

SECTION 1: INTRODUCTION AND SUMMARY

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Introduction

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

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

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

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

Who uses the Comprehensive Plan?

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

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

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

HIV Prevention in Vermont: A Rural Challenge

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

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

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

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

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

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

CDC’S New Initiative: *Advancing HIV Prevention*

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

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

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

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

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

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

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

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

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

Guide to Acronyms and Abbreviations

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

Executive Summary: Highlights of the 2004 Comprehensive Plan

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

Section 1: Introduction and Summary

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

Section 2: Community Services Assessment

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

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

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

MSM Needs Assessment – Participant Survey: Selected Findings

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

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

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

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

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

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

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

MSM Needs Assessment – Provider Interviews: Selected Findings

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

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

Most common responses:

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

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

Most common responses:

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

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

Most common responses:

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

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

Most common responses:

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

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

Most common responses:

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

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

Most common responses:

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

Question: Who is not being well-reached?

Most common responses:

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

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

Most common responses:

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

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

Most common responses:

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

IDU Needs Assessment: Selected Findings

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

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

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

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

GAP ANALYSIS

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

Gap Analysis: MSM

Geographic gaps

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

HIV Prevention Intervention Gaps

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

Underserved Populations

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

Related factors

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

Gap Analysis: IDU

Geographic gaps

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

HIV Prevention Intervention Gaps

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

Underserved Populations – IDU who are:

- Women
- Youth

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

Related factors

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

Gap Analysis: People at Increased Risk Through Heterosexual Contact

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

Geographic gaps and underserved populations

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

Gap Analysis: People Living with HIV/AIDS

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

Geographic gaps

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

Underserved Populations

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

Related gaps

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

Section 3: Prioritization of Populations

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

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

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

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

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

People at Increased Risk Through Heterosexual Transmission: 36.5%

Injection Drug Users (IDU): 25.5%

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

Section 4: Prevention for Positives (PFP)

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

Guiding principles discussed in this section include the following:

1. Prevention must be a shared responsibility.

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

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

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

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

MSM Sub-Populations

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

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

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

Venues

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

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

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

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

MSM: Other Recommendations

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

Prevention, with recommendations pertaining to:

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

Capacity Building, with recommendations pertaining to:

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

Other Issues, with recommendations pertaining to:

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

Section 6: People at Increased Risk through Heterosexual Transmission

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

Men, Women and Youth* who:

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

Women and Youth* who:

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

Youth* who are:

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

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

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

Women at Increased Risk: Related Issues

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

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

Youth at Increased Risk: Related Issues

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

Men at Increased Risk: Related Issues

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

Section 7: Injection Drug Users (IDU)

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

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

IDU Sub-Populations

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

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

Venues

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

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

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

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

IDU: Other Recommendations

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

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

Section 8: Interventions

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

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

Elements of a Successful HIV Prevention Program:

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

Behavioral Theories:

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

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

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

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

Diffusion of Effective Behavioral Interventions for HIV Prevention (DEBIs)

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

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

Compendium of HIV Prevention Interventions with Evidence of Effectiveness

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

Prevention For Positives (PFP) Interventions

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

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

Section 9: Vermont Department of Health Activities

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

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

APPENDICES

Appendix 1: Epidemiological Profile

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

Key findings from this section include the following:

The Epidemic in Vermont

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

Communities of Color

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

Women

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

Modes of Exposure

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

Appendix 2: Prevention For Positives - Interventions Fact Sheets

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

Appendices 3 and 4: MSM and IDU Needs Assessment

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

- END OF SECTION 1: INTRODUCTION AND SUMMARY -