

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

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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 [plus \$41,516 attributed Other, for GLBTQ youth]		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.

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What are the primary ways you spend your free time? (n=204)

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.

MSM SURVEY RESULTS – pg. 2 of 4

2. Which of the following do you not participate in but would most like to if it was available? (n=165; 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.

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What health topics are of greatest interest to you? (n=201)

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? (n=201)

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... (n=202)

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

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Highest grade completed (n=198)

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

Annual household income (n=195)

<\$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

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What resources would help you better serve MSM?

(n=12)	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?

	(n = 10)			
	Never	Rarely	Sometimes	Frequently
By Phone	0	1	2	7
By appointment	0	2	3	5
At Community/Public Events	1	0	6	3
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.