Prevention Needs Assessment Report 2022

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Acknowledgments

Thank you to the 2,038 Connecticut residents who completed the survey. Their collective responses offer insight into the HIV, HCV, STD, and SUD epidemics and guidance for improving care and prevention services in Connecticut. Thank you to Luis Diaz-Matos for leading and overseeing all Prevention Needs Assessment efforts. Thank you to RDE Systems for developing the survey tool, and to Katie Herting for compiling the results in this report.

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Glossary of Terms

Acronym	Definition
CT DPH	Connecticut Department of Public Health
FPL	Federal Poverty Level
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
MAT	Medication Assisted Therapy
MOUD	Medications for Opioid Use Disorder
PCP	Primary Care Provider
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
Transgender Man	A man who was assigned female at birth but identifies as a man.
Transgender or Non-Binary	A combined gender category used for disparity evaluations containing both transgender respondents (those whose gender identity differs from what is typically associated with their sex assigned at birth) or respondents who identify as non-binary.
Transgender Woman	A woman who was assigned male at birth but identifies as a woman.

List of Tables and Figures

Executive Summary

There were 2,038 Connecticut residents who completed the Prevention Needs Assessment (PNA) survey. The PNA collected information about respondents' demographics, HIV testing history, pre and post-exposure prophylaxis awareness and use, STD and hepatitis C (HCV) testing and treatment, substance use, mental health, sexual practices, marketing of services, and opportunities for improvement in prevention services.

The survey was administered both online and in person. Upon completion of the survey, participants were offered a $10 Walmart gift card. The data collection spanned from October 31, 2022, to December 31, 2022.

Forty-five percent (35%) of respondents identified as men, 36% as women, 12% as transgender women, 5% as transgender men, and 2% as non-binary. When looking at respondents by age, 3% were 10-19 years old, 38% were 20-29 years old, 37% were 30-39 years old, 12% were 40-49 years old, 7% were 50-59 years old, and 3% were 60+ years old.

Respondents identified as the following races and ethnicities: White (43%), Black (25%), Hispanic (20%), Native Hawaiian or Pacific Islander (3%), American Indian or Alaska Native (3%), Asian (2%), more than one race (4%), and some other race (1%). Respondents were asked about their sexual orientation. Sixty-one percent (61%) identified as heterosexual, 14% as bisexual, 10% as gay, 7% as asexual, 5% as lesbian, 1% as pansexual, 1% as queer, and 1% as questioning.

Annual income was assessed among all respondents. Twenty-two percent (22%) earned $13,590 or less per year, which equates to 100% less of the Federal Poverty Level (FPL). Black, Hispanic, and respondents aged 50+ were more likely to have an income at or below 100% FPL. Forty-six percent (46%) of respondents reported ever receiving money or goods in exchange for sex. Respondents who identified as lesbian, transgender or non-binary, gay, bisexual, or 20-39 years old were more likely to have engaged in transactional sex.

Prevention programs strive to keep the wait time for services less than 2 weeks. Forty percent (40%) of respondents reported waiting 2 weeks or less to receive services, 18% waited 3 weeks, 12% waited 1 month, and 7% waited more than one month. Over half of respondents (53%) were very or extremely satisfied with the prevention services they received. Only 2% were not satisfied.

Respondents were asked about HIV testing they had received. The overwhelming majority had ever been tested for HIV (81%), with only 16% never being tested and 2% not sure if they had ever been tested. Among those who had been tested, at their most recent HIV test, 73% tested negative, 26% tested positive, and 1% didn't know their results. Thirty-four percent (34%) of respondents reported ever being denied an HIV test. The following respondents were more likely to have ever been denied an HIV test: Bisexual, asexual, lesbian, gay, Hispanic, transgender, or non-binary, and those aged 20-39 years old.

When asked about pre-exposure prophylaxis (PrEP), 81% of respondents had heard of it and 24% were currently taking it. Lesbian, bisexual, gay, transgender, or non-binary, and White respondents were more likely to have heard of PrEP. Among respondents who were aware of PrEP but did not take it, the number one reason for not taking it was they didn't think they needed it. Among

respondents who were aware of PrEP but couldn't get it, the top two barriers to accessing PrEP were "I can't use my insurance because of privacy concerns," and, "I'm afraid to talk to my doctor about it." The number one reason respondents stopped taking PrEP was "Too many labs and/or doctor's visits."

Seventy-six percent (76%) of respondents had heard of post-exposure prophylaxis (PEP), with 28% having used PEP. A clinic or health center was the most frequently utilized facility where PEP was accessed (42%). The number one barrier to accessing PEP was not feeling comfortable asking for it.

When asked about condom use, 27% of respondents stated they always used one, and 12% never used one. The top three reasons these respondents didn't use a condom were because they were having sex with their regular partner (42%), they were having sex with someone they know (26%), and they already had sex with that person without a condom (20%).

Over half of respondents reported being tested for STDs in the past 12 months (61%), while 34% reported not being tested. About a third of respondents (31%) reported being tested at a clinic or health center. All respondents were asked what would make it more likely for them to get an STD test. Almost half of respondents (48%) said they would be more likely to be tested if it were free.

A new Viral Hepatitis Testing Law (HB6733) became effective in Connecticut on October 1, 2023, that requires hepatitis C (HCV) testing among certain populations. Sixty-eight percent (68%) of respondents reported ever being tested for HCV. Lesbian, and transgender or non-binary respondents were more likely to have ever been tested. Among respondents who had ever been tested for HCV, 54% had ever tested positive, with 38% testing positive within the past 12 months. Among respondents who tested positive for HCV, 85% had received treatment.

When asked about the number of days over the past month they had felt stressed, depressed, hopeless, isolated, anxious, or had other emotional problems, only 11% reported feeling like this for all 30 days. Thirty-five percent of respondents reported feeling suicidal within the past 12 months.

Forty-five percent (45%) of respondents reported not using any drugs in the last 12 months. Half of respondents reported ever injecting drugs, with 34% injecting drugs within the past 12 months. Seventy-four percent (74%) of respondents who had ever injected drugs reported also sharing needles or works. Among all respondents, 48% reported that they have wanted to stop using drugs, or someone close to them asked them to stop using drugs.

All respondents were asked about ways prevention services could be improved. More education with the most frequently selected improvement opportunity for HIV, STD, and HCV prevention services. For substance use disorder, the number one improvement opportunity was increased access to substance use treatment.

Introduction

A cross-sectional survey design was employed to assess various aspects of HIV prevention needs among Connecticut residents. A total of 2,038 participants were included in the study. Recruitment methods included a combination of social media outreach and traditional methods. Inclusion criteria comprised individuals residing in Connecticut who may have received HIV Prevention Services.

The goals of the survey were to:

1. Identify gaps in prevention services.
2. Assess knowledge of PrEP and PEP.
3. Identify opportunities for improvement in service delivery.

The results of the survey will be used to inform Connecticut's Integrated HIV Prevention and Care Plan and to address disparities in PrEP and PEP awareness and use.

Methods

Survey Development

The 2022 Prevention Needs Assessment was developed by staff in the HIV Prevention Program at the Connecticut Department of Health (CT DPH) and members of the Connecticut HIV Planning Consortia Needs Assessment Project Committee. Information was collected about respondents' demographics, HIV testing history, pre and post-exposure prophylaxis awareness and use, STD and hepatitis C (HCV) testing and treatment, substance use, mental health, sexual practices, marketing of services, and opportunities for improvement in prevention services. The survey was modeled off of HIV needs assessments conducted by Nevada, Ohio, and San Diego.

