# STATE OF MAINE
# COMPREHENSIVE HIV PREVENTION PLAN

# *UPDATE*

*June 2003*

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Maine
HIV Prevention
**COMMUNITY**
**PLANNING GROUP**

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**State of Maine**
**Comprehensive HIV Prevention Plan**

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## Overview

This document was prepared by the Maine HIV Prevention Community Planning Group (CPG) as an update of Chapter 5 of the 2001 ***State of Maine Comprehensive HIV Prevention Plan*** for the Maine Bureau of Health, and HIV prevention providers. Reflecting challenges found in a large rural state, the CPG felt that to best meet the diverse needs of the people at risk for HIV, the state should be divided into Northern, Central and Southern regions. When comparing one region to the other, one sees differences in demographics, geography and access to services resulting in different HIV prevention needs from region to region.

Following guidelines from the Centers for Disease Control and Prevention (CDC), the CPG prioritized populations whose behaviors put themselves or others at risk for HIV infection. The group reviewed HIV and STD epi data; hepatitis C data; the Needle Sharer Needs Assessment from the Bureau of Health (BOH); and the CPG Statewide Needs Assessment of males who have sex with males, males who have sex with females, and females who have sex with males. Populations were prioritized according to region, transmission risk, gender, age, race and ethnicity. Needs for the prioritized populations were determined and a set of corresponding interventions to address those needs were chosen. The CPG also conducted a Gap Analysis by comparing the needs of the populations to the available services as listed in the BOH Resource Inventory of Currently Funded Interventions, and the CPG Statewide Resource Inventory which lists services provided regardless of funding source. Any service "gaps" were noted.

**As a result of this process, the CPG has prioritized the following population as the NUMBER ONE PRIORITIY POPULATION throughout all regions of the State:**

1. **All people who are HIV-positive AND who engage in unsafe sex and/or share injection equipment thereby putting themselves or others at risk for HIV infection.**

To begin to address the prevention needs of this population, the CPG recommends that current money set aside by the Bureau of Health for people who are positive be used to fund two Prevention Case Manager (PCM) Programs, Community Level Interventions (CLI) and Partner Counseling and Referral Services (PCRS) as interventions for this population in 2004.

The CPG recommends that the Bureau of Health conduct an extensive statewide Needs Assessment of people who are positive to be completed by January of 2004.

In addition to the first priority population, this Update also includes regionally prioritized populations whose HIV status is unknown or negative with corresponding behavioral and demographic characteristics. Updated epidemiological data for the three behaviorally-based Prioritized Populations in each region, and their identified needs and interventions, are also included. The names of the three behaviorally-based populations have been changed so that the acronyms will correspond to those in common usage:

| PREVIOUS NAME | **NEW NAME** |
|---|---|
| Unsafe Sexual Contact, Both Partners Male | Males who have Unsafe Sex with Males (**MSM**) |
| Sharing Needles and Injection Equipment | Injection Drug Users who Share Needles or Injection Equipment (**IDU**) |
| Unsafe Sexual Contact, Partners of the Opposite Sex | Heterosexuals who have Unsafe Sex (**HET**) |

It is important to note that Maine's populations of color are disproportionately affected by HIV and have been prioritized regionally according to the unsafe behaviors that put them at risk. The CPG realized there may be other specific needs for communities of color, however, the critical needs identified for behavioral populations cut across cultural and linguistic lines as do identified interventions.

In addition there are other populations who have characteristics that require special prevention strategies and cultural competencies. These other populations may include the deaf community, youth, and people who have a mental illness or other disability and/or who are homeless or incarcerated etc. The critical needs and interventions for the behavioral populations listed in this Update apply to members of these populations who engage in unsafe behaviors. See Chapter 6 of the 2001 *State of Maine Comprehensive HIV Prevention Plan* for additional information about these populations.

This revision completely replaces the May 2002 Update and all of Chapter 5 of the 2001 HIV Prevention Plan. Please note that the other Chapters of the 2001 Plan remain current, and should be used in conjunction with the new information presented here. A Glossary of Commonly Used Terms and Acronyms, an Intervention Information Chart and the results of the Gap Analysis of met and unmet HIV prevention needs are included as Attachments.

# 5. REGIONAL HIV PREVENTION PRIORITIES

## 5.1 NORTHERN REGION

### CHAPTER OVERVIEW

The following section lists the prioritized populations for **Northern Maine**. A description of the region is provided as well as the behavioral and demographic characteristics of the populations. The needs of the prioritized populations are listed along with interventions designed to meet those needs. The CPG conducted a gap analysis of met and unmet HIV prevention needs and the results are discussed in Attachment III.

### 5.1.1 NORTHERN MAINE REGIONAL DESCRIPTION:

**Counties in Northern Maine:** Aroostook, Hancock, Penobscot, Piscataquis, Washington

**Some Pertinent Regional Facts** from the US Census and State Government websites are as follows**:**

| | Aroostook | Hancock | Penobscot | Piscataquis | Washington |
|---|---|---|---|---|---|
| **Land area** | 6,672 square miles | 1,588 square miles | 3,396 square miles | 3,966 square miles | 2,568 square miles |
| **Cities** | Caribou, Presque Isle | Ellsworth | Bangor (metropolitan area), Brewer, Old Town | None, County Seat - Dover-Foxcroft | Calais, Eastport |
| **2001 population estimate** | 73,140 | 52,336 | 145,385 | 17,177 | 33,573 |
| **Persons per square mile 2000** | 11.1 | 32.6 | 42.7 | 4.3 | 13.2 |
| **Persons under 18** | 22.3% | 22.3% | 22.8% | 23.4% | 22.9% |
| **Persons 65 and over** | 17% | 16% | 13.1% | 17.4% | 17.3% |
| **White persons in 2000** | 96.6% | 97.6% | 96.6% | 97.8% | 93.5% |
| **Other races or Hispanic ethnicity over 1%** | Native Americans/Alaskan Native: 1.4% | 2 or more races: 1.1% | Native Am/Alaskan Native: 1%, 2 or more races: 1% | 2 or more races: 1% | Native Am/Alaskan Native: 4.4%, 2 or more races: 1.1% |
| **Below poverty in 1999** | 14.3% | 10.2% | 13.7% | 14.8% | 19% |

## 5.1.2 NORTHERN MAINE EPI DATA

Epidemiologic data describing HIV and AIDS in Northern Maine was provided by the Bureau of Health, HIV/STD Program, and comes from HIV and AIDS case reports made to BOH by Maine health care providers. Case reports reflect Maine residents who are diagnosed with HIV or AIDS for the first time; these reports do not take into account individuals who were diagnosed with HIV or AIDS in another state before moving to Maine. This brief overview uses estimates of overall HIV prevalence and HIV and AIDS diagnoses during the past five years (1998-2002) to characterize the disease in Northern Maine. Please note that percentages are rounded and may not total 100%.

It is estimated that approximately 220 people with HIV live in the northern part of the state, accounting for 18% of the estimated 1,200 people living in Maine with the disease.

Between 1998 and 2002 a total of 45 people in Northern Maine were diagnosed with HIV, including 34 males and 11 females. The following table shows diagnoses by county for the five-year period, along with a cumulative rate per 100,000 population. The cumulative rate is used to show how many diagnoses occurred for every 100,000 people, and reflects the number of diagnoses proportionate to the total population of the geographic area. In the table, counties are rank-ordered by their rate. The total for the entire Northern Maine region is also included in the table.

| County | HIV Diagnoses, 1998-2002 | Cumulative HIV Case Rate per 100,000 Population |
|---|---|---|
| Aroostook | 11 | 15 |
| Hancock | 8 | 15 |
| **Northern Region** | **45** | **14** |
| Penobscot | 21 | 14 |
| Washington | 4 | 12 |
| Piscataquis | 1 | 6 |

The table shows that the rate for the Northern Region was 14 diagnoses per 100,000 population. Of the five counties, Aroostook and Hancock had slightly higher rates than the region as a whole, both with 15 diagnoses per 100,000 population. Piscataquis County had the lowest rate, with 6 diagnoses per 100,000 population.

Concerning mode of transmission, 27% of diagnoses were among males who have sex with males and 20% were among injection drug users. Another 44% were attributed to heterosexual sex, including 19% with an at-risk partner and 25% with a partner whose risk status was unknown. Mode of transmission was unknown or not disclosed for 9% of diagnoses.

Age at diagnosis varied widely. Twenty percent of diagnoses were among people under 24 years old. Forty-two percent were among people between the ages of 25 and 39, and 38% were among people aged 40 years or older.

The majority of people diagnosed with HIV were White (78%). Another 11% were African American/Black, 9% were Native American, and 2% were Hispanic.

Between 1998 and 2002, 49% of people in Northern Maine who received an HIV diagnosis were subsequently diagnosed with AIDS within one year of their initial HIV-positive test. Since it can take years for an HIV-infected person to progress to an AIDS diagnosis, people diagnosed with AIDS soon after testing positive for HIV have probably been infected with HIV for a long time without knowing. These people have not received timely medical care for their HIV and could have infected others without knowing.

The Northern Region experienced a total of 54 AIDS diagnoses during the five-year period, and 19 deaths among people with AIDS.

## 5.1.3 PRIORITIZED POPULATIONS NORTHERN REGION

**NORTHERN REGION:** Aroostook, Hancock, Penobscot, Piscataquis, and Washington Counties

| Rank* | Behavior | Gender | Age Range | Race | Ethnicity | HIV Status* |
|---|---|---|---|---|---|---|
| **1.** | MSM | Male | < 29 | White | Non-Hispanic | Unknown or negative |
| **2.** | MSM | Male | > 29 | White | Non-Hispanic | Unknown or negative |
| **3.** | HET | Female | < 29 | White | Non-Hispanic | Unknown or negative |
| **4.** | HET | Female | > 29 | White | Non-Hispanic | Unknown or negative |
| **5.** | IDU | Male | 15 and up | White | Non-Hispanic | Unknown or negative |
| **6.** | HET | Male | 15 - 35 | White | Non-Hispanic | Unknown or negative |
| **7.** | MSM, IDU, HET | All | 10 and up | Native Am. | | Unknown or negative |

MSM = Males who have Unsafe Sex with Males
IDU = Injection Drug Users who Share Needles and Injection Equipment
HET = Heterosexuals who have Unsafe Sex
< = Less than
> = Greater than

***NOTE:** People who are HIV-positive and who engage in behaviors that put themselves and others at risk are the number one priority population. See the Overview at the beginning of this Update for additional information.

**Justification for Prioritization**

Epi data including HIV incidence and rate; STD data including incidence and rate; Hepatitis C data; Needs Assessment data; Resource Inventory data; Maine Case Management data; the current HIV Prevention Plan and Update; and CPG member expertise were all used in determining prioritized populations.

In particular, the following information from the CPG prioritization process helped to inform the final decisions:

- The epi data clearly shows that all ages of MSM continue to be affected by HIV.
- Comparing new epi data to previous epi data, heterosexuals are increasingly affected, particularly females of all ages.
- Epi data and the IDU Needs Assessment data show the need to target at risk IDU.
- Anecdotal data and higher rates show the need to target Native Americans.

## 5.1.4 BEHAVIORAL POPULATION DESCRIPTION: Males who have Unsafe Sex with Males (MSM)

Males who have Unsafe Sex with Males are not a single homogenous group. They represent a wide variety of men (both young and adult males from different races and socioeconomic backgrounds) with diverse health and social needs. Males who have unsafe sex with males are at risk for acquiring or transmitting HIV because of the unsafe sexual behaviors they engage in, not because of how they identify themselves.

HIV is transmitted from an HIV positive man to an HIV negative man through infected bodily fluids, including blood, semen, and pre-ejaculate fluid. The specific behaviors that cause HIV transmission are unprotected anal and/or oral sex, sharing dirty needles and/or works, and sharing dirty instruments for tattooing and/or body piercing. For males who have unsafe sex with HIV positive males, unprotected anal intercourse remains the greatest risk for HIV transmission.

The reality of HIV is woven into the physical, psychological, emotional, and social aspects of men's lives including dating and intimacy, sexual desire and love, alcohol and recreational drug use, homophobia and racism, abuse and coercion, as well as individual self-esteem. HIV prevention programs must acknowledge all of these elements.

### ➢ DEMOGRAPHIC CHARACTERISTICS: Males who have Unsafe Sex with Males (MSM)

Demographic characteristics are different ways of describing people. The following characteristics may be useful in designing prevention programs, but it is important to remember that people's behaviors and the environmental factors that affect those behaviors need to be the target of interventions. The following characteristics are <u>not</u> listed in order of priority.

Individuals who:

- are a member of a racial or ethnic minority
- are economically disadvantaged
- are isolated (geographically, socially, emotionally)
- are homeless
- are migrant workers
- are transgendered
- are HIV+
- have a history of sexual abuse, coercion, and/or nonconsensual sex
- have a history of violence, including domestic violence, gay bashing or other forms of physical abuse
- have a physical and/or developmental disability
- have a diagnosed or undiagnosed mental illness
- have a sero-discordant sexual partner

- **BEHAVIORAL CHARACTERISTICS:**
  **Males who have Unsafe Sex with Males (MSM)**

Certain behaviors may increase the level of risk for this population, including the following, which are not listed in order of priority:

- having multiple unsafe sex partners
- increasing the number of unsafe sexual encounters
- using alcohol and recreational drugs
- exchanging sex for money (as in sex work or prostitution), and/or goods and/or services (e.g. lodging, food, clothing etc.)
- having unsafe sex with a partner of unknown sero-status
- having a sexual addiction or compulsive need to have sex

- **Additional Resources**

Carnes, P., & Delmonico, D. (Eds.). (2001). Special issue: HIV and sexual compulsivity. *Sexual Addiction & Compulsivity,* 12(2).

