latinos/Latina and African American.

Counties of interest: Sampling took place in four counties: Chittenden (Burlington), Caledonia (St. Johnsbury), Windham (Brattleboro) and Rutland (Rutland).

HIV status: Preferably, at least 30% participants would be HIV positive.

A minimum of 10 IDU service providers distributed as follows:

Key informants were recruited as per the following goals:

- 5 HIV Prevention (includes harm reduction programs) and care services providers for IDUs: 2 in Burlington, 1 in Windham, 1 in Caledonia county and 1 in Rutland
- 1 Health Department/ADAP staff
- 2 substance abuse treatment facility - identify with ADAP and 1 key informants among mental health providers that have an HIV prevention program

Appendix 4A: IDU Needs Assessment: Materials and Methods – pg. 3 of 3

3) Data collection

Service providers were interviewed by the CPG consultant, using the designated interview guide. Prior to data collection, the key providers were identified with help from the IDU Needs Assessment Committee, Alcohol and Drug Abuse Program (ADAP) and based on the HIV resource guide. Key informants were chosen based on their experience with IDU and their capacity to provide extensive information on IDUs and their need for services.

Injection drug users would preferably be interviewed by the service provider they are accustomed to. Service providers were to use the designated interview guide.

Injection drug users were identified by the service provider based on the named criteria (see below).

The interviewer read the consent form to each participant (see Interview Guide in Appendix 4). Upon verbal consent, the participant would be screened for eligibility. The participant would be interviewed only if s/he was eligible.

Injection drug users who completed the interview received a gift certificate for the amount of \$25 to encourage participation.

4) Recruiting and screening injection drug users

Respondents were required to:

- Have injected drugs within the past 12 months
- Be a Vermont resident for at least 6 months
- Be at least 18 years old
- Be willing to participate
- Be fully coherent at the time of interview

Participant Interview Guide

Interview number _____

Date: _____ County of interview: _____

Place of Interview: _____

Section 1: Participant Information

1-1) What county do you live in? _____

1-2) What is your age? _____

1-3) Do you identify as: _____ Male _____ Female _____ Transgender

1-4) Would you say that you are (*read the options*): _____ Hispanic or _____ Non-Hispanic

1-5) I'm going to read a list of race options. Let me know if any apply to you. You can answer yes more than once: *Check all that apply.*

- _____ American Indian or Alaska Native
- _____ Asian
- _____ Black or African American
- _____ Native Hawaiian or Other Pacific Islander
- _____ White or Caucasian
- _____ Any other race that I haven't mentioned? _____

1-6) Have you ever been tested for HIV?

_____ Yes _____ No (if no, skip to 1-7)

_____ Don't know/Don't remember (skip to 1-7) _____ Declined to answer (skip to 1-7)

1-6A) IF YES: What kind of test was your last HIV test?

_____ Blood test _____ Oral test (Orasure)

_____ Other: _____ Don't know/Don't remember

Appendix 4B: IDU Participant Interview Guide - pg. 2 of 10

1-6B) IF YES: What was the result of your last HIV test?

HIV Positive HIV Negative

Don't know/don't remember Declined to answer

1-7) Have you ever been tested for Hepatitis C (HCV)?

Yes No

Don't know/Don't remember Declined to answer

1-7A) IF YES: What was the result of your last HCV test?

Hep C Positive Hep C Negative

Don't know/Don't remember Declined to answer

1-7B) IF HCV POSITIVE: Have you ever been in treatment for Hepatitis C?

Yes No

Don't know/Don't remember Declined to answer

1-8) Have you been immunized for Hepatitis A?

Yes No

Don't know/Don't remember Declined to answer

1-9) Have you been immunized for Hepatitis B?

Yes No

Don't know/Don't remember Declined to answer

Section 2: HIV Prevention Services

I'm going to ask you about your experience with AIDS and HIV, which is the virus that causes AIDS.

Question 1- What do you know about AIDS and HIV, the virus that causes AIDS?

