

Chapter Four

The Gap Analysis

What is a Gap Analysis?

It is a description of the unmet HIV prevention needs, or service gaps, for the high-risk populations defined in the epidemiologic profile (Chapter One). The unmet needs are identified by a comparison of the needs assessment (Chapter Three) and resource inventory (Chapter Two). In other words, the gap analysis shows the difference between what is available and what is needed. The gap analysis does not quantify service gaps in terms of the number of people from a specific target population who are in need of HIV prevention services. Rather, it identifies unmet service needs for specific populations and indicates the relative size of the service gap for different populations.

What is its Significance to Community Planning?

This information is then reviewed and analyzed in order to determine met and unmet service needs among specific target populations as well as for the overall project area. The resulting information and analysis may then be used to establish priorities regarding service needs and to develop strategies for addressing them. The gap analysis can also help community planning groups identify which populations are being failed by the current HIV prevention system and which should be receiving services or what those services should look like in order to improve HIV prevention for specific target populations.

Definitions

Met/Unmet need: “A met need within a specific target population for HIV prevention services is one that is currently being addressed through existing HIV prevention resources. These resources are available to, appropriate for, and accessible to that population (as determined through the community services assessment of prevention needs). For example, a project area with an organization for African American gay, bisexual, lesbian, and transgender individuals may meet the HIV/AIDS education needs of African American men who have sex with men through its outreach, public information, and group counseling efforts.

An unmet need is a requirement for HIV prevention services within a specific target population that is not currently being addressed through existing HIV prevention services and activities, either because no services are available or because available services are either inappropriate for or inaccessible to the target population. For example, a project area lacking Spanish-language HIV counseling and testing services will not meet the needs of Latinos with limited-English proficiency.”¹

¹ 2003 – 2008 *HIV Prevention Community Planning Guidance*, Appendix D, Glossary of HIV Prevention Terms. Centers for Disease Control and Prevention.

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Introduction

In mid-2008, Coloradans Working Together: Preventing HIV/AIDS began work on the revised 2007-2009 Colorado Comprehensive Plan for HIV Prevention Gap Analysis. To complete the Gap Analysis for 2008, staff from the Administration Program of the Colorado Department of Public Health and Environment (CDPHE), a Program consisting of staff from Research and Evaluation, and Planning, convened to plan for how to conduct this important Chapter of the Comprehensive Plan. Through meetings with key staff, it was decided that this version of the Gap Analysis would go further than previous Gap Analyses, and not

just look at unmet needs in terms of region or resources, but assess the degree to which available services address factors associated with increased HIV risk as these were described in Appendix A of Chapter Two, the resource inventory.

The most recent needs assessments have shown that there are a number of “factors” that place individuals and groups at increased risk of acquiring or transmitting HIV and this gap analysis will also address whether services that are being provided in the State are addressing such factors.

Unmet HIV Prevention Needs of Men Who Have Sex With Men

1. Unmet Needs for Rural Men Who Have Sex With Men (MSM)

Based on our analysis of need, demand, priority, barriers, suitability, and availability of HIV interventions in rural areas, the following unmet needs appear to be most pressing for men who have sex with men:

- a. Geographic availability of HIV prevention interventions is a major issue. Currently, availability is concentrated in a few areas – sometimes related to epidemiology, sometimes not – leaving very large areas of the state with little or no onsite interventions.
- b. Counseling, testing, and referral is poorly marketed in rural Colorado. The sites are marginally accessible, at best. The capacity for alternative forms of testing – social network testing, outreach testing, integrated with other interventions – is also very low, but these alternative forms are more promising to reach rural MSM who are infected but are unaware of their serostatus.
- c. For rural MSM of all races and ethnicities, there is a need for financially stable organizations that are competent to serve, and willing to openly advocate for MSM.
- d. There needs to be continued support/TA/BC to increase ManReach’s (a Rural MSM intervention) capacity to engage rural men in areas outside metro Denver.
- e. Much of the research concerning social networks among MSM has been conducted among urban men who identify as gay. Rural MSM social networks are very different, especially among those who do not gay-identify; for instance, they tend to be more linear (i.e., person A knows B, B knows C, but A does not know C directly). For providers to use these social networks to deliver interventions, more research and capacity building will be essential.
- f. Substance abuse treatment is not widely available in rural Colorado, particularly inpatient treatment. Gay-friendly treatment that takes a harm reduction approach is rarer, and competent services for MSM/intravenous drug users (IDU) are almost certainly unavailable. Given its rural popularity, treatment for methamphetamine is urgently needed.
- g. Providers of HIV-related care in rural areas need state-of-the-art prevention skills and materials tailored to the needs of MSM.