Real, T. (1997). Don't want to talk about it: Overcoming the secret legacy of male depression. New York NY: Scribner.

Trussler, T., Marchand, R. (1997). Field guide community HIV health promotion. Vancouver, BC: AIDS Vancouver/Health Canada.

van der Kolk, B.A., (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry, 1,* 253-265.

van der Kolk, B.A. & van der Hart, O. (1991). The intrusive past: The flexibility of memory and the engraving of trauma. *American Imago,* 48(4), 425-454.

## 5.1.5 BEHAVIORAL POPULATION DESCRIPTION: Injection Drug Users who Share Needles or Injection Equipment (IDU)*

According to epidemiological data, the number of injection drug users (IDU) or people with histories of injection drug use who have tested positive for HIV or have AIDS continues to grow. The higher quality and lower price of injection drugs coupled with increased availability contributes to a rise in the number of people who use injection drugs. The continued social and political stigmatization of IDU also contributes to the risky behavior of sharing needles, increasing an IDU's risk for contracting HIV.

Injection drug users cannot be identified by where they live or how much they earn. However, some identified situations and behaviors put these individuals at increased risk. It is important to note that the sexual partners and unborn children of injection drug user's are also at increased risk for HIV infection.

The following description, though not exhaustive, includes the epidemiological, behavioral and demographic characteristics of IDU who are at risk of HIV infection, re-infection or transmission. They may be any race, gender, age, ethnicity or sexual orientation, and may have other special needs.

**Note: the phrase "sharing needles" means the sharing of a needle, syringe, spoon or a cooker, glass of water or other fluid, and cotton or other absorbent material. These items are collectively known in street terminology as "works." In addition this includes the sharing of needles for tattooing, body piercing, or for the injection of steroids, vitamins and/or hormones.*

### ➢ DEMOGRAPHIC CHARACTERISTICS:
### Injection Drug Users who Share Needles or Injection Equipment (IDU)

Demographic characteristics are different ways of describing people. The following characteristics may be useful in designing prevention programs, but it is important to remember that people's behaviors and the environmental factors that affect those behaviors need to be the target of interventions. The following characteristics are not listed in order of priority.

Individuals who:

- are a member of a racial or ethnic minority
- are economically disadvantaged
- are homeless
- are migrant workers
- are youth under age 24
- are incarcerated
- are transgendered
- are HIV+
- have a history of physical, sexual and/or emotional trauma
- have a physical and/or developmental disability
- have a diagnosed or undiagnosed mental illness

### ➢ BEHAVIORAL CHARACTERISTICS:
### Injection Drug Users who Share Needles or Injection Equipment (IDU)

Certain behaviors may increase the level of risk for this population, including the following, which are not listed in order of priority:

- using or abusing prescription drugs, alcohol and other chemicals
- engaging in unprotected sex
- exchanging unprotected sex for money, goods and/or services
- injecting vitamins and/or steroids or hormones
- engaging in unlicensed body piercing or tattooing

## 5.1.6 BEHAVIORAL POPULATION DESCRIPTION: Heterosexuals who have Unsafe Sex (HET)

Heterosexuals who have Unsafe Sex refers to females and males of any age who engage in behaviors that could place them at increased risk for HIV infection from their opposite sex partner. Overall heterosexual females are at greater risk for contracting HIV than are their heterosexual male counterparts.

It is important to note that, within this population, HIV is much more readily transmitted from male to female than from female to male (Padian, Shiboski, Glass, and Vittinghoff, 1997). Most HIV infection results from HIV-positive male partners, who having contracted HIV through injection drug use or sex with other males, transmit the infection to their female partners (Campbell, 1995). These males are not being effectively reached by current HIV prevention efforts regarding safer sex behaviors. Therefore, pertinent information related to this population may also be found in the Population Descriptions for "Males who have Unsafe Sex with Males" and "Injection Drug Users who Share Needles or Injection Equipment." Heterosexual males who do not fit into either of these categories may be at increased risk by having unprotected sex with HIV+ females. The following descriptions include the epidemiological, demographic and behavioral characteristics of this population.

REFERENCES

Padian, N., Shiboski, S., Glass, S., Vittinghoff, E. (1997). Heterosexual transmission of Human Immunodeficiency Virus (HIV) in northern California: Results from a ten-year study. *American Journal of Epidemiology,* 146(4): 350-356.

Campbell, C. (1995). Male gender roles and sexuality: Implications for women's AIDS risk and prevention. *Social Science Medicine,* 41(2): 197-210.

### ➢ DEMOGRAPHIC CHARACTERISTICS: Heterosexuals who have Unsafe Sex (HET)

Demographic characteristics are different ways of describing people. The following characteristics may be useful in designing prevention programs, but it is important to remember that people's behaviors and the environmental factors that affect those behaviors need to be the target of interventions. The following characteristics are <u>not</u> listed in order of priority.

Individuals who:

- are a member of a racial or ethnic minority
- are economically disadvantaged
- are homeless
- are isolated (geographically, socially, emotionally)
- are migrant workers
- are youth under age 24

- are incarcerated
- are transgendered
- are currently infected with, or have a partner who is infected with, sexually transmitted diseases
- are HIV+
- have low self esteem
- have a history of sexually transmitted diseases
- have a history of physical, sexual and/or emotional trauma
- have a physical and/or developmental disability
- have a diagnosed or undiagnosed mental illness

➢ **BEHAVIORAL CHARACTERISTICS:**
**Heterosexuals who have Unsafe Sex (HET)**

Certain behaviors may increase the level of risk for this population, including the following, which are <u>not</u> listed in order of priority:

- HIV-positive individuals who have unprotected sex with their opposite sex partner(s)
- individuals who have unprotected sex with needle sharers
- gay, bisexual and non-gay identified males who have unprotected sex with males and unprotected sex with females
- individuals who use injection drugs and share drug injecting equipment
- individuals who trade unprotected sex for money, drugs, etc.
- individuals who have unprotected sex with multiple sex partners
- individuals who use/abuse alcohol and/or other non-injection drugs especially “crack,” cocaine and methamphetamines and also engage in unprotected sex
- individuals who have unprotected sex with sex workers
- young females who have unprotected sex with older males

## 5.1.7 CRITICAL HIV PREVENTION NEEDS FOR THE PRIORITIZED POPULATIONS IN THE NORTHERN REGION

### ➢ Critical Needs for Males who have Unsafe Sex with Males (MSM) in Northern Maine

These needs are <u>not</u> listed in order of priority.

- Increase knowledge of HIV status.
- Increase access to Counseling Testing and Referral (CTR) including anonymous CTR and Partner Counseling Testing and Referral.
- Increase awareness of personal risk.
- Increase skills that eliminate or decrease HIV transmission.
- Increase self-esteem and self-efficacy (belief in ability to change personal behavior) including motivation, intention and commitment.

**Additional Need for Native American MSM in Northern Maine**

- Interventions targeting Native Americans should be culturally and linguistically appropriate.

### ➢ Critical Statewide System Needs for MSM

In addition to the needs listed above, there are broad systems needs that fall under the responsibility of various programs and agencies within the State. The CPG feels that it is critical that these needs be met in order for HIV prevention to occur. It is important to create better links between prevention and other types of care (e.g. case management, substance abuse treatment, mental health treatment, etc.). The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for MSM and are <u>not</u> listed in order of priority.

- Increase access to affordable, culturally competent services including:
    - substance abuse treatment
    - housing
    - health care
    - prevention programs in correctional facilities
    - needle exchange sites
    - methadone programs
    - training for providers
- Changing MSM community norms and strengthening peer support.
- Make HIV prevention a routine part of medical care.

## ➢ Critical Needs for Injection Drug Users who Share Needles or Injection Equipment (IDU) in Northern Maine

These needs are not listed in order of priority.

- Increase awareness of personal risk.
- Increase knowledge of HIV disease, transmission, prevention, services, resources and support.
- Increase use of risk reduction practices.
- Increase community norms and peer support of behaviors that reduce the risk of HIV transmission.
- Increase access to Counseling Testing and Referral (CTR) and Partner Counseling Testing and Referral.

### Additional Need for Native American IDU in Northern Maine

- Interventions targeting Native Americans should be culturally and linguistically appropriate.

## ➢ Critical Statewide System Needs for IDU

In addition to the needs listed above, there are broad systems needs that fall under the responsibility of various programs and agencies within the State. The CPG feels that it is critical that these needs be met in order for HIV prevention to occur. It is important to create better links between prevention and other types of care (e.g. case management, substance abuse treatment, mental health treatment, etc.). The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for IDU and are not listed in order of priority.

- Increase the number of needle exchange sites throughout the State so that they are easily accessible.
- Increase the number of methadone programs throughout the State so that they are easily accessible.
- Increase the availability of mental health counseling.
- Increase pharmacy access for syringe purchases.
- Increase access to substance abuse treatment.
- Make HIV prevention a routine part of medical care.

## ➢ Critical Needs for Male and Female Heterosexuals who have Unsafe Sex (HET) in Northern Maine

These needs are not listed in order of priority.

- Increase awareness of personal risk.
- Increase knowledge of HIV status.
- Increase self-esteem and self efficacy (motivation, intention and commitment) to be able to reduce high risk behaviors and decrease transmission.
- Increase access to Counseling Testing and Referral and Partner Counseling Testing and Referral Services.
- Increase use of risk reduction practices which could include the use of communication, problem solving and decision making skills to reduce HIV transmission.

### Additional Need for Male HET in Northern Maine

- Increase identification of high risk behaviors and ability to assess own risk of infection.

### Additional Need for Native American HET in Northern Maine

- Interventions targeting Native Americans should be culturally and linguistically appropriate.

## ➢ Critical Statewide System Needs for HET

In addition to the needs listed above, there are broad systems needs that fall under the responsibility of various programs and agencies within the State. The CPG feels that it is critical that these needs be met in order for HIV prevention to occur. It is important to create better links between prevention and other types of care (e.g. case management, substance abuse treatment, mental health treatment, etc.). The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for HET and are not listed in order of priority.

- Increase access to affordable housing and comprehensive health care services (including substance abuse treatment, mental health counseling, HIV prevention programs in correctional facilities, etc.).
- Make HIV prevention a routine part of medical care.

## 5.1.8 INTERVENTIONS FOR NORTHERN MAINE

The following section lists a set of interventions to meet the critical needs identified for each prioritized population of unknown or negative HIV status**. The behavioral populations are listed in order of priority; however, the needs and interventions are not listed in order of priority. See Chapter 3 of the 2001 HIV Prevention Plan for an explanation of the intervention types, behavioral science theory, and the characteristics of effective HIV prevention programs. See Attachment II for a more detailed description of the interventions listed below.

****NOTE:** See the Overview at the beginning of this Update for information about interventions for people who are HIV-positive who engage in unsafe behavior that puts themselves and others at risk.

### 1. Males who have Unsafe Sex with Males (MSM), under the age of 29, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase access* to Counseling Testing and Referral (CTR) which includes Partner Counseling and Referral Services and anonymous CTR | • Increase Counseling Testing and Referral activities (see access* below)<br>• Health Communication/Public Information |
| • Increase awareness of personal risk | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level interventions<br>• Counseling Testing and Referral |
| • Increase skills that eliminate or decrease HIV transmission | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase self esteem and self-efficacy (belief in ability to change personal behavior) including motivation, intention and commitment | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Community Level Interventions |

## 2. MSM, over the age of 29, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Increase Counseling Testing and Referral activities (see access* below)<br>• Health Communication/Public Information |
| • Increase awareness of personal risk | • Multi-session Individual Level Interventions<br>• Multi-session Group Level Interventions<br>• Counseling Testing and Referral |
| • Increase skills that eliminate or decrease HIV transmission | • Multi-session, Individual Level Interventions<br>• Multi-session Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase self esteem and self-efficacy (belief in ability to change personal behavior) including motivation, intention and commitment | • Multi-session Individual Level Interventions<br>• Multi-session Group Level Interventions<br>• Community Level Interventions |

## 3. Heterosexuals who have Unsafe Sex (HET), FEMALE, under the age of 29, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Counseling Testing and Referral including Outreach Counseling Testing and Referral and Partner Counseling and Referral Service |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Health Communication/Public Information<br>• Outreach<br>• Increase Counseling Testing and Referral activities (see access* below) |
| • Increase awareness of personal risk | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase self esteem and self-efficacy (motivation, intention and commitment) to be able to reduce high risk behaviors and decrease transmission | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase use of risk reduction practices which could include the use of communication, problem solving and decision making skills to reduce HIV transmission | • Individual Risk Reduction Counseling<br>• Peer led, multi-session Group Level Interventions |

### 4. HET, FEMALE, over the age of 29, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Counseling Testing and Referral including Outreach Counseling Testing and Referral and Partner Counseling and Referral Services |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Health Communication/Public Information<br>• Outreach<br>• Increase Counseling Testing and Referral activities (see access* below) |
| • Increase awareness of personal risk | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions |
| • Increase self esteem and self-efficacy (motivation, intention and commitment) to be able to reduce high risk behaviors and decrease transmission | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase use of risk reduction practices which could include the use of communication, problem solving and decision making skills to reduce HV transmission. | • Individual Risk Reduction Counseling<br>• Peer led, multi-session Group Level Interventions |

### 5. Injection Drug Users who Share Needles and Injection Equipment (IDU), MALE, over the age of 15, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase awareness of personal risk | • Multi-session Individual Level Interventions ~ preferably peer led<br>• Multi-session Group Level Interventions ~ preferably peer led<br>• Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase knowledge of HIV disease, transmission, prevention, services, resources and support | • Outreach<br>• Single-session Group Level Interventions<br>• Single-session Individual Level Interventions |
| • Increase use of risk reduction practices | • Multi-session Group Level Interventions<br>• Multi-session Individual Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase community norms and peer support of behaviors that reduce the risk of HIV transmission | • Community Level Interventions |
| • Increase access* to Counseling Testing and Referral, including anonymous CTR, which includes Partner Counseling and Referral Services | • Increase Counseling Testing and Referral activities (see access* below) |

### 6. HET, MALE, 15-35, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Health Communication/Public Information<br>• Counseling Testing and Referral including Outreach Counseling Testing and Referral and Partner Counseling and Referral Services |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Health Communication/Public Information<br>• Outreach<br>• Increase Counseling Testing and Referral activities (see access* below) |
| • Increase awareness of personal risk | • Multi-session Individual Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase self esteem and self-efficacy (motivation, intention and commitment) to be able to reduce high risk behaviors and decrease transmission | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase use of risk reduction practices which could include the use of communication, problem solving and decision making skills to reduce HV transmission | • Individual Risk Reduction Counseling<br>• Multi-session Individual Level Interventions<br>• Multi-session Group Level Interventions |
| • Increase identification of high risk behaviors and ability to assess own risk of infection | • Individual Risk Reduction Counseling<br>• Multi-session Individual Level Interventions<br>• Multi-session Group Level Interventions |

### 7. NATIVE AMERICAN, MSM, HET & IDU, Male and Female, both youth and adult

In addition to the information listed above for MSM, HET and IDU, interventions for Native Americans include:

- Counseling Testing and Referral and Partner Counseling and Referral Services
- Outreach
- Individual Level Interventions
- Community Level Interventions
- Health Communication and Public Information

The CPG recommends that all interventions that target Native Americans should be culturally and linguistically appropriate and peer led.

