

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 -