Question 2- Where did you learn about it? *Get as much info as possible about the different types of interventions/program (see question 3, below)*

Question 3- Can you help me classify the programs that you have been to? I am going to read a list of different kinds of services, where there may be a discussion about HIV or AIDS. Let me know if you have experienced any of these services. *(Find out where services were received -- provider, location.)*

- Have you been to a counseling and testing session? *When they talk about HIV and draw blood or swab your mouth for testing.*
- Has someone ever come up to you in the street, a shooting gallery, at home, etc. to talk about HIV or AIDS? *Street outreach, institutional outreach, etc.*
- Have you ever called an 800 number to get information about HIV or AIDS? *Information/Hotline*
- Has anyone talked to you one-on-one about HIV or AIDS, and taught you how to clean injection equipment, use a condom, negotiate safer sex with your partner, etc.? *Individual Level Intervention*

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- Has anyone talked to you in a group, with other users, to teach you about how to clean injection equipment, use a condom, negotiate safer sex with your partner, etc.? *Group Level Intervention*
- Have you ever participated in any larger events with a social component, where you get together, have fun and talk about issues for users? *Community Level Intervention*
- Have you ever seen a message about HIV or AIDS in a brochure, poster or a billboard, or have you seen a public presentation, or a TV commercial or broadcast about HIV or AIDS? *Public Information (print, broadcast, etc.)*
- Have you been to a needle exchange program, where they give you new needles/syringes in exchange for used needles/syringes?
- Have you ever received prevention case management services where someone worked with you on an ongoing basis to provide support, help dealing with systems (court, jail, probations), help you get services (drug treatment, healthcare, housing, jobs) and help you reduce the risk of HIV/Hep C transmission (help getting sterile syringes, condoms, safer sex and safer injection information)? Some places may use other terms for PCM, like “harm reduction coordination.”
- Have you ever been in a substance abuse treatment program, including medication assisted treatment, such as methadone and buprenorphine? *May be more than one occasion; residential; outpatient; compulsory or voluntary; medication assisted treatment; abstinence-based program.*
- Is there any other program you’ve participated in, where HIV or AIDS was mentioned? If so, describe:

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Question 4- Based on everything we just talked about -- What do you think about the services you received in general? What was good, what was not good? How did you connect to the services? How did you get there and/or why did you participate? (*Quality of services, staff, location, time, etc.; referral, friend, mandated participation, etc.*)

Question 5- ? If you had the opportunity to change something, what would you have changed about the services or programs you participated in? For what reasons? Would you be more likely to use the services if those changes were made? Why? What are some reasons why you wouldn't use these kinds of services?

Question 6- What are you doing now to protect yourself from HIV infection?

Question 7- How did the program(s) we've talked about change what you were doing or not doing to protect yourself or your partners from HIV, the virus that causes AIDS?

Question 8- How did that happen? What convinced you to change? Which program contributed the most to that change? Why?

Question 9- Are there ways you would have liked to have learned about HIV/AIDS that we haven't discussed? Are there services you would like to receive but haven't? If so, what should those services look like (who, what, where, how delivered)?

Section 3: Counseling and testing / treatment and care

I'd like to ask you some more about HIV testing.

Work through this section quickly; go for succinct answers versus a longer discussion.

I remember you saying that you have never been tested:

Question 13- What might lead you to get tested? Is there anything that has kept you from getting tested?

Question 14- Where would you go if you wanted to be tested? Why? What kind of test would you use if you had the choice? Why? *Give choice if necessary (oral, blood test)*

I remember you saying that you have been tested:

Question 15- Where did you get tested? How did you connect with the service (*word of mouth, referral, etc.*)? What do you think about the session?

Question 16- Tell me about the counseling you received (if any). Was it helpful? Why or why not? What was that experience like (positive and negative)?

Question 17- Where would you go if you wanted to be tested again? Why?

If participant has tested positive: I remember you saying that you were positive, I'd like to ask about your experience with treatment services after you got tested.

Question 18- Did you receive medical treatment and/or health care services after you got your HIV test results? Why or why not? If so, what has that experience been like (positive and negative)?

Question 19- How long did it take you to receive care? Did you receive care services quickly/right away? Why or why not? If not, what might help you access those services now?

Section 4: Effective/Culturally Competent HIV prevention interventions

Now I would like to have a sense of what would work for people who inject if I wanted to talk to them about HIV or AIDS. This section is very important because it will help the Vermont Department of Health know how to spend federal dollars to prevent people who inject drugs from getting HIV or Hepatitis C.

Question 20- Based on your experience or just your opinion, what should be the TOP priorities to help people who inject do it safely, avoid sharing injection equipment, get connected to treatment, or encourage them to use condoms and barriers? Are there services people who inject would like to receive but haven't? If so, what should those services look like (what, who, where, how delivered)?

(What should HIV prevention for users look like, and what should the top priorities be? It may be helpful to refer back to the list in Question 3 again.)

Question 21- Where do you think people who inject would prefer to hear about HIV or AIDS? In what setting? Under what circumstances? *Would they rather talk about it in a drug treatment facility, methadone clinic, needle exchange, at the hospital, in an office, etc.?*

Question 22- How do people want to hear about it: in a one-on-one discussion, a discussion in a group with other users, a discussion on the phone, or just be handed material (condom, bleach kits, other)?