*Access refers to testing that is:

- available as part of all programs
- free
- available after hours and on weekends
- available where the person can't be identified
- available on a walk-in basis
- available in many different places or venues

In addition, the CPG feels that there should be more trained counselors and outreach in the field

# 5.2 CENTRAL REGION

## CHAPTER OVERVIEW

The following section lists the prioritized populations for **Central Maine**. A description of the region is provided as well as the behavioral and demographic characteristics of the populations. The needs of the prioritized populations are listed along with interventions designed to meet those needs. The CPG conducted a gap analysis of met and unmet HIV prevention needs and the results are discussed in Attachment III.

## 5.2.1 CENTRAL MAINE REGIONAL DESCRIPTION:

**Counties in Central Maine:** Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset and Waldo Counties

**Some Pertinent Regional Facts** from the US Census and State Government websites are as follows**:**

| | Androscoggin | Franklin | Kennebec | Knox | Lincoln | Oxford | Sagadahoc | Somerset | Waldo |
|---|---|---|---|---|---|---|---|---|---|
| **Land area** | 470 square miles | 1,698 square miles | 868 square miles | 366 square miles | 456 square miles | 2,078 square miles | 254 square miles | 3,926 square miles | 730 square miles |
| **Cities** | Lewiston/Auburn (metropolitan area) | None, County Seat – Franklin | Augusta, Gardiner, Hallowell, Waterville | Rockland | None, County Seat – Wiscassett | None, County Seat – Paris | Bath | None, County Seat – Skowhegan | Belfast |
| **2001 population estimate** | 104,131 | 29,586 | 117,782 | 40,147 | 34,316 | 55,378 | 35,761 | 51,014 | 37,252 |
| **Persons per square mile 2000** | 220.7 | 17.4 | 135 | 108.3 | 73.7 | 26.3 | 138.7 | 13 | 49.7 |
| **Persons under 18** | 23.9% | 23.5% | 23.8% | 22.4% | 22.7% | 24.2% | 25.8% | 24.7% | 24.2% |
| **Persons 65 and over** | 14.4% | 14.2% | 14.2% | 17.2% | 18.2% | 16.1% | 12.3% | 14.3% | 13.6% |
| **White persons in 2000** | 97% | 98% | 97.5% | 98.3% | 98.5% | 98.3% | 96.5% | 98% | 97.9% |
| **Other races or Hispanic ethnicity over 1%** | Hispanic: 1%, 2 or more races: 1.2% | None | 2 or more races: 1% | None | None | None | Hispanic: 1.1%, 2 or more races: 1.2% | None | 2 or more races: 1.1% |
| **Below poverty in 1999** | 11.1% | 14.6% | 11.1% | 10.1% | 10.1% | 11.8% | 8.6% | 14.9% | 13.9% |

## 5.2.2 CENTRAL MAINE EPI DATA

Epidemiologic data describing HIV and AIDS in Central Maine was provided by the Bureau of Health, HIV/STD Program, and comes from HIV and AIDS case reports made to BOH by Maine health care providers. Case reports reflect Maine residents who are diagnosed with HIV or AIDS for the first time; these reports do not take into account individuals who were diagnosed with HIV or AIDS in another state before moving to Maine. This brief overview uses estimates of overall HIV prevalence and HIV and AIDS diagnoses during the past five years (1998-2002) to characterize the disease in Central Maine. Please note that percentages are rounded and may not total 100%.

It is estimated that approximately 360 people with HIV live in the central part of the state, accounting for 30% of the estimated 1,200 people living in Maine with the disease.

Between 1998 and 2002 a total of 53 people in Central Maine were diagnosed with HIV, including 45 males and 8 females. The following table shows diagnoses by county for the five-year period, along with a cumulative rate per 100,000 population. The cumulative rate is used to show how many diagnoses occurred for every 100,000 people, and reflects the number of diagnoses proportionate to the total population of the geographic area. In the table, counties are rank-ordered by their rate. The total for the entire Central Maine region is also included in the table.

| County | HIV Diagnoses, 1998-2002 | Cumulative HIV Case Rate per 100,000 Population |
|---|---|---|
| Sagadahoc | 6 | 17 |
| Androscoggin | 17 | 16 |
| **Central Region** | **53** | **11** |
| Kennebec | 13 | 11 |
| Franklin | 3 | 10 |
| Knox | 3 | 8 |
| Lincoln | 2 | 6 |
| Somerset | 4 | 8 |
| Waldo | 3 | 8 |
| Oxford | 2 | 4 |

The table shows that the rate for the Central Region is 11 diagnoses per 100,000 population. Of the ten counties, Sagadahoc and Androscoggin Counties had higher rates than the region as a whole, with 17 diagnoses per 100,000 population for Sagadahoc and 16 per 100,000 for Androscoggin. Oxford County had the lowest rate, with 4 diagnoses per 100,000 population.

Concerning mode of transmission, 49% of diagnoses were among males who have sex with males and 15% were among injection drug users. Another 30% were attributed to heterosexual sex, including 15% with an at-risk partner and 15% with a partner whose risk status was unknown. Mode of transmission was unknown or not disclosed for 6% of diagnoses.

Age at diagnosis in Central Maine tended to be 30 years-old and above. Overall, 6% of diagnoses were among people under 24 years old. Thirty-four percent were among people between the ages of 25 and 39, and 60% were among people aged 40 years or older.

The majority of people diagnosed with HIV were White (89%). Another 7% were African American/Black, 2% were Native American, and 2% were Hispanic.

Between 1998 and 2002, 59% of people in Central Maine who received an HIV diagnosis were subsequently diagnosed with AIDS within one year of their initial HIV-positive test. Since it can take years for an HIV-infected person to progress to an AIDS diagnosis, people diagnosed with AIDS soon after testing positive for HIV have probably been infected with HIV for a long time without knowing. These people have not received timely medical care for their HIV, and could have infected others without knowing.

The Central Region experienced a total of 46 AIDS diagnoses during the five-year period, and 24 deaths among people with AIDS.

## 5.2.3 PRIORITIZED POPULATIONS CENTRAL REGION: Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset and Waldo Counties

| Rank* | Behavior | Gender | Age Range | Race | Ethnicity | HIV Status* |
|---|---|---|---|---|---|---|
| **1.** | MSM | Male | 15-39 | White | Non-Hispanic | Negative or unknown |
| **2.** | IDU | Male | 15-39 | White | Non-Hispanic | Negative or unknown |
| **3.** | HET | Female | 15-29 | White | Non-Hispanic | Negative or unknown |
| **4.** | IDU | Male | 15-29 | Black/African Am AND/OR | Hispanic | Negative or unknown |
| **5.** | MSM | Male | 15-29 | Black/African Am AND/OR | Hispanic | Negative or unknown |

MSM = Males who have Unsafe Sex with Males
IDU = Injection Drug Users who Share Needles and Injection Equipment
HET = Heterosexuals who have Unsafe Sex

***NOTE:** People who are HIV-positive and who engage in behaviors that put themselves and others at risk are the number one priority population. See the Overview at the beginning of this Update for additional information.

**Justification for Prioritization**

Epi data including HIV incidence and rate; STD data including incidence and rate; Hepatitis C data; Needs Assessment data; Resource Inventory data; Maine Case Management data; the current HIV Prevention Plan and Update; and CPG member expertise were all used in determining prioritized populations.

In particular, the following information from the CPG prioritization process helped to inform the final decisions:

- Epi data shows that MSM have the highest incidence and consensus that prevention should start early due to concurrent diagnosis.
- Epi data shows that IDU have the second highest incidence. In addition, information from the Maine Youth Drug and Alcohol Use Survey 2002, the BOH Needle Sharer Needs Assessment as well as anecdotal information also shows that there is a growing population of IDU's in the Region.

- Epi data shows that HET's are the third highest incidence. There is a growing trend of younger women with STD's.
- Anecdotal information as well as crime statistics show a growing trend of IDU who are African American and Hispanic.

## 5.2.4 BEHAVIORAL POPULATION DESCRIPTION: Males who have Unsafe Sex with Males (MSM)

Males who have Unsafe Sex with Males are not a single homogenous group. They represent a wide variety of men (both young and adult males from different races and socioeconomic backgrounds) with diverse health and social needs. Males who have unsafe sex with males are at risk for acquiring or transmitting HIV because of the unsafe sexual behaviors they engage in, not because of how they identify themselves.

HIV is transmitted from an HIV positive man to an HIV negative man through infected bodily fluids, including blood, semen, and pre-ejaculate fluid. The specific behaviors that cause HIV transmission are unprotected anal and/or oral sex, sharing dirty needles and/or works, and sharing dirty instruments for tattooing and/or body piercing. For males who have unsafe sex with HIV positive males, unprotected anal intercourse remains the greatest risk for HIV transmission.

The reality of HIV is woven into the physical, psychological, emotional, and social aspects of men's lives including dating and intimacy, sexual desire and love, alcohol and recreational drug use, homophobia and racism, abuse and coercion, as well as individual self-esteem. HIV prevention programs must acknowledge all of these elements.

### ➢ DEMOGRAPHIC CHARACTERISTICS: Males who have Unsafe Sex with Males (MSM)

Demographic characteristics are different ways of describing people. The following characteristics may be useful in designing prevention programs, but it is important to remember that people's behaviors and the environmental factors that affect those behaviors need to be the target of interventions. The following characteristics are <u>not</u> listed in order of priority.

Individuals who:

- are a member of a racial or ethnic minority
- are economically disadvantaged
- are isolated (geographically, socially, emotionally)
- are homeless
- are migrant workers
- are transgendered
- are HIV+
- have a history of sexual abuse, coercion, and/or nonconsensual sex
- have a history of violence, including domestic violence, gay bashing or other forms of physical abuse
- have a physical and/or developmental disability

- have a diagnosed or undiagnosed mental illness
- have a sero-discordant sexual partner

➢ **BEHAVIORAL CHARACTERISTICS:**
**Males who have Unsafe Sex with Males (MSM)**

Certain behaviors may increase the level of risk for this population, including the following, which are not listed in order of priority:

- having multiple unsafe sex partners
- increasing the number of unsafe sexual encounters
- using alcohol and recreational drugs
- exchanging sex for money (as in sex work or prostitution), and/or goods and/or services (e.g. lodging, food, clothing etc.)
- having unsafe sex with a partner of unknown sero-status
- having a sexual addiction or compulsive need to have sex

➢ **Additional Resources**

Carnes, P., & Delmonico, D. (Eds.). (2001). Special issue: HIV and sexual compulsivity. *Sexual Addiction & Compulsivity,* 12(2).

Real, T. (1997). Don't want to talk about it: Overcoming the secret legacy of male depression. New York NY: Scribner.

Trussler, T., Marchand, R. (1997). Field guide community HIV health promotion. Vancouver, BC: AIDS Vancouver/Health Canada.

van der Kolk, B.A., (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry, 1,* 253-265.

van der Kolk, B.A. & van der Hart, O. (1991). The intrusive past: The flexibility of memory and the engraving of trauma. *American Imago,* 48(4), 425-454.

## 5.2.5 BEHAVIORAL POPULATION DESCRIPTION: Injection Drug Users who Share Needles or Injection Equipment (IDU)*

According to epidemiological data, the number of injection drug users (IDU) or people with histories of injection drug use who have tested positive for HIV or have AIDS continues to grow. The higher quality and lower price of injection drugs coupled with increased availability contributes to a rise in the number of people who use injection drugs. The continued social and political stigmatization of IDU also contributes to the risky behavior of sharing needles, increasing an IDU's risk for contracting HIV.

Injection drug users cannot be identified by where they live or how much they earn. However, some identified situations and behaviors put these individuals at increased risk. It is important to note that the sexual partners and unborn children of injection drug user's are also at increased risk for HIV infection.

The following description, though not exhaustive, includes the epidemiological, behavioral and demographic characteristics of IDU who are at risk of HIV infection, re-infection or transmission. They may be any race, gender, age, ethnicity or sexual orientation, and may have other special needs.

**Note: the phrase "sharing needles" means the sharing of a needle, syringe, spoon or a cooker, glass of water or other fluid, and cotton or other absorbent material. These items are collectively known in street terminology as "works." In addition this includes the sharing of needles for tattooing, body piercing, or for the injection of steroids, vitamins and/or hormones.*

### ➢ DEMOGRAPHIC CHARACTERISTICS: Injection Drug Users who Share Needles or Injection Equipment (IDU)

Demographic characteristics are different ways of describing people. The following characteristics may be useful in designing prevention programs, but it is important to remember that people's behaviors and the environmental factors that affect those behaviors need to be the target of interventions. The following characteristics are not listed in order of priority.