The survey was available in both paper and electronic formats. The online survey tool was developed by RDE Systems and could be accessed by computers, smartphones, and tablets. The survey was translated into Spanish, and computer-generated audio was available in English and Spanish.

Survey Administration

The survey was administered both online and in-person to expand accessibility. Upon completion of the survey, participants were offered a $10 Walmart gift card. Gift cards were provided in person, or mailed to respondents.

Marketing of the survey included targeted ads on Facebook and posts on LinkedIn. Program staff were encouraged to share the links with their clients. In-person outreach also occurred outside of Walmart stores where participants could complete the survey on an iPad in real time.

The data collection spanned from October 31, 2022, to December 31, 2022. There were 2,038 respondents in total. Some survey questions incorporated skip logic, so n-values are indicated throughout the report.

Data Analysis

Data analysis was conducted using Microsoft Excel for initial data processing and organization. Subsequently, Power BI (Business Intelligence) was employed for in-depth analysis and visualization, facilitating a comprehensive exploration of the survey data. This combination of tools ensured a robust and insightful examination of the collected information, aiding in the identification of trends and patterns relevant to HIV prevention needs among the surveyed population.

Limitations

Despite the efforts made in conducting the study, it is essential to acknowledge several limitations that may influence the interpretation of the findings.

1. Sampling Bias
    - The use of social media and traditional outreach methods for participant recruitment may introduce sampling bias, as individuals not engaged in these channels might be underrepresented.

2. Self-Reported Data
    - The study relied on self-reported data, which can be subject to recall bias and social desirability bias. Participants might not have accurately remembered or disclosed certain information, leading to potential inaccuracies.

3. Generalizability
    - The study's findings may not be fully generalizable to the entire population, as participants were limited to Connecticut residents who may have received HIV Prevention Services. The regional focus could impact the broader applicability of the results.

4. Survey Instrument Limitations
    - The survey instrument, despite being carefully designed, may have limitations in capturing the complexity of certain variables. Some aspects of HIV prevention needs and mental health, for instance, might not have been fully captured by the selected survey questions.

5. Inclusion Criteria Challenges
    - The inclusion criteria specifying individuals who may have received HIV Prevention Services could introduce selection bias, as it might exclude those who could benefit from such services but have not yet accessed them.

6. Data Collection Period
    - The limited timeframe for data collection (October 31, 2022, to December 31, 2022) may not capture potential variations in HIV prevention needs and mental health status that could occur at different times of the year.

7. Survey Administration Method
    - The use of both online and in-person survey administration methods could introduce mode effects, potentially influencing participant responses differently based on the chosen mode.

8. Limited Mental Health Variables
    - While the study incorporated mental health variables, the scope might be limited. More comprehensive assessments could provide a more nuanced understanding of mental health factors related to HIV prevention needs.

9. Data Analysis Tools
    - The use of MS Excel and Power BI for data analysis, while effective, may not cover all advanced statistical techniques. This limitation may impact the depth of statistical analysis conducted on the collected data.

Results

Demographics

A total of 2,038 respondents completed the survey. Respondents were asked to identify some demographics about themselves. Many of these demographic variables were used to evaluate for disparities in the survey results.

Figure 1 below shows the distribution of respondents by gender.

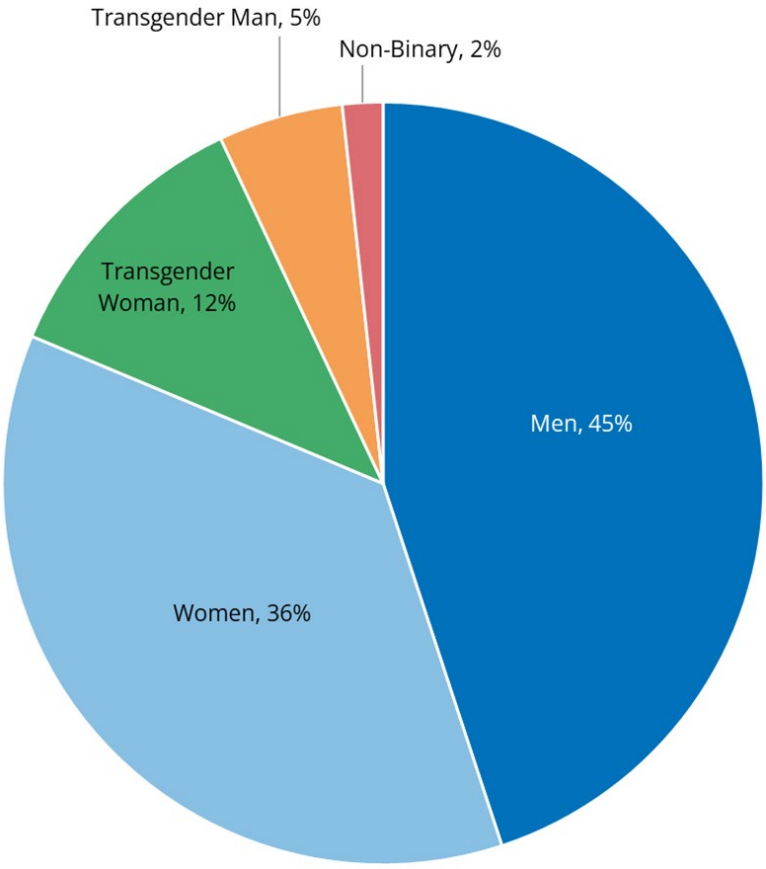

Figure 1. Gender among all respondents (N=2,038).

Slightly less than half of respondents identified as men (45%), thirty-six percent (36%) identified as women, about one quarter identified as transgender women (12%), five percent (5%) identified as transgender men, and only 2% identified as non-binary.

When looking at respondents by age (Figure 2), Three-quarters of respondents were between the ages of 20-29 years old (38%) or between the ages of 30-39 years old (37%). This was followed by respondents aged 40-49 years old (12%), aged 50-59 years old (7%), aged 60+ years old (3%), and those aged 10-19 years old (3%).

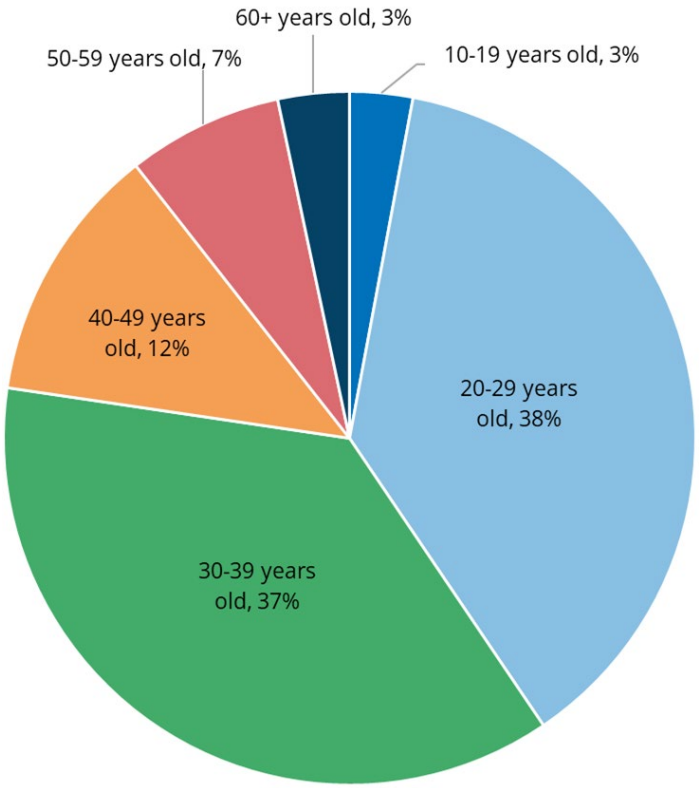

Figure 2. Age among all respondents (N=2,038)

All respondents were asked about their sexual orientation, which can be seen below in Figure 3.