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- h. To meet the needs of young rural MSM, providers will require extensive new expertise to enable them to effectively use youth networks and overcome deep-rooted shame.
 - i. More HIV prevention interventions are needed for rural MSM with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by rural agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by rural HIV prevention providers who are competent to serve MSM with disabilities. Rural MSM with disabilities are also extremely difficult to locate in some cases.
 - j. Perceived and actual breeches of confidentiality discourage rural residents from seeking out HIV prevention interventions. Providers of HIV care and prevention must be assisted in addressing this serious barrier.
 - k. Providers of HIV prevention for MSM should never assume that their male clients are not also having sex with women. Both these men and their female partners need effective HIV prevention interventions.
 - l. There is a need for a strong Community Level Intervention (CLI) and Health Communication/Public Information (HC/PI) for Rural MSM.
 - m. HIV prevention among MSM is often approached in isolation rather than addressing issues affecting MSM in a more holistic, integrated fashion. 3. Gay men participating in focus groups have called for the meaningful involvement of gay/bi men in planning, implementing, and evaluating interventions targeting gay men.
- 2. Unmet Needs for Urban Men Who Have Sex With Men**
- Based on our analysis of need, demand, priority, barriers, suitability, and availability of HIV interventions in urban areas, the following unmet needs appear to be most pressing for men who have sex with men:
- a. Overall, the urban HIV prevention system for MSM appears to be weakest in providing counseling testing and referral (CTR) (specifically, social network testing), individual level intervention (ILI), and public information (PI). Funding from alternative sources and strategic capacity building will be needed to fully correct these weaknesses. There is also a need for a more holistic, integrated approach to HIV prevention, and for meaningful involvement of gay/bi men in planning, implementing, and evaluating interventions targeting gay men.
 - b. Structural and community interventions are urgently needed to confront hopelessness and promote healthy expectations of the future among urban MSM. These interventions should take a holistic, integrated approach to MSM health, including other STDs, community building, creating new prevention messages in light of prevention fatigue, addressing stigma, meeting basic needs, substance use, and mental health issues (with special emphasis on depression and the dynamics of relationships).
 - c. A harm reduction approach should be more completely integrated into all interventions for urban MSM.
 - d. There is an urgent need for gay-specific substance abuse prevention and treatment tailored for MSM and taking a harm reduction approach.
 - e. For MSM who are in the early stages of the coming-out process, HIV prevention providers should better utilize the gay community to reach out to those who are not yet gay identifying.
 - f. Providers of HIV-related care need state-of-the-art prevention skills and materials tailored to the needs of MSM.
 - g. There is a need for financially stable organizations run by and for African Americans and Latinos who will openly

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- and effectively advocate for the needs of their community members who are MSM.
- h. Agencies who serve injectors must build their competency in dealing with the unique issues of MSM/IDU.
 - i. HIV prevention programs for young MSM must build their competency to deal with the unique needs of this generation (especially the fluidity of their definition of sexual orientation and their need for open discussions that dissipate shame).
 - j. Transgender persons are systematically excluded from many gay venues and face many barriers when seeking assistance from programs that are segregated by sex. Such programs must be re-thought for these clients, and must directly confront the serious mental health and isolation issues that transgender persons face on a daily basis.
 - k. More HIV prevention interventions are needed for urban MSM with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by urban agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by urban HIV prevention providers who are competent to serve MSM with disabilities.
- l. Providers of HIV prevention for MSM should never assume that their male clients are not also having sex with women. Both these men and their female partners need effective HIV prevention interventions.
 - m. Perceived and actual breaches of confidentiality discourage urban residents (especially non-gay identifying MSM) from seeking out HIV prevention interventions. Providers of HIV care and prevention must be assisted in addressing this serious barrier.
 - n. There is a need for a strong CLI and HC/PI for Urban MSM. Histories of STI among MSM recently testing HIV positive would suggest the need for counseling/other interventions for such MSM after their diagnosis with an STI (i.e., before they become HIV infected).