Individuals who:

- are a member of a racial or ethnic minority
- are economically disadvantaged
- are homeless
- are migrant workers
- are youth under age 24
- are incarcerated
- are transgendered
- are HIV+
- have a history of physical, sexual and/or emotional trauma
- have a physical and/or developmental disability
- have a diagnosed or undiagnosed mental illness

### ➢ BEHAVIORAL CHARACTERISTICS: Injection Drug Users who Share Needles or Injection Equipment (IDU)

Certain behaviors may increase the level of risk for this population, including the following, which are not listed in order of priority:

- using or abusing prescription drugs, alcohol and other chemicals
- engaging in unprotected sex
- exchanging unprotected sex for money, goods and/or services
- injecting vitamins and/or steroids or hormones
- engaging in unlicensed body piercing or tattooing

## 5.2.6 BEHAVIORAL POPULATION DESCRIPTION: Heterosexuals who have Unsafe Sex (HET)

Heterosexuals who have Unsafe Sex refers to females and males of any age who engage in behaviors that could place them at increased risk for HIV infection from their opposite sex partner. Overall heterosexual females are at greater risk for contracting HIV than are their heterosexual male counterparts.

It is important to note that, within this population, HIV is much more readily transmitted from male to female than from female to male (Padian, et al, 1997). Most HIV infection results from HIV-positive male partners, who having contracted HIV through injection drug use or sex with other males, transmit the infection to their female partners (Campbell, 1995). These males are not being effectively reached by current HIV prevention efforts regarding safer sex behaviors. Therefore, pertinent information related to this population may also be found in the Population Descriptions for "Males who have Unsafe Sex with Males" and "Injection Drug Users who Share Needles or Injection Equipment." Heterosexual males who do not fit into either of these categories may be at increased risk by having unprotected sex with HIV+ females. The following descriptions include the epidemiological, demographic and behavioral characteristics of this population.

REFERENCES

Padian, N., Shiboski, S., Glass, S., Vittinghoff, E. (1997). Heterosexual transmission of Human Immunodeficiency Virus (HIV) in northern California: Results from a ten-year study. *American Journal of Epidemiology,* 146(4): 350-356.

Campbell, C. (1995). Male gender roles and sexuality: Implications for women's AIDS risk and prevention. *Social Science Medicine,* 41(2): 197-210.

### ➢ DEMOGRAPHIC CHARACTERISTICS: Heterosexuals who have Unsafe Sex (HET)

Demographic characteristics are different ways of describing people. The following characteristics may be useful in designing prevention programs, but it is important to remember that people's behaviors and the environmental factors that affect those behaviors need to be the target of interventions. The following characteristics are <u>not</u> listed in order of priority.

Individuals who:

- are a member of a racial or ethnic minority
- are economically disadvantaged
- are homeless
- are isolated (geographically, socially, emotionally)
- are migrant workers
- are youth under age 24

- are incarcerated
- are transgendered
- are currently infected with, or have a partner who is infected with, sexually transmitted diseases
- are HIV+
- have low self esteem
- have a history of sexually transmitted diseases
- have a history of physical, sexual and/or emotional trauma
- have a physical and/or developmental disability
- have a diagnosed or undiagnosed mental illness

➢ **BEHAVIORAL CHARACTERISTICS:**
**Heterosexuals who have Unsafe Sex (HET)**

Certain behaviors may increase the level of risk for this population, including the following, which are <u>not</u> listed in order of priority:

- HIV-positive individuals who have unprotected sex with their opposite sex partner(s)
- individuals who have unprotected sex with needle sharers
- gay, bisexual and non-gay identified males who have unprotected sex with males and unprotected sex with females
- individuals who use injection drugs and share drug injecting equipment
- individuals who trade unprotected sex for money, drugs, etc.
- individuals who have unprotected sex with multiple sex partners
- individuals who use/abuse alcohol and/or other non-injection drugs especially “crack,” cocaine and methamphetamines and also engage in unprotected sex
- individuals who have unprotected sex with sex workers
- young females who have unprotected sex with older males

## 5.2.7 CRITICAL HIV PREVENTION NEEDS FOR THE PRIORITIZED POPULATIONS IN THE CENTRAL REGION

### ➢ Critical Needs for Males who have Unsafe Sex with Males (MSM) in Central Maine

These needs are <u>not</u> listed in order of priority.

- Increase knowledge of HIV status.
- Increase access to Counseling Testing and Referral (CTR) including anonymous CTR and Partner Counseling Testing and Referral.
- Increase awareness of personal risk.
- Increase skills that eliminate or decrease HIV transmission.
- Increase self-esteem and self-efficacy (belief in ability to change personal behavior) including motivation, intention and commitment.

**Additional Need for Black/African American and Hispanic MSM in Central Maine**

- Interventions targeting Blacks/African Americans and Hispanics should be culturally and linguistically appropriate.

### ➢ Critical Statewide System Needs for MSM

In addition to the needs listed above, there are broad systems needs that fall under the responsibility of various programs and agencies within the State. The CPG feels that it is critical that these needs be met in order for HIV prevention to occur. It is important to create better links between prevention and other types of care (e.g. case management, substance abuse treatment, mental health treatment, etc.). The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for MSM and are <u>not</u> listed in order of priority.

- Increase access to affordable, culturally competent services including:
    - substance abuse treatment
    - housing
    - health care
    - prevention programs in correctional facilities

    - needle exchange sites
    - methadone programs
    - training for providers
- Changing MSM community norms and strengthening peer support.
- Make HIV prevention a routine part of medical care.

## ➢ Critical Needs for Injection Drug Users who share Needles and Injection Equipment (IDU) in Central Maine

These needs are not listed in order of priority.

- Increase awareness of personal risk.
- Increase knowledge of HIV disease, transmission, prevention, services, resources and support.
- Increase use of risk reduction practices.
- Increase community norms and peer support of behaviors that reduce the risk of HIV transmission.
- Increase access to Counseling Testing and Referral (CTR) and Partner Counseling Testing and Referral.

**Additional Need for Black/African American and Hispanic IDU in Central Maine**

- Interventions targeting Blacks/African Americans and Hispanics should be culturally and linguistically appropriate.

## ➢ Critical Statewide System Needs for IDU

In addition to the needs listed above, there are broad systems needs that fall under the responsibility of various programs and agencies within the State. The CPG feels that it is critical that these needs be met in order for HIV prevention to occur. It is important to create better links between prevention and other types of care (e.g. case management, substance abuse treatment, mental health treatment, etc.). The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for IDU and are not listed in order of priority.

- Increase the number of needle exchange sites throughout the State so that they are easily accessible.
- Increase the number of methadone programs throughout the State so that they are easily accessible.
- Increase the availability of mental health counseling.
- Increase pharmacy access for syringe purchases.
- Increase access to substance abuse treatment.
- Make HIV prevention a routine part of medical care.

## ➢ Critical Needs for Male and Female Heterosexuals who have Unsafe Sex (HET) in Central Maine

These needs are not listed in order of priority.

- Increase awareness of personal risk.
- Increase knowledge of HIV status.
- Increase self-esteem and self efficacy (motivation, intention and commitment) to be able to reduce high risk behaviors and decrease transmission.
- Increase access to Counseling Testing and Referral and Partner Counseling Testing and Referral Services.
- Increase use of risk reduction practices which could include the use of communication, problem solving and decision making skills to reduce HIV transmission.

### Additional Need for Black/African American and Hispanic HET in Central Maine

- Interventions targeting Blacks/African Americans and Hispanics should be culturally and linguistically appropriate.

## ➢ Critical Statewide System Needs for HET

In addition to the needs listed above, there are broad systems needs that fall under the responsibility of various programs and agencies within the State. The CPG feels that it is critical that these needs be met in order for HIV prevention to occur. It is important to create better links between prevention and other types of care (e.g. case management, substance abuse treatment, mental health treatment, etc.). The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for HET and are not listed in order of priority.

- Increase access to affordable housing and comprehensive health care services (including substance abuse treatment, mental health counseling, HIV prevention programs in correctional facilities, etc.).
- Make HIV prevention a routine part of medical care.

## 5.2.8 INTERVENTIONS FOR CENTRAL MAINE

The following section lists a set of interventions to meet the critical needs identified for each prioritized population of unknown or negative HIV status**. The behavioral populations are listed in order of priority; however, the needs and interventions are not listed in order of priority. See Chapter 3 of the 2001 HIV Prevention Plan for an explanation of the intervention types, behavioral science theory, and the characteristics of effective HIV prevention programs. See Attachment II for a more detailed description of the interventions listed below.

****NOTE:** See the Overview at the beginning of this Update for information about interventions for people who are HIV-positive who engage in unsafe behavior that puts themselves and others at risk.

### 1. Males who have Unsafe Sex with Males (MSM), 15-39, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase access* to Counseling Testing and Referral (CTR) which includes Partner Counseling and Referral Services and anonymous CTR | • Increase Counseling Testing and Referral activities (see access* below)<br>• Health Communication/Public Information |
| • Increase awareness of personal risk | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Counseling Testing and Referral |
| • Increase skills that eliminate or decrease HIV transmission | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase self esteem and self-efficacy (belief in ability to change personal behavior) including motivation, intention and commitment | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Community Level Interventions |

## 2. Injection Drug Users who Share Needles and Injection Equipment (IDU), MALE, 15-39, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase awareness of personal risk | • Multi-session Individual Level Interventions ~ Preferably peer led<br>• Multi-session Group Level Interventions ~ Preferably peer led<br>• Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase knowledge of HIV disease, transmission, prevention, services, resources and support. | • Outreach<br>• Single-session Group Level Interventions<br>• Single-session Individual Level Interventions |
| • Increase use of risk reduction practices | • Multi-session Group Level Interventions<br>• Multi-session Individual Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase community norms and peer support of behaviors that reduce the risk of HIV transmission | • Community Level Interventions |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Increase Counseling Testing and Referral activities (see access* below) |

## 3. Heterosexuals who have Unsafe Sex (HET), FEMALE, 15-29, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Counseling Testing and Referral including Outreach Counseling Testing and Referral and Partner Counseling and Referral Services |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Health Communication/Public Information<br>• Outreach<br>• Increase Counseling Testing and Referral activities (see access* below) |
| • Increase awareness of personal risk | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions |
| • Increase self esteem and self-efficacy (motivation, intention and commitment) to be able to reduce high risk behaviors and decrease transmission | • Peer led, multi-session led Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase use of risk reduction practices which could include the use of communication, problem solving and decision making skills to reduce HV transmission | • Individual Risk Reduction Counseling<br>• Peer led, multi-session Group Level Interventions |

### 4. BLACK/AFRICAN AMERICAN and/or HISPANIC, IDU, MALE, 15 -29

All interventions targeting Blacks/African Americans and Hispanics should be culturally and linguistically appropriate.

| Needs | Interventions |
|---|---|
| • Increase awareness of personal risk | • Multi-session Individual Level Interventions ~ preferably peer led<br>• Multi-session Group Level Interventions ~ preferably peer led<br>• Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase knowledge of HIV disease, transmission, prevention, services, resources and support | • Outreach<br>• Single-session Group Level Interventions<br>• Single-session Individual Level Interventions |
| • Increase use of risk reduction practices | • Multi-session Group Level Interventions<br>• Single-session Individual Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase community norms and peer support of behaviors that reduce the risk of HIV transmission | • Community Level Interventions |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Increase Counseling Testing and Referral activities (see access* below) |

## 5. BLACK/AFRICAN AMERICAN and/or HISPANIC, MSM, MALE, 15 -29

All interventions targeting Blacks/African Americans and Hispanics should be culturally and linguistically appropriate.

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Increase Counseling Testing and Referral activities (see access* below) |
| • Increase awareness of personal risk | • Community Level Interventions |
| • Increase skills that eliminate or decrease HIV transmission | • Single- or multi-session Individual Level Interventions |
| • Increase self esteem and self-efficacy (belief in ability to change personal behavior) including motivation, intention and commitment | • Community Level Interventions |

*Access refers to testing that is:

- available as part of all programs
- free
- available after hours and on weekends
- available where the person can't be identified
- available on a walk-in basis
- available in many different places or venues

In addition, the CPG feels that there should be more trained counselors and outreach in the field

# 5.3 SOUTHERN REGION

### CHAPTER OVERVIEW

The following section lists the prioritized populations for **Southern Maine**. A description of the region is provided as well as the behavioral and demographic characteristics of the populations. The needs of the prioritized populations are listed along with interventions designed to meet those needs. The CPG conducted a gap analysis of met and unmet HIV prevention needs and the results are discussed in Attachment III.

## 5.3.1 SOUTHERN MAINE REGIONAL DESCRIPTION:

**Counties in Southern Maine:** Cumberland and York

**Some Pertinent Regional Facts** from the US Census and State Government websites are as follows**:**

| | Cumberland | York |
|---|---|---|
| **Land area** | 836 square miles | 991 square miles |
| **Cities** | Portland (metropolitan area), South Portland, Westbrook | Biddeford, Saco |
| **2001 population estimate** | 266,988 | 192,704 |
| **Persons per square mile 2000** | 317.9 | 188.5 |
| **Persons under 18** | 23.3% | 24.8% |
| **Persons 65 and over** | 13.3% | 13.6% |
| **White persons in 2000** | 95.7% | 97.6% |
| **Other races or Hispanic ethnicity over 1%** | Black/African Am: 1.1%, Asian: 1.4%, 2 or more races: 1.1%, Hispanic: 1% | None |
| **Below poverty in 1999** | 7.9% | 8.2% |

## 5.3.2 SOUTHERN MAINE EPI DATA

Epidemiologic data describing HIV and AIDS in Southern Maine was provided by the Bureau of Health, HIV/STD Program, and comes from HIV and AIDS case reports made to BOH by Maine health care providers. Case reports reflect Maine residents who are diagnosed with HIV or AIDS for the first time; these reports do not take into account individuals who were diagnosed with HIV or AIDS in another state before moving to Maine. This brief overview uses estimates of overall HIV prevalence and HIV and AIDS diagnoses during the past five years (1998-2002) to characterize the disease in Southern Maine. Please note that percentages are rounded and may not total 100%.