Question 23- What would be a good time to talk to people who inject about HIV/AIDS? Why is that? What are the worst times to address HIV and AIDS with users?

Question 24- What kind of person would users prefer to hear about HIV or AIDS from? Why? Who would users not like to hear about HIV or AIDS from? Why? *(Be sure to ask for both positive and negative examples.)*

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Question 25- What do you think might keep people away from these kinds of HIV prevention services? What turns them off? What makes it hard for people to address HIV and AIDS with users? What are biggest barriers or obstacles?

(What are the challenges for: recruiting users to participate in programs; speaking with IDUs; encouraging people to limit or stop sharing injection equipment; to stop using; to use condoms and barriers; to get tested.)

Question 26- Do you think there are certain people, or kinds of people, who aren't being reached with HIV prevention programs, HIV testing, and/or HIV/AIDS care? Who? *(youth, women, people of color, people living with HIV, MSM, etc.)*

Question 27- Outside of the HIV prevention services we've talked about, what other kinds of services do you think users MOST need in this area? *(methadone; access to health care; social services, e.g., housing, financial assistance, mental health services; etc.)*

Question 28- What do you think are the main health concerns of users in this area? Why do you think so? How should those concerns be addressed?

(HIV, HCV, other conditions, addiction, access to providers, cultural competency, etc.)

Section 5: Injection Drug Use in Your Area

For this section, the questions get more specific to what you think is going on in this area. I don't want you to name names or give any information you are uncomfortable giving. Remember that this is an anonymous survey and that it's okay to pass on any question. Also remember that the information that you give me will be kept confidential, and that only the research team will have access to it.

Drug use

Question 29- What kinds of places around here do people use to shoot up? And why do you think those are the places they choose to do it? *(NOT looking for specific places, just general answers: homes; shooting galleries; public restrooms; on the street; parks; in cars; etc.)*

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Question 30- What are the ways people get their drugs? *(Don't need to name sources; looking for general answers: from friends; from a dealer; in shooting galleries; on the street; etc.)*

Question 31- What kind of drugs are used? How are the drugs injected? *(injection equipment used; other paraphernalia used; how injected (intravenous; subcutaneously; intramuscular); parts of body or areas of skin where injected; overall injection practices)*

How about yourself? Could you describe the way you usually inject?
(injection equipment used; other paraphernalia used; how injected (intravenous; subcutaneously; intramuscular); parts of body or areas of skin where injected; overall injection practices)

Risk behavior: needle sharing

Question 32- Where do users around here get needles? syringes? other injection equipment?

Question 33- Do you think there is a lot of sharing of injection equipment going on around here? If so, what gives you that impression? Are there places where it's more common for people to share injection equipment? If so, what are they? What are the most common reasons for people to share injection equipment? *(don't feel at risk; sharing only with one partner; can't get injection equipment; pressure to do so)*

Risk Behavior: Condom use

I'd also like to ask you a few questions about condoms.

Question 34- Where do people get condoms around here?

Question 35- Do you think there is a lot of unprotected sex going on around here? If so, what gives you that impression? What do you think are the most common reasons for people to have unprotected sex? *(don't feel at risk; sex only with one partner; can't get condoms; drug-related impaired judgment; trading sex for resources; pressure to have sex; assault/coercion)*

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Attitude towards HIV/AIDS

Question 36- Lastly, I'd like to know how you think users feel about HIV and AIDS. Do they think about it a lot? Do users know about the ways in which HIV is spread and prevented? Are people concerned about HIV/AIDS? Why or why not? *(What are IDU's feelings around HIV? Do they feel at risk? Is it on peoples' minds? What are the misconceptions about HIV, transmission, etc.?)*

Question 37- That's everything I have. Is there anything else you'd like to add? Anything you think is important that we haven't talked about?

Thank you for participating in this survey.

Give gift certificate to participant.

Service Provider Interview Guide

Interview number _____

Date: _____ Interviewer: _____

Place of interview: _____ County of interview: _____

Section 1: Provider's profile

Age: _____ years **Gender:** ___ Male ___ Female ___ Transgender

Ethnicity: ___ Hispanic ___ Non-Hispanic

Race: *Check all that applies*

___ American Indian or Alaska Native ___ Asian ___ Black or African American
___ Native Hawaiian or Other Pacific Islander ___ White ___ Other

Organization: _____ **Provider's Position:** _____

Type of services provided by your organization:

Describe your involvement/work with injection drug users:

Section 2: Description of injection drug users

Question 1: How would you describe the injection drug users that you serve, based on sociodemographic characteristics and behavioral characteristics?