Unmet HIV Prevention Needs of People at Risk through Sex with Partners of the Opposite Sex

1. Unmet Needs for Rural People at risk through High Risk Heterosexual contact (HRH)

Based on our analysis of need, demand, priority, barriers, suitability, and availability of HIV interventions in rural areas, the following unmet needs appear to be most pressing for high risk heterosexuals:

- a. Geographic availability of HIV prevention interventions is a major issue. Currently, availability is concentrated in a few areas – sometimes related to epidemiology, sometimes not – leaving very large areas of the state with little or no onsite interventions. Overall, the rural HIV prevention system for POS appears to be weakest in providing ILI and CLI, with additional weaknesses in terms of group level intervention (GLI) and CTR. The Colorado HIV/AIDS Prevention Grant Program (CHAPP) has funded interventions in Rural areas that have minimized the gaps in interventions for men and women at risk in rural areas, however gaps still exist.
- b. Counseling, testing, and referral is very poorly marketed in rural Colorado. The sites are marginally accessible, at best. The capacity for alternative forms of testing – social network testing, outreach testing, integrated with other interventions – is also very low, but these alternative forms are more promising to reach rural HRH who are

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- infected but are unaware of their serostatus.
- c. Female partners of MSM and IDU need to be served both directly and indirectly. As a direct service, more providers should design and implement services uniquely tailored to the needs of these women. Second, as an indirect service, all HIV prevention providers with MSM and/or male IDU clients should address the manner in which these male clients are placing their female partners at risk.
 - d. Women at risk of, or living with, HIV often have multiple needs, and their HIV prevention providers should be prepared to provide or link clients to a comprehensive range of services (such as housing, health care, child care, and women-friendly substance abuse treatment).
 - e. In light of the vulnerability of survivors of domestic and sexual abuse, programs that have systematic intake procedures should assess current and past abuse, and better linkages should be made to domestic violence programs and programs that address sexual abuse.
 - f. Providers of HIV-related care in rural areas need state-of-the-art prevention skills and materials tailored to the needs of HRH.
 - g. More HIV prevention programs should be designed to effectively deal with the risky behavior of men who have sex with women. More research and better service models are needed, especially in regard to rural men.
 - h. Programs should be sensitive to men who identify as heterosexual, or who prefer to describe themselves as heterosexual due to the stigma generated by homophobia. Some MSM will only access programs that are either “orientation neutral” or that are at least ostensibly for heterosexual men.
 - i. Transgender persons are systematically excluded from many venues and face many barriers when seeking assistance from programs that are segregated by sex. Such programs must be re-thought for these clients, and must directly confront the serious mental health and isolation issues that transgender persons face on a daily basis.
 - j. More HIV prevention interventions are needed for rural people with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by rural agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by rural HIV prevention providers who are competent to serve HRH with disabilities.
 - k. Perceived and actual breaches of confidentiality discourage rural residents from seeking out HIV prevention interventions. Providers of HIV care and prevention must be assisted in addressing this serious barrier.
 - l. To address the issues of rural women at high risk and their male sexual partners, agencies that deliver services related to domestic violence and substance use are underutilized as potential settings and providers of HIV prevention.
 - m. Structural and community interventions are needed to address the erroneous belief that HIV is exclusively a gay disease and the barriers imposed by the often harsh rural political environment.
 - n. Affordable and accessible mental health and substance abuse services for at-risk, Rural men and women are lacking. These services are greatly needed as a method of HIV prevention.
 - o. Rural high risk heterosexuals are in need of CLI, HC/PI, Outreach, ILI and GLI. As a group, Rural heterosexual men and women are one of the most underserved populations in Colorado in terms of HIV prevention. Additionally, there is more information needed to address the needs of HRH in rural areas. Most available information from needs assessments are Denver-centric.