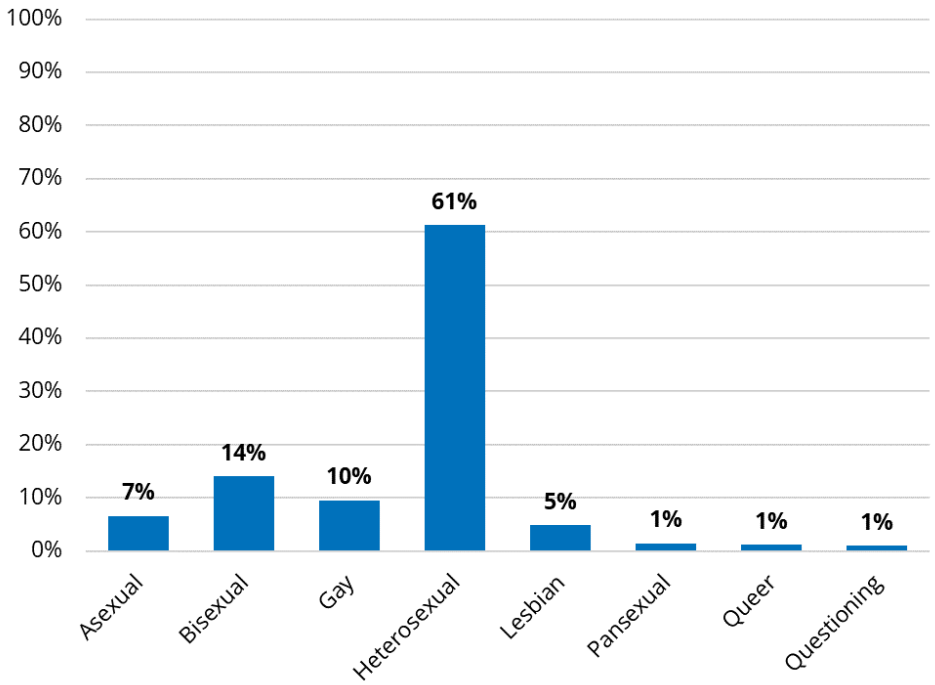

Figure 3. Sexual orientation among all respondents (N=2,038).

The majority of respondents identified as heterosexual (61%). About one quarter identified as bisexual (14%), followed by gay (10%), asexual (7%), and lesbian (5%). Respondents who identified as pansexual, queer, or questioning each only accounted for one percent (1%) of respondents.
When looking at respondents by race and ethnicity (Figure 4), those who identified as White accounted for forty-three percent (43%) of respondents. Black/African American individuals represented twenty-five percent (25%) of respondents, followed by Hispanic (20%), more than one race (4%), Native Hawaiian or Pacific Islander (3%), American Indian or Alaska Native (3%), Asian (2%), and some other race (1%).

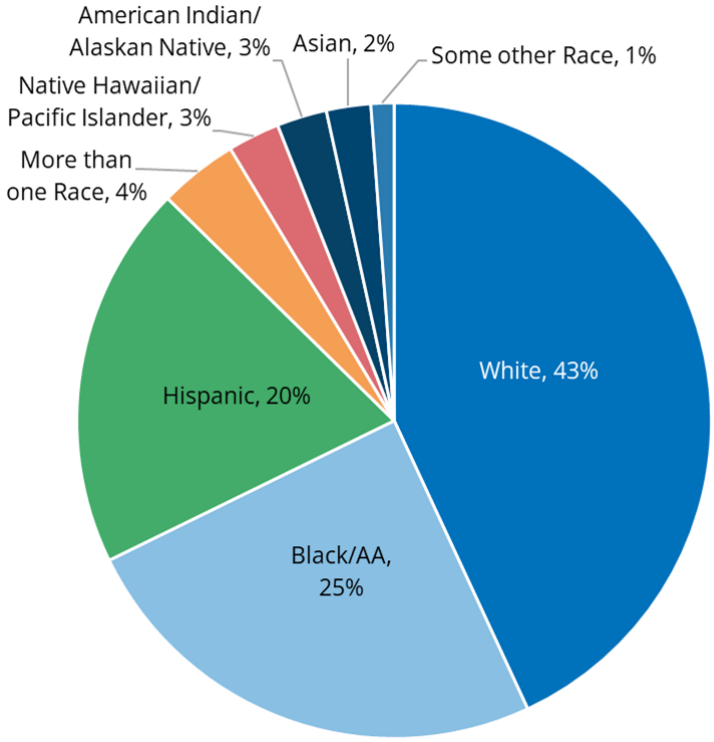

Figure 4. Race and ethnicity among all respondents (N=2,038).

Respondents' income was assessed using the 2022 Federal Poverty Guidelines for a household of one, outlined in Table 1 below.

Table 1. 2022 Federal Poverty Guidelines.

Income Amount	FPL %
$13,590 or less	0% - 100%
$13,591 - $20,384	101% -150%
$20,385 to $27,180	151% - 200%
$27,181 to $33,974	201% - 250%
$33,975 to $40,769	251% - 300%
$40,770 to $54,359	301% - 400%
$54,360 to $67,949	401% - 499%
$67,950 or more	500% +

Figure 5 displays income among all respondents. About one-quarter of respondents (22%) had an income less than or equal to $13,590 annually (0% - 100% FPL). The remaining seventy-eight percent (78%) of respondents had an income above $13,590 (101% FPL or greater).

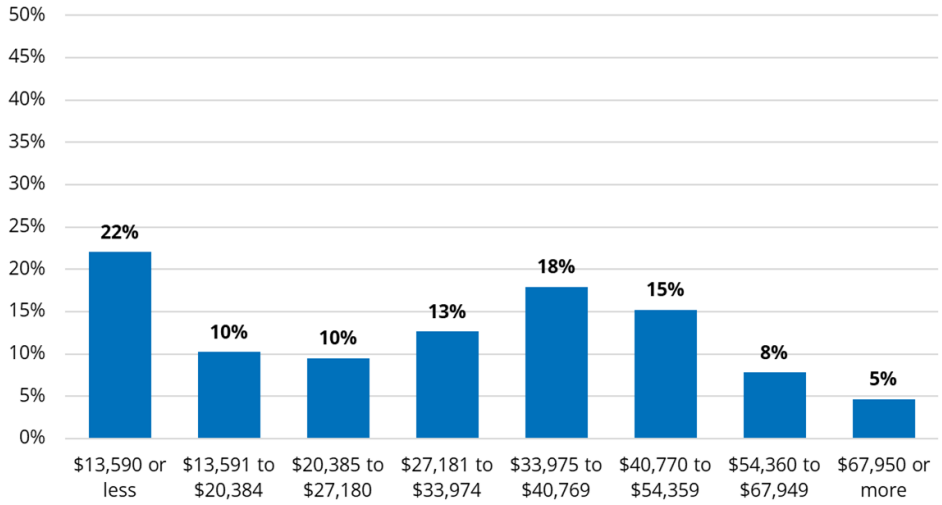

Figure 5. Income among all respondents (N=2,038).

Some disparities were identified when looking at income by sexual orientation, race and ethnicity, and gender (Figure 6). Respondents who identified as pansexual, queer, or questioning are included in the figure, however, their results were not considered in the disparity analysis due to their small population size.

The following populations were more likely to have an income at or below 100% of the Federal Poverty Level compared to all respondents (22%):

- Black respondents (29%, n=503)
- Hispanic respondents (30%, n=399)
- Respondents aged 50+ (54%, n=216)

The following populations were more likely to have an income above 100% of the Federal Poverty Level compared to all respondents (78%):

- Transgender or Non-Binary respondents (94%, n=381)
- Gay respondents (94%, n=195)
- Lesbian respondents (92%, n=99)
- Respondents aged 20-39 (86%, n=766)

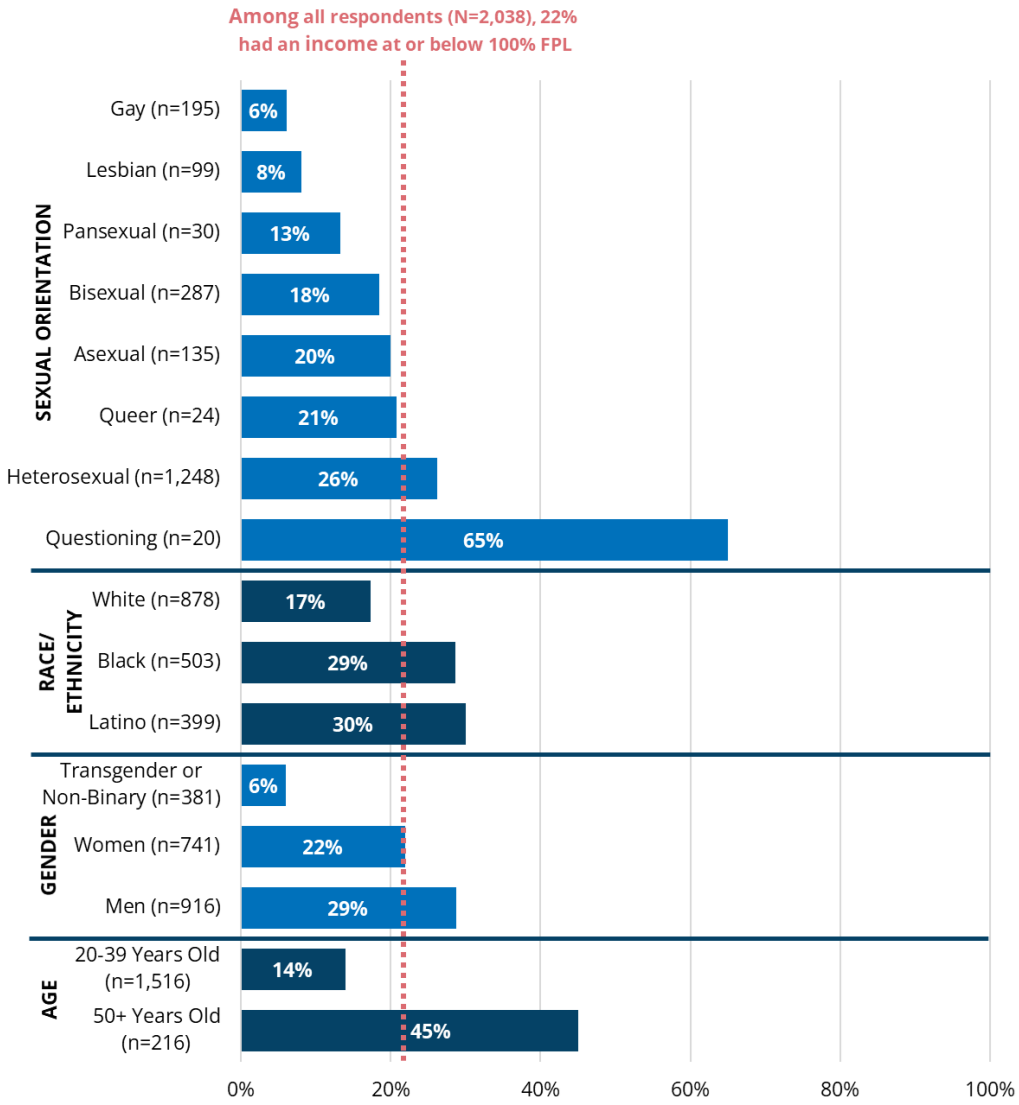

Figure 6. Income at or below 100% FPL by sexual orientation, race, ethnicity, gender, and age.
Respondents who identified as pansexual, queer, or questioning are included in the figure, however, their results should not be considered a disparity due to their small population size. The red dotted line indicates the percent of all respondents with an annual income at or below $13,590 per year (22%).

Figure 7 shows the proportion of respondents who had ever received money or goods in exchange for sex (i.e., transactional sex). Slightly more than half of respondents had not engaged in transactional sex (54%), while forty-six percent (46%) had.

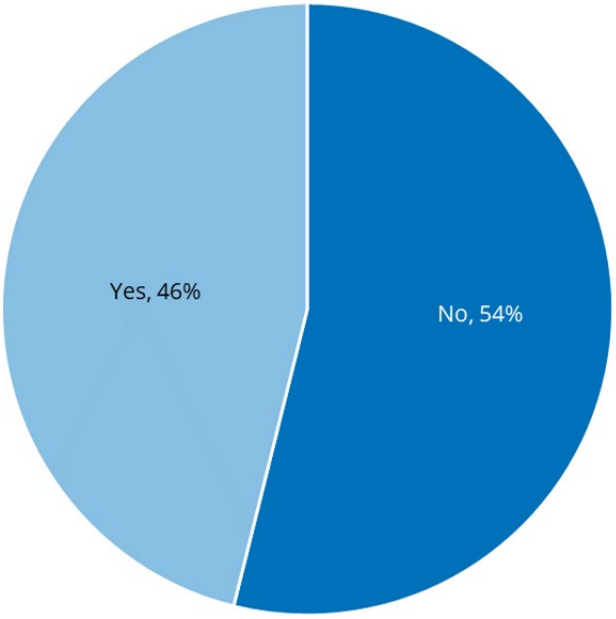

Figure 7. Ever received money or goods in exchange for sex (N=2,038).

When evaluated for disparities, some populations were more or less likely to have ever received money or goods in exchange for sex. They can be seen in Figure 8 below. Respondents who identified as lesbian (88%), transgender or non-binary (82%), gay (76%) bisexual (68%), and those between the ages of 20-39 years old (53%) were more likely to have ever engaged in transactional sex compared to all respondents (46%).

Respondents who identified as women (39%), men (37%), heterosexual (31%), or those aged 50 years old or greater were less likely to have ever engaged in transactional sex compared to all respondents (46%).

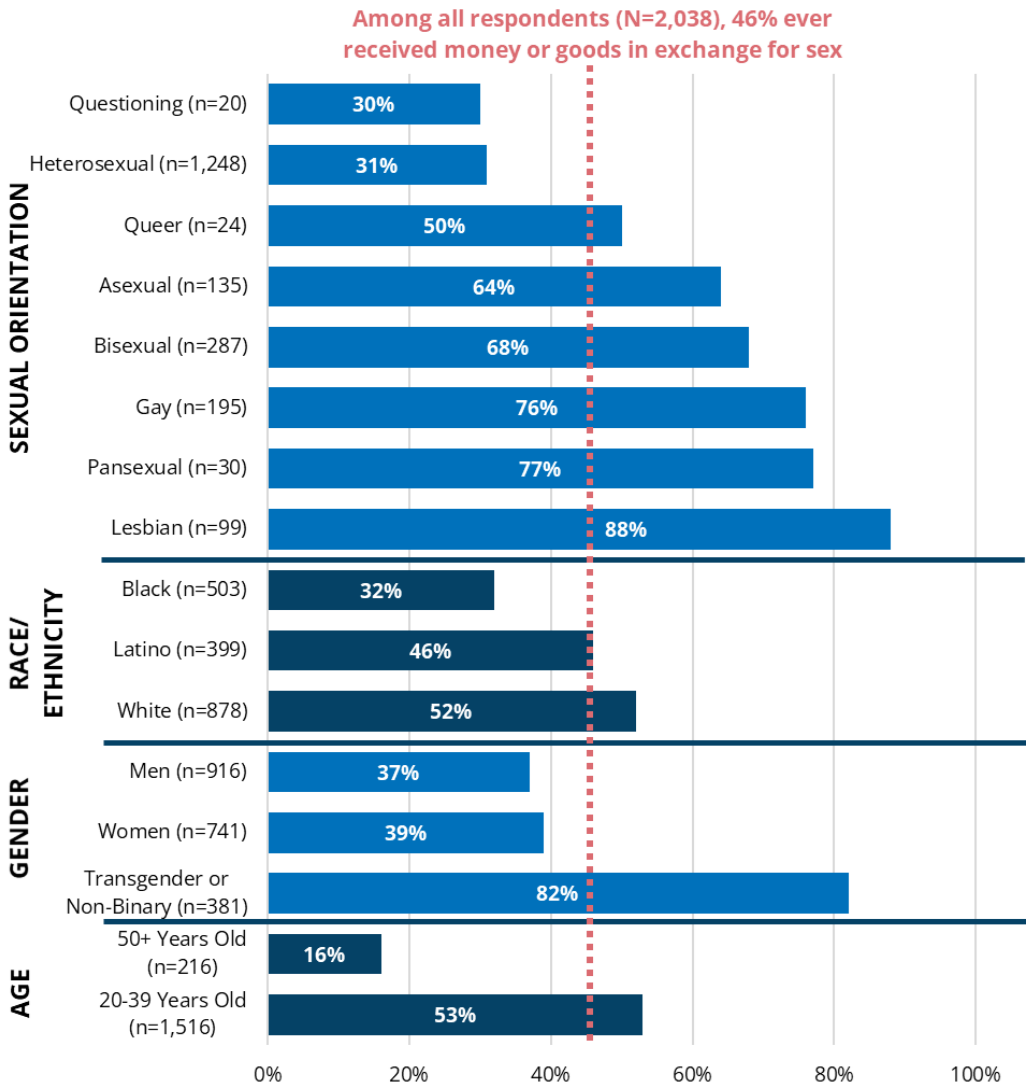

Figure 8. Disparities among respondents who ever received money or goods in exchange for sex by sexual orientation, race, ethnicity, gender, and age. *Respondents who identified as pansexual, queer, or questioning are included in the figure, however, their results should not be considered a disparity due to their small population size. The red dotted line indicates the percentage of all respondents who ever received money or goods in exchange for sex (46%).*

OPPORTUNITIES FOR IMPROVEMENT

- Address social determinants of health such as transportation and childcare to facilitate access to essential services.
- Ensure accessibility of safer sex kits (i.e., condoms, lube, and dental dams), SSPs, and PrEP and PEP, including resources and payment options.
- Expand free testing and screening services for HIV, STD, HCV, and SUD.

Marketing

The CT DPH has been steadfast in its commitment to raising awareness about HIV prevention and treatment options among the state's residents. Over the years, the DPH has implemented a

comprehensive and multi-channel marketing strategy to reach diverse audiences. Past efforts involved strategic messaging placement on buses, bus stations, gas stations, and grocery stores, ensuring a broad geographical coverage. Additionally, the department utilized traditional media outlets such as radio and television, as well as modern platforms like streaming services and social media to disseminate information.

Noteworthy campaigns reflect the DPH's innovative approach to engaging specific populations. The *#RequestFreeHIVTestCT* campaign, for instance, is a targeted initiative aimed at initiating conversations around At-Home HIV Testing, particularly tailored for Black men and women. Another impactful campaign, *#WhatsYourStory*, adopts a storytelling theme to showcase 25 unique lived experiences related to HIV, presented through visually striking content. Furthermore, the T.E.S.T CT campaign underscores Connecticut's dedication to making HIV testing a routine practice in clinical settings, including Emergency Departments, emphasizing the state's commitment to accessible healthcare and prevention strategies.

These initiatives collectively contribute to a holistic and inclusive approach to HIV awareness and prevention in Connecticut. Campaign resources can be downloaded at https://positivepreventionct.org/campaigns/.

Respondents were asked about ways they had received communications regarding HIV, sexually transmitted diseases (STDs), hepatitis C virus (HCV), and substance use disorder (SUD), and their communication preferences.

Figure 9 displays ways respondents had received communications about HIV, STDs, HCV, and SUD. About half of respondents received information on social media (49%), closely followed by healthcare providers (48%).

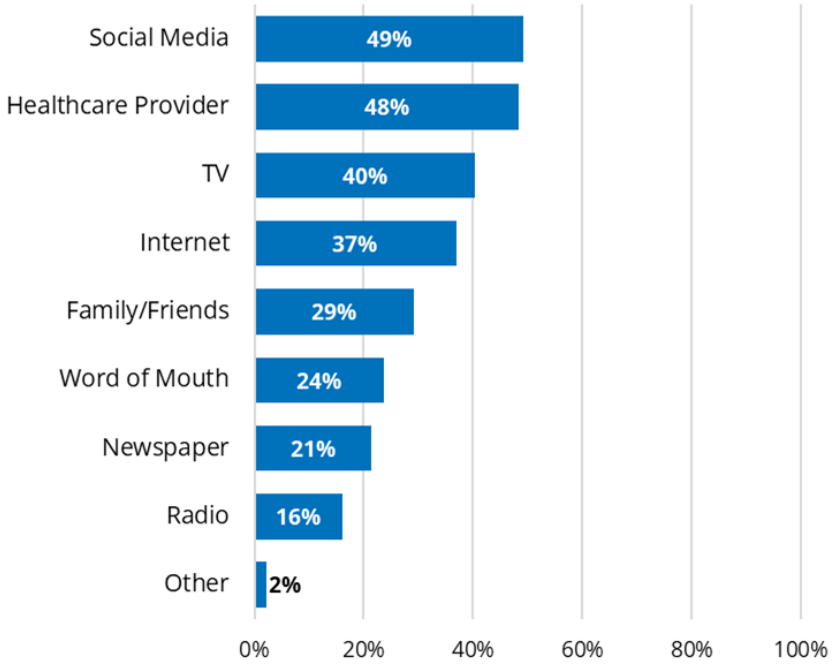

Figure 9. Where do you currently access information about HIV, STDs, HCV, and SUD (N=2,038)?
Respondents were asked to select all that apply.

Respondents' communication preferences (as seen in Figure 10 below) closely mirrored how they currently receive information about HIV, STDs, HCV, and SUD. This suggests that current marketing efforts are being conducted in ways respondents prefer.

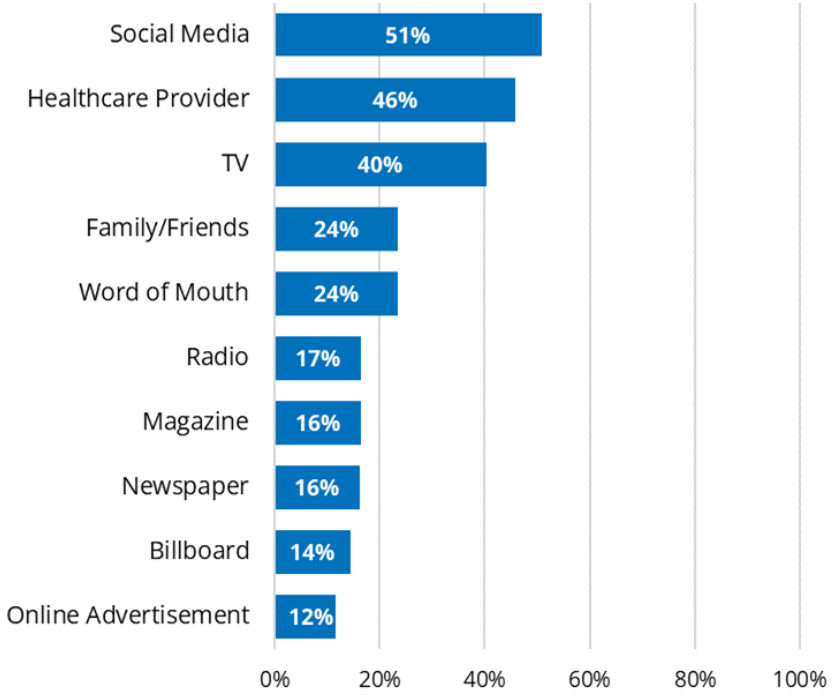

Figure 10. What are the best types of media for you to receive information about HIV, STDs, HCV, and SUD (N=2,038)? *Respondents were asked to select all that apply.*

OPPORTUNITIES FOR IMPROVEMENT

- Maintain emphasis on social media campaigns for outreach, while identifying the most effective platforms for each audience.
- Foster engagement with the population through focus groups or listening sessions to gather diverse perspectives.
- Implement academic detailing through personalized educational sessions with healthcare professionals and utilize provider toolkits and fact sheets to deliver tailored information and resources to facilitate informed decision-making and optimize patient care.
- Obtain additional resources for a local Public Service Announcement (PSA) promoting HIV prevention services and how to access them.
- Increase community outreach efforts.

Service Delivery

In the pursuit of continuous improvement and tailored support for individuals at risk of or living with HIV, the Service Delivery section of the HIV Prevention Needs Assessment survey plays a pivotal role. This section delves into crucial aspects of service provision, aiming to gather valuable insights into the experiences of participants, including factors such as wait time, satisfaction with services, and the history and outcomes of HIV testing. By examining these elements, we aim to comprehensively assess the effectiveness and accessibility of our prevention services, ensuring that we meet the diverse needs of our community and advance our commitment to proactive HIV prevention.

Respondents were asked about the prevention services (e.g., PrEP; HIV, STD, or HCV testing; Syringe service program; Partner services, etc.) they've received. The time it took to receive prevention services are displayed below in Figure 11.

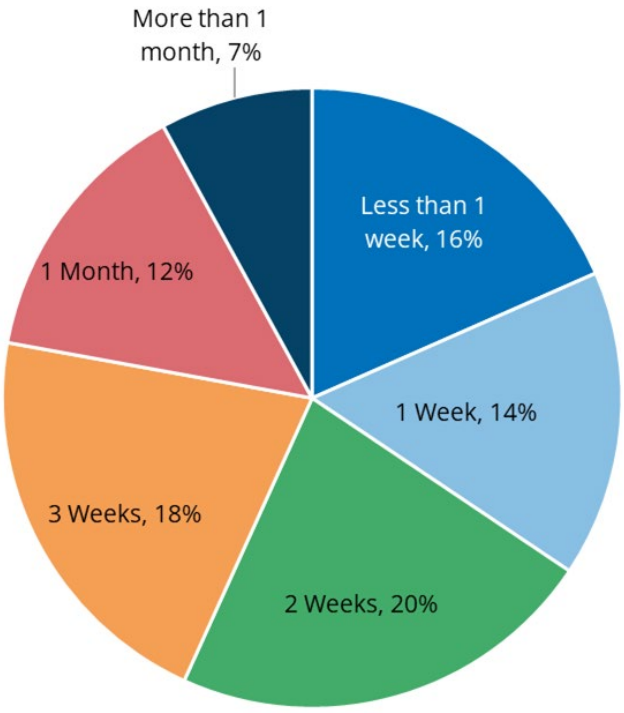

Figure 11. Prevention services wait time (N=2,038).

Prevention services have a goal wait time of 2 weeks or fewer. The wait time to receive prevention services was fairly evenly split between less than 1 week and 1 month (range of 12% to 20%). Only 7% of respondents had to wait more than one month to receive services. It should be noted that there was no response option in the survey to indicate that prevention services were not needed.

Respondents were asked to rate their satisfaction with prevention services (Figure 12). Over half of respondents indicated they were extremely or very satisfied (20% and 33%) respectively, while only 2% of respondents were not satisfied.

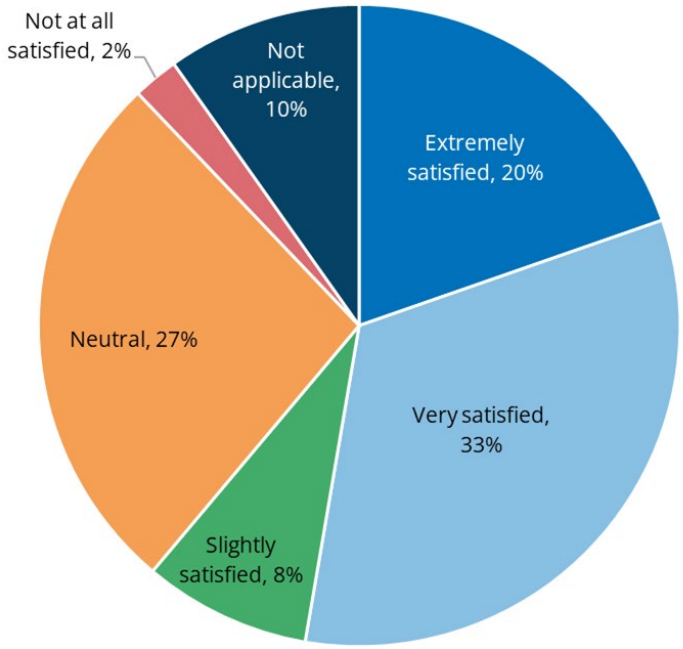

Figure 12. Prevention services satisfaction (N=2,038).

OPPORTUNITIES FOR IMPROVEMENT

- Explore ways to increase client satisfaction.
- Investigate variations in wait times across different prevention services (e.g., HIV, STD, PrEP, HCV, etc.).
- Improve provider capacity and reduce wait times to enable comprehensive care within a single visit using the Status Neutral model of care.
- Explore bundled testing modalities to increase service provisions.
- Explore other bundled service opportunities such as mobile pharmacies, mobile SSP services, and mobile testing services.
- Explore ways to integrate prevention services with other state entities (i.e., DMHAS, DOC, DCF, DSS, and DDS)

HIV Testing

Some populations are more likely to acquire HIV than others including men who have sex with men (MSM), people who inject drugs (PWID), Hispanics, and Black/African Americans. Social determinants of health (the environment in which people are born, live, learn, work, play, and other forces that affect daily life) result in some populations being more likely to be exposed to HIV.