It is estimated that approximately 615 people with HIV live in the southern part of the state, accounting for 51% of the estimated 1,200 people living in Maine with the disease.

Between 1998 and 2002 a total of 109 people in Southern Maine were diagnosed with HIV, including 88 males and 21 females. The following table shows diagnoses by county for the five-year period, along with a cumulative rate per 100,000 population. The cumulative rate is used to show how many diagnoses occurred for every 100,000 people, and reflects the number of diagnoses proportionate to the total population of the geographic area. In the table, counties are rank-ordered by their rate. The total for the entire Southern Maine region is also included in the table.

| County | HIV Diagnoses, 1998-2002 | Cumulative HIV Case Rate per 100,000 Population |
|---|---|---|
| Cumberland | 83 | 31 |
| Southern Region | 109 | 24 |
| York | 26 | 14 |

The table shows that Cumberland County had a higher rate than York County, with 31 diagnoses per 100,000 population vs. 14 for York. The regional rate was 24 diagnoses per 100,000 population.

Concerning mode of transmission, 54% of diagnoses were among males who have sex with males (MSM), 11% were among injection drug users (IDU), and 4% had a combination of MSM and IDU risk. Another 26% were attributed to heterosexual sex, including 9% with an at-risk partner and 17% with a partner whose risk status was unknown. Mode of transmission was unknown or not disclosed for 5% of diagnoses.

Age at diagnosis tended to be above 30 years-old. Six percent of diagnoses were among people under 24 years old. Fifty-five percent were among people between the ages of 25 and 39, and 39% were among people over 40 years old.

The majority of people diagnosed with HIV were White (86%). Another 9% were African American/Black, 3% were Hispanic, and 1% were Asian/Pacific Islander.

Between 1998 and 2002, 39% of people in Southern Maine who received an HIV diagnosis were subsequently diagnosed with AIDS within one year of their initial HIV-positive test. Since it can take years for an HIV-infected person to progress to an AIDS diagnosis, people diagnosed with AIDS soon after testing positive for HIV have probably been infected with HIV for a long time without knowing. These people have not received timely medical care for their HIV, and could have infected others without knowing.

The Southern Region experienced a total of 94 AIDS diagnoses during the five-year period, and 29 deaths among people with AIDS.

## 5.3.3 PRIORITIZED POPULATIONS SOUTHERN REGION: Cumberland and York Counties

| Rank* | Behavior | Gender | Age Range | Race | Ethnicity | HIV Status* |
|---|---|---|---|---|---|---|
| **1.** | MSM | Male | 15-24 | White | Non-Hispanic | Unknown or negative |
| **2.** | MSM | Male | 25-39 | White | Non-Hispanic | Unknown or negative |
| **3.** | IDU | Male | 18-40 | White | Non-Hispanic | Unknown or negative |
| **4.** | IDU | Female | 18-40 | White | Non-Hispanic | Unknown or negative |
| **5.** | IDU | Male | 18-40 | | White and Black Hispanics | Unknown or negative |
| **6.** | HET | Female | 13-40 | All | All | Unknown or negative |
| **7.** | HET | Male | 13-40 | Black/African American | | Unknown or negative |

MSM = Males who have Unsafe Sex with Males
IDU = Injection Drug Users who Share Needles and Injection Equipment
HET = Heterosexuals who have Unsafe Sex

***NOTE:** People who are HIV-positive and who engage in behaviors that put themselves and others at risk are the number one priority population. See the Overview at the beginning of this Update for additional information.

**Justification for Prioritization**
Epi data including HIV incidence and rate; STD data including incidence and rate; Hepatitis C data; Needs Assessment data; Resource Inventory data; Maine Case Management data; the current HIV Prevention Plan and Update; and CPG member expertise were all used in determining prioritized populations.

In particular, the following information from the CPG prioritization process helped to inform the final decisions:

- Epi data, STD data, trends, HIV status and concurrent diagnosis and focus on prevention.
- Epi data with a focus on prevention.
- All IDU categories derived from epi data with a focus on prevention and targeting those who use the needle exchange.
- HET's derived from epi and STD data with a focus on prevention.

## 5.3.4 BEHAVIORAL POPULATION DESCRIPTION: Males who have Unsafe Sex with Males (MSM)

Males who have Unsafe Sex with Males are not a single homogenous group. They represent a wide variety of men (both youth and adult males from different races and socioeconomic backgrounds) with diverse health and social needs. Males who have unsafe sex with males are at risk for acquiring or transmitting HIV because of the unsafe sexual behaviors they engage in, not because of how they identify themselves.

HIV is transmitted from an HIV positive man to an HIV negative man through infected bodily fluids, including blood, semen, and pre-ejaculate fluid. The specific behaviors that cause HIV transmission are unprotected anal and/or oral sex, sharing dirty needles and/or works, and sharing dirty instruments for tattooing and/or body piercing. For males who have unsafe sex with HIV positive males, unprotected anal intercourse remains the greatest risk for HIV transmission.

The reality of HIV is woven into the physical, psychological, emotional, and social aspects of men's lives including dating and intimacy, sexual desire and love, alcohol and recreational drug use, homophobia and racism, abuse and coercion, as well as individual self-esteem. HIV prevention programs must acknowledge all of these elements.

### ➢ DEMOGRAPHIC CHARACTERISTICS: Males who have Unsafe Sex with Males (MSM)

Demographic characteristics are different ways of describing people. The following characteristics may be useful in designing prevention programs, but it is important to remember that people's behaviors and the environmental factors that affect those behaviors need to be the target of interventions. The following characteristics are <u>not</u> listed in order of priority.

Individuals who:

- are a member of a racial or ethnic minority
- are economically disadvantaged
- are isolated (geographically, socially, emotionally)
- are homeless
- are migrant workers
- are transgendered
- are HIV+
- have a history of sexual abuse, coercion, and/or nonconsensual sex
- have a history of violence, including domestic violence, gay bashing or other forms of physical abuse
- have a physical and/or developmental disability

- have a diagnosed or undiagnosed mental illness
- have a sero-discordant sexual partner

➢ **BEHAVIORAL CHARACTERISTICS:**
**Males who have Unsafe Sex with Males (MSM)**

Certain behaviors may increase the level of risk for this population, including the following, which are not listed in order of priority:

- having multiple unsafe sex partners
- increasing the number of unsafe sexual encounters
- using alcohol and recreational drugs
- exchanging sex for money (as in sex work or prostitution), and/or goods and/or services (e.g. lodging, food, clothing etc.)
- having unsafe sex with a partner of unknown sero-status
- having a sexual addiction or compulsive need to have sex

➢ **Additional Resources**

Carnes, P., & Delmonico, D. (Eds.). (2001). Special issue: HIV and sexual compulsivity. *Sexual Addiction & Compulsivity,* 12(2).

Real, T. (1997). Don't want to talk about it: Overcoming the secret legacy of male depression. New York NY: Scribner.

Trussler, T., Marchand, R. (1997). Field guide community HIV health promotion. Vancouver, BC: AIDS Vancouver/Health Canada.

van der Kolk, B.A., (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry, 1,* 253-265.

van der Kolk, B.A. & van der Hart, O. (1991). The intrusive past: The flexibility of memory and the engraving of trauma. *American Imago,* 48(4), 425-454.

## 5.3.5 BEHAVIORAL POPULATION DESCRIPTION: Injection Drug Users who Share Needles or Injection Equipment (IDU)*

According to epidemiological data, the number of injection drug users (IDU) or people with histories of injection drug use who have tested positive for HIV or have AIDS continues to grow. The higher quality and lower price of injection drugs coupled with increased availability contributes to a rise in the number of people who use injection drugs. The continued social and political stigmatization of IDU also contributes to the risky behavior of sharing needles, increasing an IDU's risk for contracting HIV.

Injection drug users cannot be identified by where they live or how much they earn. However, some identified situations and behaviors put these individuals at increased risk. It is important to note that the sexual partners and unborn children of injection drug user's are also at increased risk for HIV infection.

The following description, though not exhaustive, includes the epidemiological, behavioral and demographic characteristics of IDU who are at risk of HIV infection, re-infection or transmission. They may be any race, gender, age, ethnicity or sexual orientation, and may have other special needs.

**Note: the phrase "sharing needles" means the sharing of a needle, syringe, spoon or a cooker, glass of water or other fluid, and cotton or other absorbent material. These items are collectively known in street terminology as "works." In addition this includes the sharing of needles for tattooing, body piercing, or for the injection of steroids, vitamins and/or hormones.*

- **DEMOGRAPHIC CHARACTERISTICS:**
  **Injection Drug Users who Share Needles or Injection Equipment (IDU)**

Demographic characteristics are different ways of describing people. The following characteristics may be useful in designing prevention programs, but it is important to remember that people's behaviors and the environmental factors that affect those behaviors need to be the target of interventions. The following characteristics are not listed in order of priority.

Individuals who:

- are a member of a racial or ethnic minority
- are economically disadvantaged
- are homeless
- are migrant workers
- are youth under age 24
- are incarcerated
- are transgendered
- are HIV+
- have a history of physical, sexual and/or emotional trauma
- have a physical and/or developmental disability
- have a diagnosed or undiagnosed mental illness

- **BEHAVIORAL CHARACTERISTICS:**
  **Injection Drug Users who Share Needles or Injection Equipment (IDU)**

Certain behaviors may increase the level of risk for this population, including the following, which are not listed in order of priority:

- using or abusing prescription drugs, alcohol and other chemicals
- engaging in unprotected sex
- exchanging unprotected sex for money, goods and/or services
- injecting vitamins and/or steroids or hormones
- engaging in unlicensed body piercing or tattooing

## 5.3.6 BEHAVIORAL POPULATION DESCRIPTION: Heterosexuals who have Unsafe Sex (HET)

Heterosexuals who have Unsafe Sex refers to females and males of any age who engage in behaviors that could place them at increased risk for HIV infection from their opposite sex partner. Overall heterosexual females are at greater risk for contracting HIV than are their heterosexual male counterparts.

It is important to note that, within this population, HIV is much more readily transmitted from male to female than from female to male (Padian, et al, 1997). Most HIV infection results from HIV-positive male partners, who having contracted HIV through injection drug use or sex with other males, transmit the infection to their female partners (Campbell, 1995). These males are not being effectively reached by current HIV prevention efforts regarding safer sex behaviors. Therefore, pertinent information related to this population may also be found in the Population Descriptions for "Males who have Unsafe Sex with Males" and "Injection Drug Users who Share Needles or Injection Equipment." Heterosexual males who do not fit into either of these categories may be at increased risk by having unprotected sex with HIV+ females. The following descriptions include the epidemiological, demographic and behavioral characteristics of this population.

REFERENCES

Padian, N., Shiboski, S., Glass, S., Vittinghoff, E. (1997). Heterosexual transmission of Human Immunodeficiency Virus (HIV) in northern California: Results from a ten-year study. *American Journal of Epidemiology,* 146(4): 350-356.

Campbell, C. (1995). Male gender roles and sexuality: Implications for women's AIDS risk and prevention. *Social Science Medicine,* 41(2): 197-210.

### ➢ DEMOGRAPHIC CHARACTERISTICS: Heterosexuals who have Unsafe Sex (HET)

Demographic characteristics are different ways of describing people. The following characteristics may be useful in designing prevention programs, but it is important to remember that people's behaviors and the environmental factors that affect those behaviors need to be the target of interventions. The following characteristics are <u>not</u> listed in order of priority.

Individuals who:

- are a member of a racial or ethnic minority
- are economically disadvantaged
- are homeless
- are isolated (geographically, socially, emotionally)
- are migrant workers

- are youth under age 24
- are incarcerated
- are transgendered
- are currently infected with, or have a partner who is infected with, sexually transmitted diseases
- are HIV+
- have low self esteem
- have a history of sexually transmitted diseases
- have a history of physical, sexual and/or emotional trauma
- have a physical and/or developmental disability
- have a diagnosed or undiagnosed mental illness

### ➢ BEHAVIORAL CHARACTERISTICS: Heterosexuals who have Unsafe Sex (HET)

Certain behaviors may increase the level of risk for this population, including the following, which are <u>not</u> listed in order of priority:

- HIV-positive individuals who have unprotected sex with their opposite sex partner(s)
- individuals who have unprotected sex with needle sharers
- gay, bisexual and non-gay identified males who have unprotected sex with males and unprotected sex with females
- individuals who use injection drugs and share drug injecting equipment
- individuals who trade unprotected sex for money, drugs, etc.
- individuals who have unprotected sex with multiple sex partners
- individuals who use/abuse alcohol and/or other non-injection drugs especially “crack,” cocaine and methamphetamines and also engage in unprotected sex
- individuals who have unprotected sex with sex workers
- young females who have unprotected sex with older males

## 5.3.7 CRITICAL HIV PREVENTION NEEDS FOR THE PRIORITIZED POPULATIONS IN THE SOUTHERN REGION

### ➢ Critical Needs for Males who have Unsafe Sex with Males (MSM) in Southern Maine

These needs are not listed in order of priority.