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2. Unmet Needs for Urban People at risk through High Risk Heterosexual contact:

Based on our analysis of need, demand, priority, barriers, suitability, and availability of HIV interventions in urban areas, the following unmet needs appear to be most pressing high risk heterosexuals:

- a. Overall, the urban HIV prevention system for HRH appears to be weakest in providing ILI and CLI, with additional weaknesses regarding CTR. Funding from alternative sources and strategic capacity building will be needed to fully correct these weaknesses.
- b. Female partners of MSM and IDU need to be served both directly and indirectly. As a direct service, more providers should design and implement services uniquely tailored to the needs of these women. Second, as an indirect service, all HIV prevention providers with MSM and/or male IDU clients should address the manner in which these male clients are placing their female partners at risk.
- c. Women at risk or, of living with, HIV often have multiple needs, and their HIV prevention providers should be prepared to provide or seamlessly refer to a comprehensive range of services (such as housing, health care, child care, and women-friendly substance abuse treatment).
- d. More HIV prevention programs should be designed to effectively deal with the risky behavior of men who have sex with women. More research and better service models are needed.
- e. Programs should be sensitive to men who identify as heterosexual, or who prefer to describe themselves as heterosexual due to the stigma generated by homophobia. Some MSM will only access programs that are either “orientation neutral” or that are at least ostensibly for heterosexual men.
- f. In light of the vulnerability of survivors of domestic and sexual abuse, programs that have systematic intake procedures should assess current and past abuse, and better linkages should be made to domestic violence programs and programs that address sexual abuse.
- g. Structural and community interventions are urgently needed to address the stigma faced by commercial sex workers, who are too often seen only as vectors of disease, although they are more often the victim than the victimizer.
- h. Transgender persons are systematically excluded from many venues and face many barriers when seeking assistance from programs that are segregated by sex. Such programs must be re-thought for these clients, and must directly confront the serious mental health and isolation issues that transgender persons face daily.
- i. More HIV prevention interventions are needed for urban people with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by urban agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by urban HIV prevention providers who are competent to serve HRH with disabilities.
- j. Urban focus group participants have called for increased public information about HIV as well as the need to address the issue of HIV-related stigma.

Unmet HIV Prevention Needs for Injectors

1. Unmet Needs for Rural Injectors

Based on our analysis of case need, demand, priority, barriers, suitability, and availability

of HIV interventions in rural areas, the following unmet needs appear to be most pressing for injectors:

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- a. Geographic availability of HIV prevention interventions is a major issue. Currently, availability is concentrated in some areas – sometimes related to epidemiology, sometimes not – leaving very large areas of the state with little or no onsite interventions. Overall, the rural HIV prevention system for injectors appears to be weakest in providing CLI, with additional weaknesses in terms of GLI. Funding from alternative sources and strategic capacity building will be needed to fully correct these weaknesses.
- b. Counseling, testing, and referral is very poorly marketed in rural Colorado. The sites are marginally accessible, at best. The capacity for alternative forms of testing – social network testing, outreach testing, integrated with other interventions – is also very low, but these alternative forms are more promising to reach rural injectors who are infected but are unaware of their serostatus.
- c. Enacting and enforcing restrictive laws are not a sound, proven public health approach to preventing HIV among injectors. As voiced by the National Institutes of Health (NIH) consensus statement, needle exchange programs should be implemented at once.
- d. Female partners of MSM and IDU need to be served both directly and indirectly. As a direct service, more providers should design and implement services uniquely tailored to the needs of these women. Second, as an indirect service, all HIV prevention providers with MSM and/or male IDU clients should address the manner in which these male clients are placing their female partners at risk.
- e. Providers of HIV prevention interventions for injectors must effectively address sexual risks as well as injection-related risks. Programs should recognize that sexual activity varies over the duration of drug use and the drug of choice – for instance, some drugs increase the desire for sex for the first few months of use, but inhibit sex in the long run.
- f. All programs that serve injectors – especially providers of HIV prevention and drug treatment – should take a harm reduction approach, honoring basic civil rights and human dignity.
- g. Effective, confidential, humane substance abuse treatment on demand is urgently needed in rural Colorado. Given its rural popularity, treatment for methamphetamine is urgently needed.
- h. Structural and community interventions are urgently needed to address the repressive stigma faced by rural drug users.
- i. More HIV prevention interventions are needed for rural people with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by rural agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by rural HIV prevention providers who are competent to serve injectors with disabilities.
- j. Female partners of MSM and IDU need to be served both directly and indirectly. As a direct service, more providers should design and implement services uniquely tailored to the needs of these women. Second, as an indirect service, all HIV prevention providers with MSM and/or male IDU clients should address the manner in which these male clients are placing their female partners at risk.
- k. Transgender persons are systematically excluded from many venues and face many barriers when seeking assistance from programs that are segregated by sex. Such programs must be re-thought for these clients, and must directly confront the serious mental health and isolation issues that transgender persons face on a daily basis.
- l. Much of the research concerning social networks among injectors has been