Differences in HIV prevalence (the number of people living with HIV at a given time) are seen among Connecticut residents. The rate of Black men living with HIV is 5.6 times that of White men. Similarly, the rate of Hispanic men living with HIV is 4.3 times that of White men. The disparity in HIV prevalence is even greater among women. The rate of Black women living with HIV is 13.2 times that of White women. The rate of Hispanic women with HIV is 7.8 times that of White women.

Respondents were asked about HIV testing they had received. The overwhelming majority had ever been tested for HIV (81%), with only 16% never being tested and 2% not sure if they had ever been tested (Figure 13).

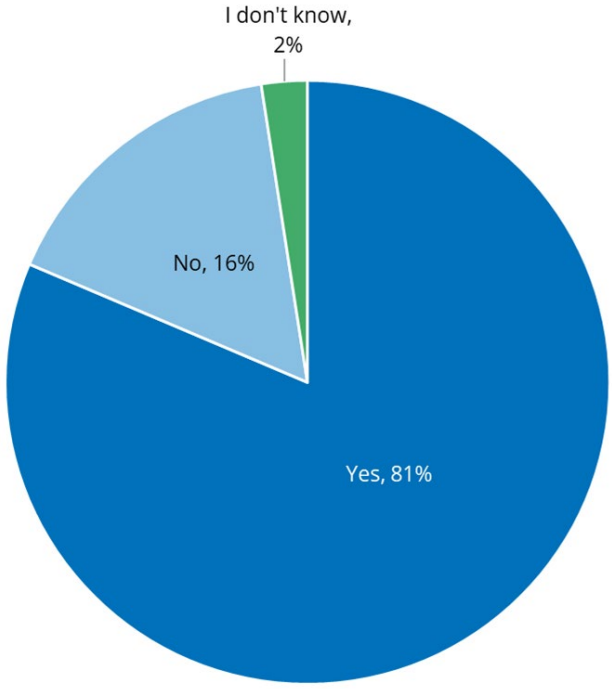

Figure 13. Ever tested for HIV (N=2,038).

Figure 14 below shows the most recent HIV testing results among respondents who had ever been tested for HIV. About three-quarters of respondents tested negative at the last test (73%), while approximately one-quarter of respondents tested positive (26%). Only 1% of respondents were unsure of their HIV test results.

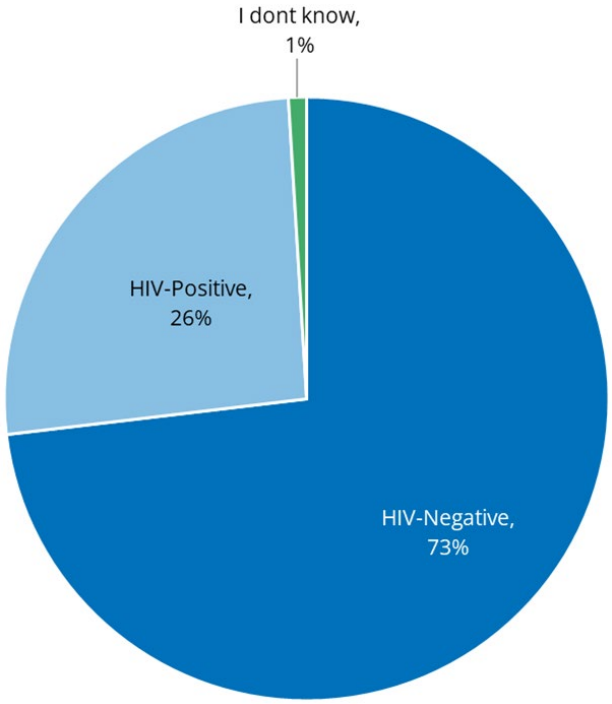

Figure 14. HIV testing results (N=1,659).

Respondents were asked about where they received their last HIV test result (Figure 15). The majority of respondents received their last test at a clinic/health center (29%) or an HIV testing site (24%).

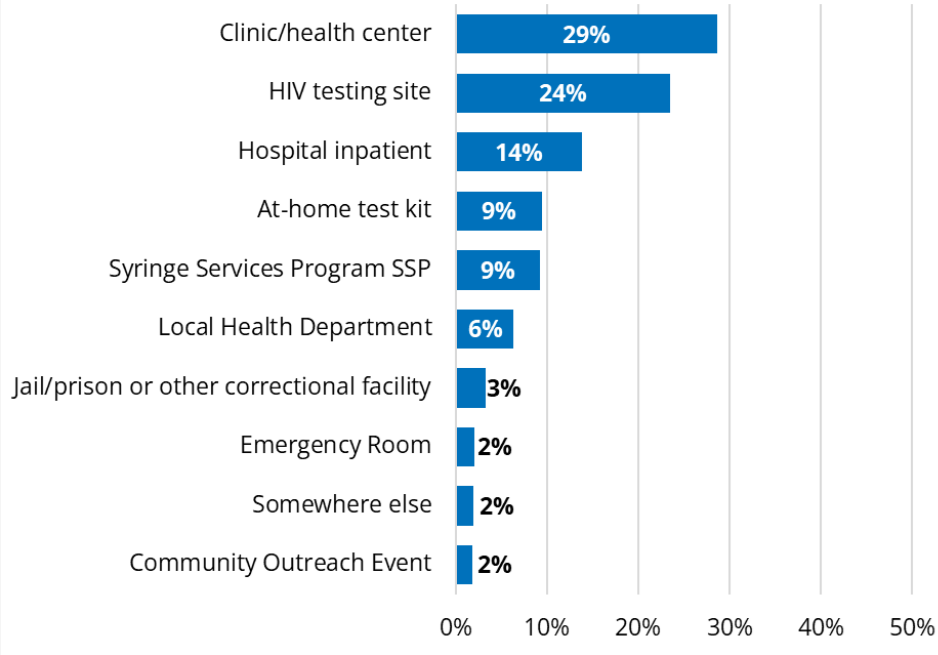

Figure 15. Location of last HIV test (N=1,659).

Thirty-four percent (34%) of all respondents reported ever being denied an HIV test. When evaluated for disparities (as seen in Figure 16), the following populations were more likely to have ever been denied an HIV test compared to all respondents:

- Bisexual (40%, n=287)
- Asexual (60%, n=135)
- Lesbian (64%, n=99)
- Gay (71%, n=195)
- Hispanic (38%, n=399)
- Transgender or Non-Binary (78%, n=381)
- Aged 20-39 years old (40%, n=1,516)