Prompt: Sociodemographics: age, race, ethnicity, gender. Behavioral characteristics can be sharing needles, unprotected vaginal, anal or oral sex; multiple sex partners, settings and circumstances in which they inject drugs etc.

Question 2: What would you say are the major health related issues among the IDU population you serve? *HIV, HCV, other conditions, addiction, access to providers, cultural competency, etc.*

Question 3: What would you say is the impact of HIV among the IDU population you serve? Are you aware of any/a few/many IDUs living with HIV? *Quantify, if possible – numbers of clients; approximate percentage of population; etc.*

Question 4: Are you aware of any issues facing IDUs living with HIV with regard to medical care and services? Is this population receiving the care they need? Why or why not? *Barriers to care; cultural competency; distrust; etc. Alternately – successful strategies for linking people to care and services.*

Section 3: Services

Question 5: What challenges or issues do you face in providing services to injection drug users? How can these issues be addressed? *What are the barriers to providing services? What keeps people from accessing your services? Is there a gap between your area of expertise and the needs of injection drug users in your area? Are there any cultural competency issues?*

Question 6: Can you identify the most critical service gaps facing injection drug users in your area? What services are needed by injection drug users, and are not provided, or are insufficient? Among the service gaps identified, which ones are the two most urgent to address. Why are they most important?

Question 7: Are there any unique needs within special populations among your target audience? If so, what are they? (*women, youth, incarcerated, homeless, etc.*)

Question 8: I'm going to ask you about a range of HIV prevention services, which you may or may not provide yourself. I'd like to know your impressions of these kinds of services – are they or would they be an effective HIV prevention strategy for this population? If so, what environments or other guiding principles would be important for success? Are IDUs in your area accessing any of these services? Why or why not (to all of the above)? *Include any general comments about service(s).*

Counseling and Testing services

Prevention Case Management

Outreach (street outreach, institutional outreach, etc.)

Information/Hotline

Individual Level Intervention (one-on-one counseling in any environment)

Group Level Intervention (guided group activity/discussion)

Community Level Intervention (larger events with a social component)

Public Information (print, broadcast, etc.)

Needle exchange

Substance Abuse Treatment

Other?

Question 9: What is your impression of harm reduction-based HIV prevention strategies for injection drug users in your area? Are they being implemented? utilized? *What do you think is the role of harm reduction in HIV prevention for injection drug users? How would you define harm reduction? What are the behavior change differences/advantages of a harm reduction (vs. abstinence-based) approach?*

Question 10: What kinds of services are effective in changing risk behavior (or supporting continued/increased risk reduction) (needle sharing, drug injection practices)?

Refer to the list of key services to guide the respondent, which describes each of the following:

Health Care and Medical Services

Health care services

Medication services

Mental and social support services

Counseling/mental health services

Case management services

HIV prevention services

HIV prevention case management

HIV education interventions (see above)

Needle exchange

Counseling and Testing

Substance abuse services

Methadone

Other medical detoxification services

Other substance abuse treatment (residential, outpatient)

Question 11: What policy changes can improve HIV prevention among injection drug users? Why would these policies improve HIV prevention? *Governmental (federal, state, local); Department of Health, Corrections, Education, Mental Health, etc.; within other agencies/providers.*

Question 12: Is there anything else about HIV prevention and services for this population that I haven't asked you about, which you feel is important? Anything you'd like to add?

Question 13: Based on everything we've discussed, what do you think should be the priorities for implementing effective HIV prevention for injection drug users in your area?

Additional comments:

Section 4: Injection Drug Use

Question 14: What kinds of places do people around here shoot up? And why do you think those are the places they choose to do it? (*homes; shooting galleries; public restrooms; on the street; parks; in cars; etc.*)

Question 15: Where do people get their drugs? (*don't need to name sources: looking for answers such as: from friends; from a dealer; shooting galleries; on the street; etc.*)

Question 16: What kinds of drugs are used? How are the drugs injected? (*material and parts of body*)

Question 17: Where do people get needles in this area?

Question 18: Do you think there is a lot of needle and/or paraphernalia sharing going on around here?

_____Yes _____No

18A) What gives you the impression that there is/is not? *What is the basis for your answer?*

18B) Are there places where it's more common for people to share needles? What are they?

Question 19: What do you think are the most common reasons for people to share needles? (*don't feel at risk; sharing only with one partner; can't get needles; pressure to do so*)

Question 20: Are you aware of injection drug users in your area engaging in other related HIV risk behaviors? *Sharing straws for snorting; trading sex for resources; unprotected sex; multiple sex partners; etc.*

Additional comments: