

## 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