- Increase knowledge of HIV status.
- Increase access to Counseling Testing and Referral (CTR) including anonymous CTR and Partner Counseling Testing and Referral.
- Increase awareness of personal risk.
- Increase skills that eliminate or decrease HIV transmission.
- Increase self-esteem and self-efficacy (belief in ability to change personal behavior) including motivation, intention and commitment.

### ➢ Critical Statewide System Needs for MSM

In addition to the needs listed above, there are broad systems needs that fall under the responsibility of various programs and agencies within the State. The CPG feels that it is critical that these needs be met in order for HIV prevention to occur. It is important to create better links between prevention and other types of care (e.g. case management, substance abuse treatment, mental health treatment, etc.). The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for MSM and are not listed in order of priority.

- Increase access to affordable, culturally competent services including:
    - substance abuse treatment
    - housing
    - health care
    - prevention programs in correctional facilities
    - needle exchange sites
    - methadone programs
    - training for providers
- Changing MSM community norms and strengthening peer support.
- Make HIV prevention a routine part of medical care.

## ➢ Critical Needs for Injection Drug Users who Share Needles and Injection Equipment (IDU) in Southern Maine

These needs are not listed in order of priority.

- Increase awareness of personal risk.
- Increase knowledge of HIV disease, transmission, prevention, services, resources and support.
- Increase use of risk reduction practices.
- Increase community norms and peer support of behaviors that reduce the risk of HIV transmission.
- Increase access to Counseling Testing and Referral (CTR) and Partner Counseling Testing and Referral.

**Additional Need for Black/African American and Hispanic IDU in Southern Maine**

- Interventions targeting Blacks/African Americans and Hispanics should be culturally and linguistically appropriate.

## ➢ Critical Statewide System Needs for IDU

In addition to the needs listed above, there are broad systems needs that fall under the responsibility of various programs and agencies within the State. The CPG feels that it is critical that these needs be met in order for HIV prevention to occur. It is important to create better links between prevention and other types of care (e.g. case management, substance abuse treatment, mental health treatment, etc.). The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for IDU and are not listed in order of priority.

- Increase the number of needle exchange sites throughout the State so that they are easily accessible.
- Increase the number of methadone programs throughout the State so that they are easily accessible.
- Increase the availability of mental health counseling.
- Increase pharmacy access for syringe purchases.
- Increase access to substance abuse treatment.
- Make HIV prevention a routine part of medical care.

## ➢ Critical Needs for Male and Female Heterosexuals who have Unsafe Sex (HET) in Southern Maine

These needs are not listed in order of priority.

- Increase awareness of personal risk.
- Increase knowledge of HIV status.
- Increase self-esteem and self efficacy (motivation, intention and commitment) to be able to reduce high risk behaviors and decrease transmission.
- Increase access to Counseling Testing and Referral and Partner Counseling Testing and Referral Services.
- Increase use of risk reduction practices which could include the use of communication, problem solving and decision making skills to reduce HIV transmission.

### Additional Need for Black/African American and Hispanic Male HET in Southern Maine

- Increase identification of high risk behaviors and ability to assess own risk of infection.

## ➢ Critical Statewide System Needs for HET

In addition to the needs listed above, there are broad systems needs that fall under the responsibility of various programs and agencies within the State. The CPG feels that it is critical that these needs be met in order for HIV prevention to occur. It is important to create better links between prevention and other types of care (e.g. case management, substance abuse treatment, mental health treatment, etc.). The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for HET and are not listed in order of priority.

- Increase access to affordable housing and comprehensive health care services (including substance abuse treatment, mental health counseling, HIV prevention programs in correctional facilities, etc.).
- Make HIV prevention a routine part of medical care.

## 5.3.8 INTERVENTIONS FOR SOUTHERN MAINE

The following section lists a set of interventions to meet the critical needs identified for each prioritized population of unknown or negative HIV status**. The behavioral populations are listed in order of priority; however, the needs and interventions are not listed in order of priority. See Chapter 3 of the 2001 HIV Prevention Plan for an explanation of the intervention types, behavioral science theory, and the characteristics of effective HIV prevention programs. See Attachment II for a more detailed description of the interventions listed below.

****NOTE:** See the Overview at the beginning of this Update for information about interventions for people who are HIV-positive who engage in unsafe behavior that puts themselves and others at risk.

### 1. Males who have Unsafe Sex with Males (MSM), 15-24, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase access* to Counseling Testing and Referral (CTR) which includes Partner Counseling and Referral Services and anonymous CTR | • Increase Counseling Testing and Referral activities (see access* below)<br>• Health Communication/Public Information |
| • Increase awareness of personal risk | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level interventions<br>• Counseling Testing and Referral |
| • Increase skills that eliminate or decrease HIV transmission | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase self esteem and self-efficacy (belief in ability to change personal behavior) including motivation, intention and commitment | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Community Level Interventions |

## 2. MSM, 25-39, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Increase Counseling Testing and Referral activities (see access* below)<br>• Health Communication/Public Information |
| • Increase awareness of personal risk | • Multi-session Individual Level Interventions<br>• Multi-session Group Level Interventions<br>• Counseling Testing and Referral |
| • Increase skills that eliminate or decrease HIV transmission | • Multi-session, Individual Level Interventions<br>• Multi-session, Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase self esteem and self-efficacy (belief in ability to change personal behavior) including motivation, intention and commitment | • Multi-session Individual Level Interventions<br>• Multi-session Group Level Interventions<br>• Community Level Interventions |

## 3. Injection Drug Users who Share Needles and Injection Equipment, (IDU), MALE, 18-40, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase awareness of personal risk | • Multi-session Individual Level Interventions ~ preferably peer led<br>• Multi-session Group Level Interventions ~ preferably peer led<br>• Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase knowledge of HIV disease, transmission, prevention, services, resources and support | • Outreach<br>• Single-session Group Level Interventions<br>• Single-session Individual Level Interventions |
| • Increase use of risk reduction practices | • Multi-session Group Level Interventions<br>• Multi-session Individual Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase community norms and peer support of behaviors that reduce the risk of HIV transmission | • Community Level Interventions |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Increase Counseling Testing and Referral activities (see access* below) |

### 4. IDU, FEMALE, 18-40, white, non-Hispanic

| Needs | Interventions |
|---|---|
| • Increase awareness of personal risk | • Multi-session Individual Level Interventions ~ preferably peer led<br>• Multi-session Group Level Interventions ~ preferably peer led<br>• Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase knowledge of HIV disease, transmission, prevention, services, resources and support | • Outreach<br>• Single-session Group Level Interventions<br>• Single-session Individual Level Interventions |
| • Increase use of risk reduction practices | • Multi-session Group Level Interventions<br>• Multi-session Individual Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase community norms and peer support of behaviors that reduce the risk of HIV transmission | • Community Level Interventions |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Increase Counseling Testing and Referral activities (see access* below) |

### 5. White and black HISPANIC, IDU, MALE, 18-40

Interventions targeting Blacks/African Americans and Hispanics should be culturally and linguistically appropriate.

| Needs | Interventions |
|---|---|
| • Increase awareness of personal risk | • Multi-session Individual Level Interventions ~ preferably peer led<br>• Multi-session Group Level Interventions ~ preferably peer led<br>• Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase knowledge of HIV disease, transmission, prevention, services, resources and support | • Outreach<br>• Single-session Group Level Interventions<br>• Single-session Individual Level Interventions |
| • Increase use of risk reduction practices | • Multi-session Group Level Interventions<br>• Multi-session Individual Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase community norms and peer support of behaviors that reduce the risk of HIV transmission | • Community Level Interventions |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Increase Counseling Testing and Referral activities (see access* below) |

## 6. Heterosexuals who have Unsafe Sex (HET), FEMALE, 13-40, all races and ethnicities

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Health Communication/Public Information<br>• Counseling Testing and Referral including Outreach Counseling Testing and Referral<br>• Peer led, single-session Group Level Interventions |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Health Communication/Public Information<br>• Outreach<br>• Increase Counseling Testing and Referral activities (see access* below) |
| • Increase awareness of personal risk | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase self esteem and self-efficacy (motivation, intention and commitment) to be able to reduce high risk behaviors and decrease transmission | • Peer led, multi-session Individual Level Interventions<br>• Peer led, multi-session Group Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase use of risk reduction practices which could include the use of communication, problem solving and decision making skills to reduce HV transmission | • Community Level Interventions<br>• Peer led, multi-session Individual Level Interventions<br>• Individual Risk Reduction Counseling |

## 7. Black/African American, HET, MALE, 13-40

All interventions targeting Blacks/African Americans should be culturally and linguistically appropriate.

| Needs | Interventions |
|---|---|
| • Increase knowledge of HIV status | • Peer led Outreach<br>• Health Communication/Public Information<br>• Counseling Testing and Referral including Outreach Counseling Testing and Referral |
| • Increase access* to Counseling Testing and Referral which includes Partner Counseling and Referral Services and anonymous CTR | • Health Communication/Public Information<br>• Outreach<br>• Increase Counseling Testing and Referral activities (see access* below) |
| • Increase awareness of personal risk | • Peer led, multi-session Individual Level Interventions<br>• Health Communication/Public Information<br>• Individual Risk Reduction Counseling |
| • Increase self esteem and self-efficacy (motivation, intention and commitment) to be able to reduce high risk behaviors and decrease transmission | • Peer led, multi-session Individual Level Interventions<br>• Individual Risk Reduction Counseling |
| • Increase use of risk reduction practices which could include the use of communication, problem solving and decision making skills to reduce HV transmission | • Individual Risk Reduction Counseling<br>• Peer led, multi-session Individual Level Interventions |
| • Increase identification of high risk behaviors and ability to assess own risk of infection | • Counseling Testing and Referral |

*Access refers to testing that is:

- available as part of all programs
- free
- available after hours and on weekends
- available where the person can't be identified
- available on a walk-in basis
- available in many different places or venues

In addition, the CPG feels that there should be more trained counselors and outreach in the field

# Attachment I

## Glossary of Commonly Used Terms and Acronyms

# Glossary of Commonly Used Terms and Acronyms *

**AED Academy for Educational Development**
An agency, funded by the Centers for Disease Control and Prevention, which provides training & technical assistance for Community Planning Groups (CPG's).

***Agency***
An organization that provides some service such as an AIDS service organization (ASO), a community-based organization (CBO), or a governmental organization.

**AIDS Acquired Immuno-Deficiency Syndrome**
A disease caused by the human immunodeficiency virus (HIV) in which the body's immune system breaks down leaving the person open to developing a variety of life-threatening illnesses (opportunistic infections). The clinical definition of AIDS requires a medical diagnosis that includes a CD4 count less than or equal to 200, or one or more opportunistic infections.

**AIDS Prevalence**
A statistical term referring to the number or percentage of people living with AIDS in a given population.

**ASO AIDS Service Organization**
An agency that provides HIV/AIDS related services to the community such as support, health services, case management, prevention, housing, advocacy, intervention, information and referral.

**Behavioral Science**
The study of human behavior, including psychology and sociology, that seeks to understand the behaviors and actions of individuals or groups of people in a given situation, i.e., why people do what they do.

**BOH Bureau of Health**
An agency of the Maine Department of Human Services, in which the HIV/STD Program functions.

**Bylaws**
Standing rules written by a group to govern the way they function in order to achieve their goal. Bylaws address issues of voting, quorums, attendance, etc.

**C & T Counseling and Testing**
A process to determine your HIV status that includes counseling before and after the test. The counseling helps clients assess their own risk and develop methods to decrease their risk or change their behavior. See also CTR.

**CTR Counseling Testing and Referral Services**
Components of an effective HIV intervention activity by which a person may learn what their HIV status is and is given appropriate referrals for follow-up services.

**CAN Coastal AIDS Network**
An AIDS Service Organization located in Belfast.

**Capacity Building**
Strengthening the abilities and knowledge of individuals or groups so that they may better do their work.

**CBO Community-Based Organization**
An agency providing services to specific groups of people in a defined area. Examples of the types of groups served include minority groups, the homeless, and people with a mental illness. An AIDS service organization is a type of CBO that provides services to people at risk of or living with HIV.

**CDC The Centers for Disease Control and Prevention**
The federal agency responsible for the public health of the nation. It tracks diseases that endanger public health, such as HIV and tuberculosis. The CDC is located in Atlanta, Georgia.

**CD4 cells** Immune cells, also called T-helper cells, which help your body fight off infection and disease. HIV kills these cells.

**CPG Maine HIV Prevention Community Planning Group**
The federally mandated HIV prevention planning group responsible for developing a comprehensive HIV prevention plan responsive to the epidemic in Maine.

**Community**
A group of people living in a defined area who share something in common, such as language, ethnicity, geographic area, behavior, or belief.

**Competitive Award**
Funding awarded based on the quality of the funding application. Applications are reviewed and scored according to set criteria by a panel of reviewers.

**Comprehensive HIV Prevention Plan**

The result of the community HIV prevention planning process. This is a plan that has taken into account many different points of view and perspectives in order to provide the most effective HIV prevention efforts for a specific area.

**Conflict of Interest**

A conflict between one's obligation to the public good and one's self-interest; for example, if the board of a community-based organization is deciding whether to receive services from Company A and one of the board members also owns stock in Company A, that person would have a conflict of interest.

**DASS Dayspring AIDS Support Services (Dayspring)**

An AIDS service organization that is part of a larger organization, HealthReach, located in Augusta.

**DEAN Downeast AIDS Network**

An AIDS service organization located in Ellsworth.

**DHS Maine Department of Human Services**

The lead state agency addressing health and human service needs.

**DOE Maine Department of Education**

The lead state agency addressing educational needs.

**EMAN Eastern Maine AIDS Network**

An AIDS service organization located in Bangor.

**Epidemic**

The rapid spread or sudden existence of something, such as a disease.

**EPI Epidemiology**

The study of epidemics and epidemic diseases such as HIV and tuberculosis.

**EPI Profile Epidemiologic Profile**

The State of Maine Epidemiologic Profile is produced for the CPG by the Bureau of Health HIV/AIDS Epidemiologist. It describes how HIV/AIDS affects people living in Maine including which populations, age groups and ethnic groups are affected by HIV in a defined area.

**Ethnicity**

A group of people who share a common characteristic such as the same place of origin, language, race, behaviors, or beliefs.

**Evidence Based**
In prevention planning, this means that plans are made using information that has been proven to be true.

**Frannie Peabody Center** **Formerly The AIDS Project (TAP) and Peabody House**
An AIDS service organization located in Portland.

**Fiscal Year**
A twelve-month period set up for accounting purposes. For example, the federal government's fiscal year runs October 1 to September 30 of the following year.

**Focus Group**
A special type of group in which people who have certain characteristics provide information about a topic of interest. This qualitative data is collected during a focused discussion led by a skilled facilitator in a non-threatening environment.

**Grantee**
The organization receiving funds from an outside source.

**Guidance** A CDC document that defines the process of HIV prevention community planning, and gives additional information and rules about applying for HIV prevention funds.

**HIV Human Immunodeficiency Virus**
The virus that damages the immune system and causes AIDS.

**HIV/AC Maine HIV/AIDS Advisory Committee (Advisory Committee)**
A group formed by the legislature that makes recommendations to all departments and agencies of the state on the subject of HIV/AIDS.

**HIV Prevention Community Planning**
A form of planning, started by the CDC, in which people representing communities at-risk for and infected by HIV work with scientists, other experts, and health department staff in order to decide on the most effective ways of stopping the spread of HIV in their area.

**HIV-Related Mortality Data**
Statistics that represent the number deaths caused by HIV infection.

**HIV Seroprevalence Data**
Statistics that measure the amount of HIV infection among selected populations.

**IDU/IVDU Injection Drug User/Intravenous Drug User**

A term used to refer to people who inject drugs directly into their bloodstream by using a needle and syringe.

**Inclusion**

According to the CDC, inclusion means involving the views, perspectives, and needs of all communities affected by HIV in a meaningful way in the HIV prevention community planning process.

**Intervention**

An activity designed to help people change or avoid behavior that may result in HIV infection. Interventions Types include:

- Individual Level Interventions (ILI) which include Counseling Testing and Referral (CTR) and Individual Risk Reduction Counseling (IRRC) among others
- Group Level Interventions (GLI)
- Outreach (OUT)
- Community Level Interventions (CLI)
- Partner Counseling and Referral Services (PCRS)
- Prevention Case Management (PCM)
- Health Communication/Public Information (HC/PI)

**KABB: Knowledge, Attitudes, Belief and Behavior Surveys**

KABB is people's knowledge, attitudes/beliefs and behaviors about HIV/AIDS. A common way we get this information is through surveys that ask people what they know, think and do about HIV/AIDS.

**Key Informant Interview**

A method of collecting information by asking questions and recording the answers of individuals with specialized knowledge about the topic of interest, either because of their position in the community or organization, or because of their personal experience/expertise.

**Letter of Concurrence/Non-Concurrence**

A part of a health department's application to the CDC for federal HIV prevention funds. This letter states whether the health department and the CPG successfully worked together in revising the HIV prevention plan, and whether the activities, programs and services, for which the health department is requesting CDC funds, respond to the priorities in the plan. The letter also explains the process used for obtaining concurrence. It is voted on by the CPG and written by the CPG Co-Chairs.

**MAA Maine AIDS Alliance**

An agency consisting of Maine's community-based HIV & AIDS service organizations.

**MASS** **Merrymeeting AIDS Support Services**

An AIDS service organization located in Brunswick.

**Needs Assessment**

The process of obtaining and analyzing findings about community needs. Needs assessments may use several methods of information and data collection to determine the type and extent of unmet needs in a particular population or community. For example, a needs assessment may use personal interviews or questionnaires with a diverse group of community members in order to determine what they know about protecting themselves from HIV infection.

**NGO** **NonGovernmental Organization**

A private agency that is not associated with federal, state, or local government. Nongovernmental organizations may provide programs or services that are similar to those offered by governmental agencies.

**Organization**

A group of people brought together for a common purpose or good.

**Outcome Evaluation**

A type of evaluation that seeks to measure the effect of a program and answers questions about the results of the program such as the change that was achieved.

**Pandemic**

Disease that occurs throughout a country or globally, over a long period of time, as with HIV and AIDS.

**Parity**

According to the CDC, parity is a situation in which all members of the community planning group are provided opportunities for orientation and skills building in order to participate in the planning process and to have an equal voice in voting and other decision-making activities.

**Participatory Planning**

The process of identifying needs and making decisions through the broad-based involvement of a wide range of viewpoints, where differences in background, perspective, and experience are essential and valued.

**PIR** **Parity, Inclusion and Representation**

According to the CDC, PIR is a term used in HIV prevention community planning that requires that members have equal voice in the process, that differences are valued, and that membership is representative of all populations affected by HIV.

**Population** *See "Target Population".*

**Prevention Program**

A group of interventions designed for reduction of any disease among individuals whose behavior, environment or genetic history places them at high risk for exposure.

**Prevention Services**

Interventions and education which are intended to help people stop behaviors that may lead to their becoming infected with HIV; may include condom education, counseling that reduces the number of sex partners, HIV antibody testing/counseling, or needle exchange programs and drug abuse counseling.

**PreventionWorks**

An AIDS service organization located in Lewiston.

**Process**

The method used in undertaking a project; different groups think about and act upon projects and tasks differently and may use diverse decision-making styles, time frames, and methods.

**Process Evaluation**

A type of evaluation that seeks to answer questions about a program such what services were delivered and how many people received the service.

**Process Objectives**

Specific activities involved in the implementation of a program in order to produce the desired results.

**PSE Public Sex Environment**

Public places where people meet and have sexual encounters such as parks, rest areas, adult book and video stores, adult movie theaters, bars, truck stops, etc.

**PWA/PLWA Person with AIDS/Person Living with AIDS**

This is the preferred terminology, rather than AIDS patient or AIDS victim.

**Qualitative Data**

Information that cannot easily be counted and is presented in the form of words, observations and descriptions.

**Quantitative Data**

Information that can be counted and is presented in the form of numbers.

**Representation**

According to the CDC representation is the assurance that those who are representing a specific community truly reflect that community's values, norms, and behaviors.

**RFP Request for Proposals**

A funding agency or organization's request seeking grant proposal submissions from service providers for the delivery of certain types of services. Bids that are accepted would then receive funding to provide the services outlined in their submitted proposal.

**Ryan White**

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act
An Act passed by Congress in 1990 that provided the first federal funding levels for HIV/AIDS care.

**Secondary Data**

Existing data, or information, that is gathered and used in a project.

**Secondary Prevention**

Prevention programs that serve the needs of people infected with HIV, informing them about how they can protect their health and prevent the further spread of the virus.

**Sero-Incidence**

A statistical term that refers to the number or rate of new HIV diagnoses in a particular period of time (one year, five years, etc.).

**Sero-Prevalence**

A statistical term referring to the number or percentage of people living with HIV in a defined population.

**Stake Holders**

Those individuals/groups who have a major interest and involvement in a process; participants in the community planning process.

**STD Sexually Transmitted Disease**

A disease that is spread through sexual contact, such as HIV, herpes, syphilis, gonorrhea, etc. Sometimes referred to as STI or sexually transmitted infection.

**Surveillance Data**
Data about communicable diseases, including HIV and AIDS, which are collected by public health officials. These data are collected from testing sites, hospitals and health care facilities and are used to monitor communicable diseases in populations and describe how they affect public health.

**Target Populations** Groups of people who are the focus of HIV prevention efforts due to high rates of HIV infection among those groups; they are defined by using CDC AIDS surveillance data broken down by ethnicity, gender, sexual orientation and other factors.

**TA Technical Assistance**
Training and skills development which allows people and groups to do their jobs better, including education and knowledge development in areas that range from leadership and communications, to creating an effective needs assessment tool and understanding statistical data.

**YRBS Youth Risk Behavior Survey**
A survey administered every other odd year with middle and high school students. It contains information on behaviors that can put youth at risk for HIV infection.

***** Note: There are many different definitions of these terms. These are the ones that are currently used by the Maine CPG.

# Attachment II

## Intervention Information Chart

# INTERVENTION INFORMATION CHART

***Intervention Type*** ***Description***

| ***Individual Level (ILI)*** | Health education and/or risk reduction counseling provided to one person at a time. ILI's assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior and include skills building activities. These interventions also facilitate linkages to services in clinics and community settings in support of behaviors and practices that prevent the transmission of HIV. | |
|---|---|---|
| **Can be used to change:** | **Examples/Method** | **Recommended/Effective in addressing** |
| **K* S*** | Single Session | HIV knowledge, information, referrals, skills |
| **K* A* B* S*** | Multi Session | Attitudes, Skills and Behaviors |
| **(See above re single- or multi-session)** | Peer-Led | Recommended for all interventions targeting youth, females and people of color. Can be single- or multi-session |

| ***Group Level (GLI)*** | Health education and/or risk reduction counseling with a skills building component provided to more than one person at a time. Provide education and support in group settings to promote and reinforce safer behaviors and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change to persons at increased risk or already infected. | |
|---|---|---|
| **Can be used to change:** | **Examples/Method** | **Recommended/Effective in addressing** |
| **K* S*** | Single Session | HIV knowledge, information, referrals, skills |
| **K* A* B* S*** | Multi Session | Attitudes, Skills and behaviors |
| **(See above re single- or multi-session)** | Peer-Led | Recommended for all interventions targeting youth, females and people of color. Can be single- or multi-session |

| ***Community Level (CLI)*** | Health education and/or risk reduction services directed at changing community norms, rather than those of the individual or a group, to increase community support of the behaviors known to reduce the risk of HIV transmission. The primary goals of these interventions are to improve health status, to promote healthy behaviors, and to change factors that affect the health of community residents. They are designed to promote community support of prevention efforts by working with the social norms or shared beliefs and values held by members of the community. Community may be defined in terms of a prioritized population or a geographic area as a way to capture the social networks that may be located within those boundaries. | |
|---|---|---|
| **Can be used to change:** | **Examples/Method** | **Recommended/Effective in addressing** |
| **Norms, A*** | Community Building Events<br>Town Meetings | Community norms, populations with strong identifications, isolated populations, addressing issues in a culturally competent way |

***KEY**
**K**=Knowledge
**A**=Attitudes
**S**=Skills
**B**=Behavior

| ***Outreach (OUT)*** | Interventions are defined by the location of activity and by the content of services provided. They reach persons at high risk, individually, or in groups, on the street or in community settings. The fundamental principle of outreach activities is that the outreach worker establishes face-to-face contact with the client in his or her environment to provide HIV risk reduction information, products, and referrals. It may be a recruitment strategy. The outreach intervention may happen distinctly or in conjunction with other interventions. | |
|---|---|---|
| **Can be used to change:**<br><br>**K*** | **Examples/Method**<br><br>Peer Education<br>"Street Outreach"<br>Needle Exchange<br>Popular Opinion Leaders | **Recommended/Effective in addressing**<br>HIV knowledge, information, referrals, products, recruitment into other interventions, reaching high risk individuals |

| ***Counseling Testing and Referral (CTR)*** | An Individual Level Intervention. Component of an effective HIV prevention intervention activity by which a person may learn their HIV sero-status. CTR services are offered free of coercion. Individuals have the opportunity to accept or refuse HIV testing. | |
|---|---|---|
| **Can be used to change:**<br><br>**K* A*** | **Examples/Method** | **Recommended/Effective in addressing** |
| | Anonymous | Low barrier service. High risk clients. Can be done in an outreach setting |
| | Confidential | Can be done in outreach setting |
| | Oral | Can be done in outreach setting |
| | Rapid Test | Can be done in outreach setting |
| | Serum | Clinic setting |

| ***Partner Counseling and Referral Services (PCRS)*** | A voluntary and confidential prevention activity conducted by trained individuals that provides services to a source patient and their sex and/or needle-sharing partners so they can reduce their risk for infection or, if already infected, may prevent transmission to others. PCRS also works to help partners gain earlier access to individual counseling, HIV testing, medical evaluation, and other prevention and support services. |
|---|---|
| **Can be used to change:**<br><br>**K* A*** | **Recommended/Effective in addressing**<br>Continuation of CTR, reducing risk of partners, early entry into testing, treatment and services |

***KEY**
**K**=Knowledge
**A**=Attitudes/beliefs
**S**=Skills
**B**=Behavior

| ***Individual Risk Reduction Counseling (IRRC)*** | An Individual Level Intervention. Personalized, client-centered session(s) with a trained counselor that creates the opportunity for the person to learn to recognize their own risk, ask questions about safer sex, and develop a personal risk reduction plan. Referrals and information relevant to the client are also provided. |
|---|---|
| **Can be used to change:**<br><br>**K* A* B* S*** | **Recommended/Effective in addressing**<br>Suitable for all populations since client-centered, beneficial to reaching an action step |

| ***Prevention Case Management (PCM)*** | Provides client-centered, intensive, on-going, individualized prevention counseling, support, education and service referral. The goal is to promote the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. It is intended for persons having difficulty initiating or sustaining behaviors that reduce or prevent HIV acquisition, transmission, or re-infection. |
|---|---|
| **Can be used to change:**<br><br>**K* A* B* S*** | **Recommended/Effective in addressing**<br>At risk HIV + individuals, high risk individuals at risk for HIV |

| ***Health Communica-tion/Public Information (HC/PI)*** | Information delivered as planned prevention messages to support risk-reduction, increase awareness, build support for safer behavior. HC/PI does not include group level interventions that include a skill component. | |
|---|---|---|
| **Can be used to change:**<br><br>**K* A*** | **Examples/Methods**<br><br>Hot line<br>Speakers Bureau<br>Media Campaign | **Recommended/Effective in addressing**<br>Basic HIV information and information on services and support. Delivering targeted information to specific populations |

***KEY**
**K**=Knowledge
**A**=Attitudes/beliefs
**S**=Skills
**B**=Behavior

# Attachment III

## Gap Analysis Results

# Gap Analysis Results

The Community Planning Group (CPG) conducted a gap analysis in which the HIV prevention needs of the prioritized populations were compared to the services available in each region in order to understand how well the needs of the populations are met. To do this, the identified needs for each behaviorally-based population were compared to two documents:

- The Resource Inventory of Currently Funded Interventions which listed the services funded by the Bureau of Health (BOH).
- The CPG Statewide Resource Inventory compiled by the CPG from surveys mailed to 439 service providers including providers not funded by the BOH.