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conducted among urban residents. Rural injector social networks are very different; for instance, they tend to be more linear (i.e., person A knows B, B knows C, but A does not know C directly). For providers to use these social networks to deliver interventions, more research and capacity building will be essential.

- m. Providers of HIV-related care in rural areas need state-of-the-art prevention skills and materials tailored to the needs of injectors.
- n. To address the issues of rural women at high risk and their male partners, agencies that deliver services related to domestic violence and substance use are underutilized as potential settings and providers of HIV prevention.
- o. Rural organizations who have earned their credibility among rural Latinos and Native Americans need capacity building and advocacy to fulfill their essential role in addressing sensitive sexual and drug issues among rural injectors of color.
- p. Providers of HIV, mental health, and substance abuse services need increased capacity to deal effectively with all three issues concurrently, in terms of both prevention and treatment/care.

2. Unmet Needs for Urban Injectors

Based on our analysis of need, demand, priority, barriers, suitability, and availability of HIV interventions in urban areas, the following unmet needs appear to be most pressing for injectors:

- a. Enacting and enforcing restrictive laws are not a sound, proven public health approach to preventing HIV among injectors. As voiced by the NIH consensus statement, needle exchange programs should be implemented at once.
- b. Providers of HIV prevention interventions for injectors must effectively address sexual risks as well as injection-related risks. Programs should recognize that sexual activity

varies over the duration of drug use and the drug of choice – some drugs increase the desire for sex for the first few months of use, but inhibit sex in the long run, for instance.

- c. All programs that serve injectors – especially providers of HIV prevention and drug treatment – should take a harm reduction approach, honoring basic civil rights and human dignity.
- d. Effective, confidential, humane substance abuse treatment on demand is urgently needed in urban Colorado.
- e. Structural and community interventions are urgently needed to address the repressive stigma faced by urban drug users.
- f. Female partners of MSM and IDU need to be served both directly and indirectly. As a direct service, more providers should design and implement services uniquely tailored to the needs of these women. Second, as an indirect service, all HIV prevention providers with MSM and/or male IDU clients should address the manner in which these male clients are placing their female partners at risk.
- g. More HIV prevention interventions are needed for urban people with disabilities. For this to be accomplished, there will need to be a combination of effective HIV interventions delivered by urban agencies serving the disabled (such as centers for independent living and mental health centers) in partnership with HIV interventions delivered by urban HIV prevention providers who are competent to serve injectors with disabilities.
- h. Transgender persons are systematically excluded from many venues and face many barriers when seeking assistance from programs that are segregated by sex. Such programs must be re-thought for these clients, and must directly confront the serious mental health and isolation issues that transgender persons face on a daily basis.
- i. Providers of HIV, mental health, and substance abuse services need increased

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capacity to deal effectively with all three issues concurrently, in terms of both

prevention and treatment/care.

Limitations of Gap Analysis

CWT acknowledges that the last needs assessment conducted with men who have sex with men (MSM) was primarily Denver-metro focused. Therefore, the information presented in this gap analysis for MSM will further describe the gap between urban MSM needs and services and those for rural MSM. In the near future, the STI/HIV section of CDPHE will be utilizing funds to address this information gap, and an addendum to this Chapter will be available in the near future.