The information gathered in these Inventories was not always complete or detailed enough to enable the CPG to determine how well a particular need was being met. In these cases, the expertise of Committee members combined with review of the information available was used in making final decisions. Any gaps in services are listed below as unmet needs. Highlights from the Gap Analysis are included on the final page.

**GAP ANALYSIS RESULTS: NORTHERN REGION** (Aroostook (Ar), Hancock (Han), Penobscot (Pen), Piscataquis (Pis), and Washington (Wa) Counties)

| *Behavior* | *Gen-der* | *Age* | *Race* | *Ethnicity* | *HIV Status* | **CRITICAL NEEDS (ABBREVIATED)** **For a detailed list of needs see "Critical HIV Prevention Needs for Prioritized Populations" for each region in the 2003 Update** | **TOTAL UNMET NEEDS ~ Gaps in Services** **List Counties** | **OVERALL ESTIMATE OF NEED FOR REGION** (met, mostly met, somewhat unmet, unmet) |
|---|---|---|---|---|---|---|---|---|
| MSM | M | < 29 | Wht | Non-His | unkn or Neg | 1.Knowledge of status | | Mostly met |
| | | | | | | 2.↑ access to CTR | All to some extent | Unmet |
| | | | | | | 3.Awareness of risk | | Mostly met |
| | | | | | | 4.Skills ↓ transmission | Ar, Pis | Somewhat unmet |
| | | | | | | 5.↑ self esteem | All to some extent | Unmet |
| MSM | M | > 29 | Wht | Non-His | unkn or Neg | 1. | Same as above | |
| | | | | | | 2. | | |
| | | | | | | 3. | | |
| | | | | | | 4. | | |
| | | | | | | 5. | | |
| HET | F | < 29 | Wht | Non-His | unkn or Neg | 1.Awareness of risk | | Mostly met |
| | | | | | | 2.Knowledge of status | | Mostly met |
| | | | | | | 3.↑ self esteem | | Unmet |
| | | | | | | 4.↑ access to CTR | | Unmet |
| | | | | | | 5.↑ risk reduction | | Mostly met |
| HET | F | > 29 | Wht | Non-His | unkn or Neg | 1. | Same as above | |
| | | | | | | 2. | | |
| | | | | | | 3. | | |
| | | | | | | 4. | | |
| | | | | | | 5. | | |
| IDU | M | 15 up | Wht | Non-His | unkn or Neg | 1.Awareness of risk | Han, Wa | Somewhat unmet |
| | | | | | | 2.Knowledge - HIV info | All | Unmet |
| | | | | | | 3.↑ risk reduction | Wa | Somewhat unmet |
| | | | | | | 4.↑ Norms | Han, Wa | Somewhat unmet |
| | | | | | | 5.↑ access to CTR | All | Unmet |
| HET | M | 15-35 | Wht | Non-His | unkn or Neg | 1.ID high risk behavior | | Somewhat unmet |
| | | | | | | 2. | | |
| | | | | | | 3. | | |
| | | | | | | 4. | | |
| | | | | | | 5. | | |
| MSM, IDU & HET | M&F | 10 up | N Am | | unkn or Neg | 1.Culturally appropriate | | Mostly met |
| | | | | | | 2. | | |
| | | | | | | 3. | | |
| | | | | | | 4. | | |
| | | | | | | 5. | | |

MSM = Males who have Unsafe Sex with Males
IDU = Injection Drug Users who Share Needles and Injection Equipment
HET = Heterosexuals who have Unsafe Sex

N Am= Native American
Non-His=Non-Hispanic
Wht= White
< = Less than
> = Greater than

↑= Increase
↓= Decrease
unkn= Unknown
Neg= Negative

**GAP ANALYSIS: CENTRAL REGION** (Androscoggin (An), Franklin (Fr), Kennebec (Ken), Knox (Kx), Lincoln (L), Oxford (Ox), Sagadahoc (Sag), Somerset (Som) and Waldo (W) Counties)

| *Behavior* | *Gen-der* | *Age* | *Race* | *Ethnicity* | *HIV Status* | **CRITICAL NEEDS (ABBREVIATED)** **For a detailed list of needs see "Critical HIV Prevention Needs for Prioritized Populations" for each region in the 2003 Update** | **TOTAL UNMET NEEDS ~ Gaps in Services** **List Counties** | **OVERALL ESTIMATE OF NEED FOR REGION** (met, mostly met, somewhat unmet, unmet) |
|---|---|---|---|---|---|---|---|---|
| MSM | M | 15 - 39 | Wht | Non-His | unkn or Neg | 1.Knowledge of status | | Mostly met |
| | | | | | | 2.↑ access to CTR | I | Somewhat unmet |
| | | | | | | 3. Awareness of risk | | Mostly met |
| | | | | | | 4.Skills ↓ transmission | | Mostly met |
| | | | | | | 5.↑ self esteem | All | Somewhat unmet |
| IDU | M | 15 - 39 | Wht | Non-His | unkn or Neg | 1.Awareness of risk | | Mostly met |
| | | | | | | 2.Knowledge - HIV info | | Mostly met |
| | | | | | | 3.↑ risk reduction | Ox | Somewhat unmet |
| | | | | | | 4.↑ Norms | All | Mostly unmet |
| | | | | | | 5.↑ access to CTR | All | Somewhat unmet |
| HET | F | 15 - 29 | Wht | Non-His | unkn or Neg | 1.Awareness of risk | Sag | Mostly met |
| | | | | | | 2.Knowledge of status | Ox, Sag | Somewhat unmet |
| | | | | | | 3.↑ self esteem | W, Kx, L, An, Ox, Sag | Mostly unmet |
| | | | | | | 4.↑ access to CTR | All | Unmet |
| | | | | | | 5.↑ risk reduction | Sag | Mostly met |
| IDU | M | 15 - 29 | Blk/ AfAm And/or | Hispanic | unkn or Neg | 1.Awareness of risk | All | Unmet |
| | | | | | | 2.Knowledge - HIV info | All | Unmet |
| | | | | | | 3.↑ risk reduction | All | Unmet |
| | | | | | | 4.↑ Norms | All | Unmet |
| | | | | | | 5.↑ access to CTR | All | Unmet |
| | | | | | | 6. Culturally appropriate | All | Unmet |
| MSM | M | 15 - 29 | Blk/ AfAm And/or | Hispanic | unkn or Neg | 1.Knowledge of status | All | Unmet |
| | | | | | | 2.Awareness of risk | All | Unmet |
| | | | | | | 3. ↑ access to CTR | All | Unmet |
| | | | | | | 4.Skills ↓ transmission | All | Unmet |
| | | | | | | 5.↑ self esteem | All | Unmet |
| | | | | | | 6.Culturally appropriate | All | Unmet |

MSM = Males who have Unsafe Sex with Males
IDU = Injection Drug Users who Share Needles and Injection Equipment
HET = Heterosexuals who have Unsafe Sex

Non-His=Non-Hispanic
Wht= White
Blk/AfAm=Black/African American
unkn= Unknown
Neg= Negative
↑= Increase
↓= Decrease

## GAP ANALYSIS: SOUTHERN REGION (Cumberland (Cumb) and York (Yk) Counties)

| *Behavior* | *Gen-der* | *Age* | *Race* | *Ethnicity* | *HIV Status* | **CRITICAL NEEDS (ABBREVIATED)** **For a detailed list of needs see "Critical HIV Prevention Needs for Prioritized Populations" for each region in the 2003 Update** | **TOTAL UNMET NEEDS ~ Gaps in Services** **List Counties** | **OVERALL ESTIMATE OF NEED FOR REGION** (met, mostly met, somewhat unmet, unmet) |
|---|---|---|---|---|---|---|---|---|
| MSM | M | 15-24 | Wht | Non-His | unkn or Neg | 1.Knowledge of status | | Mostly met |
| | | | | | | 2.↑ access to CTR | Yk, Cumb | Unmet |
| | | | | | | 3. Awareness of risk | | Somewhat unmet |
| | | | | | | 4.Skills ↓ transmission | | Somewhat unmet |
| | | | | | | 5.↑ self esteem | Yk, Cumb | Unmet |
| MSM | M | 25-39 | Wht | Non-His | unkn or Neg | 1.Knowledge of status | | |
| | | | | | | 2.↑ access to CTR | | |
| | | | | | | 3. Awareness of risk | | |
| | | | | | | 4.Skills ↓ transmission | | |
| | | | | | | 5.↑ self esteem | | |
| IDU | M | 18-40 | Wht | Non-His | unkn or Neg | 1.Awareness of risk | Yk | Somewhat unmet |
| | | | | | | 2.Knowledge - HIV info | Yk | Somewhat unmet |
| | | | | | | 3.↑ risk reduction | Yk | Somewhat unmet |
| | | | | | | 4.↑ Norms | Yk | Unmet |
| | | | | | | 5.↑ access to CTR | Yk, Cumb | Unmet |
| IDU | F | 18-40 | Wht | Non-His | unkn or Neg | 1.Awareness of risk | | |
| | | | | | | 2.Knowledge - HIV info | | |
| | | | | | | 3.↑ risk reduction | | |
| | | | | | | 4.↑ Norms | | |
| | | | | | | 5.↑ access to CTR | | |
| IDU | M | 18-40 | | White & Black Hispanic | unkn or Neg | 1.Awareness of risk | | Unmet |
| | | | | | | 2.Knowledge - HIV info | | Unmet |
| | | | | | | 3.↑ risk reduction | | Unmet |
| | | | | | | 4.↑ Norms | | Unmet |
| | | | | | | 5.↑ access to CTR | | Unmet |
| | | | | | | 6. Culturally appropriate | | Unmet |
| HET | F | 13-40 | All | All | unkn or Neg | 1.Awareness of risk | | Mostly met |
| | | | | | | 2.Knowledge of status | | Mostly met |
| | | | | | | 3.↑ self esteem | | Somewhat unmet |
| | | | | | | 4.↑ access to CTR | Yk, Cumb | Unmet |
| | | | | | | 5.↑ risk reduction | | Somewhat unmet |
| HET | M | 13-40 | Blk/ AfAm | All | unkn or Neg | 1.Awareness of risk | Yk, Cumb | Unmet |
| | | | | | | 2.Knowledge of status | Yk, Cumb | Unmet |
| | | | | | | 3.↑ self esteem | Yk, Cumb | Unmet |
| | | | | | | 4.↑ access to CTR | Yk, Cumb | Unmet |
| | | | | | | 5.↑ risk reduction | Yk, Cumb | Unmet |
| | | | | | | 6.ID risk behavior | Yk, Cumb | Unmet |

MSM = Males who have Unsafe Sex with Males
IDU = Injection Drug Users who Share Needles and Injection Equipment
HET = Heterosexuals who have Unsafe Sex

Non-His=Non-Hispanic
Wht= White
Blk/AfAm=Black/African American

unkn= Unknown
Neg= Negative
↑= increase ↓= decrease

# GAP ANALYSIS HIGHLIGHTS
# 2003

- The descriptions available made it difficult to discover various components of many of the interventions therefore, the Gap Analysis Committee made assumptions when analyzing the information.
- Most interventions did not focus on increasing self esteem and self efficacy so this was listed as an unmet, or somewhat met need.
- CTR was the only intervention that was available throughout the State through sources other than those funded by the Bureau of Health (Family Planning, Rural Health Centers, private doctors, etc.). Other interventions funded through non-BOH sources were not targeted at HIV prevention although this may be a component of the service.
- There are no HIV prevention interventions targeted specifically to African Americans/Blacks or Hispanics that are culturally and linguistically appropriate.
- No needs were listed as being completely met due to various factors including the large geographic area, available staff and funding.
- Sufficient Outreach interventions providing information about HIV transmission for IDU is lacking in all regions.
- There are no BOH funded interventions for IDU in York County.

**Non-Discrimination Notice**

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 1981, 2000 et seq.) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), the Age Discrimination Act of 1975, as amended (42 U.S.C. § 6101 et seq.), Title II of the Americans with Disabilities Act of 1990 (42 U.S.C. § 12131 et seq.), and Title IX of the Education Amendments of 1972, (34 C.F.R. Parts 100, 104, 106 and 110), the Maine Department of Human Services does not discriminate on the basis of sex, race, color, national origin, disability or age in admission or access to or treatment or employment in its programs and activities. Kim Pierce, Civil Rights Compliance Coordinator, has been designated to coordinate our efforts to comply with the U.S. Department of Health and Human Services regulations (45 C.F.R. Parts 80, 84, and 91), the Department of Justice regulations (28 C.F.R. Part 35), and the U.S. Department of Education regulations (34 C.F.R. Part 106) implementing these Federal laws. Inquiries concerning the application of these regulations and our grievance procedures for resolution of complaints alleging discrimination may be referred to Kim Pierce at 221 State Street, Augusta, Maine 04333, Telephone number: (207) 287-3488 (Voice) or 1-800-332-1003 (TDD), or the Assistant Secretary of the Office of Civil Rights of the applicable department (e.g. the Department of Education), Washington, D.C.

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