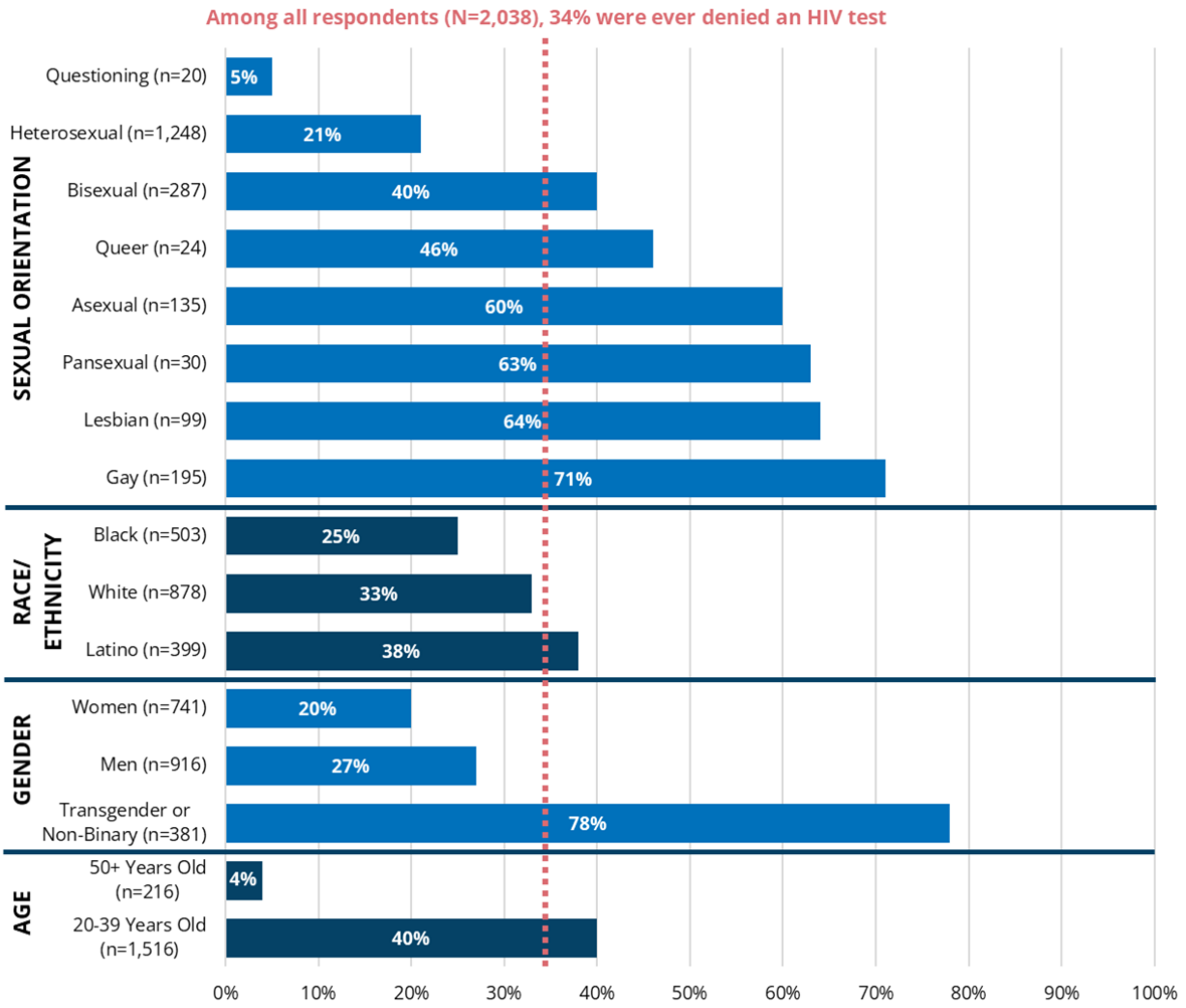

Figure 16. Disparities among respondents who were ever denied an HIV test by sexual orientation, race, ethnicity, gender, and age. *Respondents who identified as pansexual, queer, or questioning are included in the figure, however, their results should not be considered a disparity due to their small population size. The red dotted line indicates the percentage of all respondents who were ever denied an HIV test (34%).*

OPPORTUNITIES FOR IMPROVEMENT

- Encourage providers to prioritize PrEP and more frequent testing for high-risk individuals.
- Educate both providers and consumers about routine testing laws for HIV and HCV.
- Enhance understanding of gender-affirming care, provider bias, stigma, health equity, and anti-racism through training and capacity-building assistance.
- Implement syndemic screening tools to improve comprehensive health assessments.
- Expand sexual health clinics to increase accessibility to services.
- Recruit staff members who represent populations affected by the epidemic.
- Conduct focus groups with individuals who have been denied an HIV test, particularly transgender or non-binary individuals.
- Increase community outreach efforts.

Pre-Exposure Prophylaxis (PrEP)

PrEP is a biomedical HIV prevention strategy in which individuals at high risk of contracting HIV take a daily medication (usually Truvada or Descovy) or one bi-monthly injection (Apretude) to reduce their risk of infection. PrEP navigation programs are designed to help people access and adhere to PrEP effectively.

The CDC recommends that all sexually active adult and adolescent patients should receive information about PrEP. PrEP is recommended for sexually active men, women, and transgender individuals weighing at least 77 lbs.

For both men and women, PrEP with daily oral F/TDF is recommended for HIV prevention for sexually active adults and adolescents. For men only, daily oral PrEP with F/TAF is a recommended option for HIV prevention for sexually active adults and adolescents. For transgender women (persons assigned male sex at birth whose gender identity is female), daily oral PrEP with F/TAF is recommended.

For sexually active adults and adolescents who do not wish to take a daily oral regimen, PrEP with Apretude (cabotegravir extended-release injectable suspension) is recommended.

At the time of the survey, the CT DPH contracted with 8 clinical sites and 8 non-clinical sites statewide to provide PrEP and PEP navigation services. PrEP navigation refers to a set of services and support provided to individuals who are interested in or prescribed pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) for HIV prevention.

In this section of the survey, respondents were asked about their awareness and use of PrEP (pre-exposure prophylaxis). Overall, 81% of respondents had heard of PrEP and about one quarter of respondents were currently taking PrEP (24%) as seen in Figure 17.

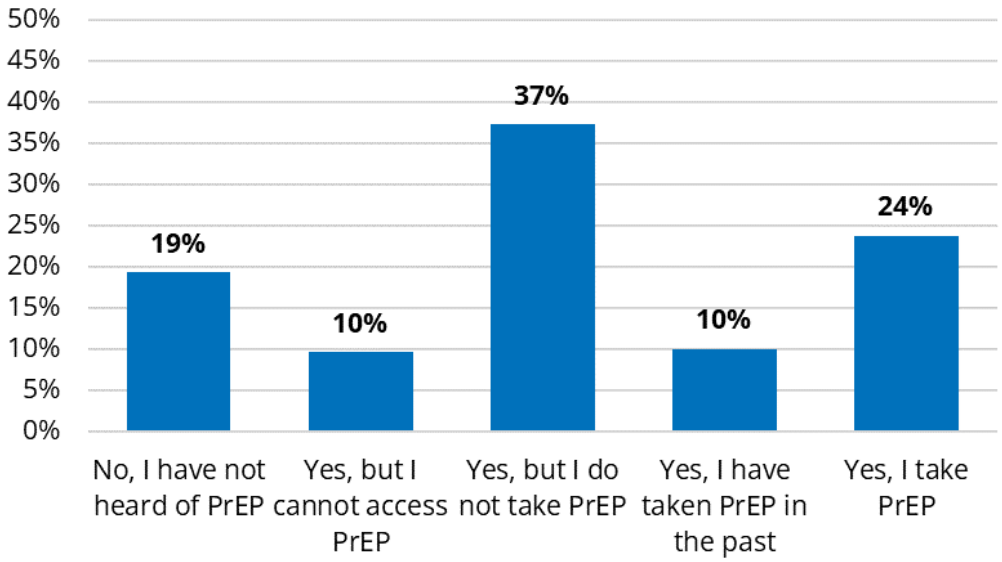

Figure 17. PrEP awareness and use (N=2,038).

Figure 18 below shows the disparities in PrEP awareness. Respondents who identified as lesbian (89%), bisexual (93%), gay (98%), transgender or non-binary (96%), or white (85%) were more likely to have ever heard of PrEP.

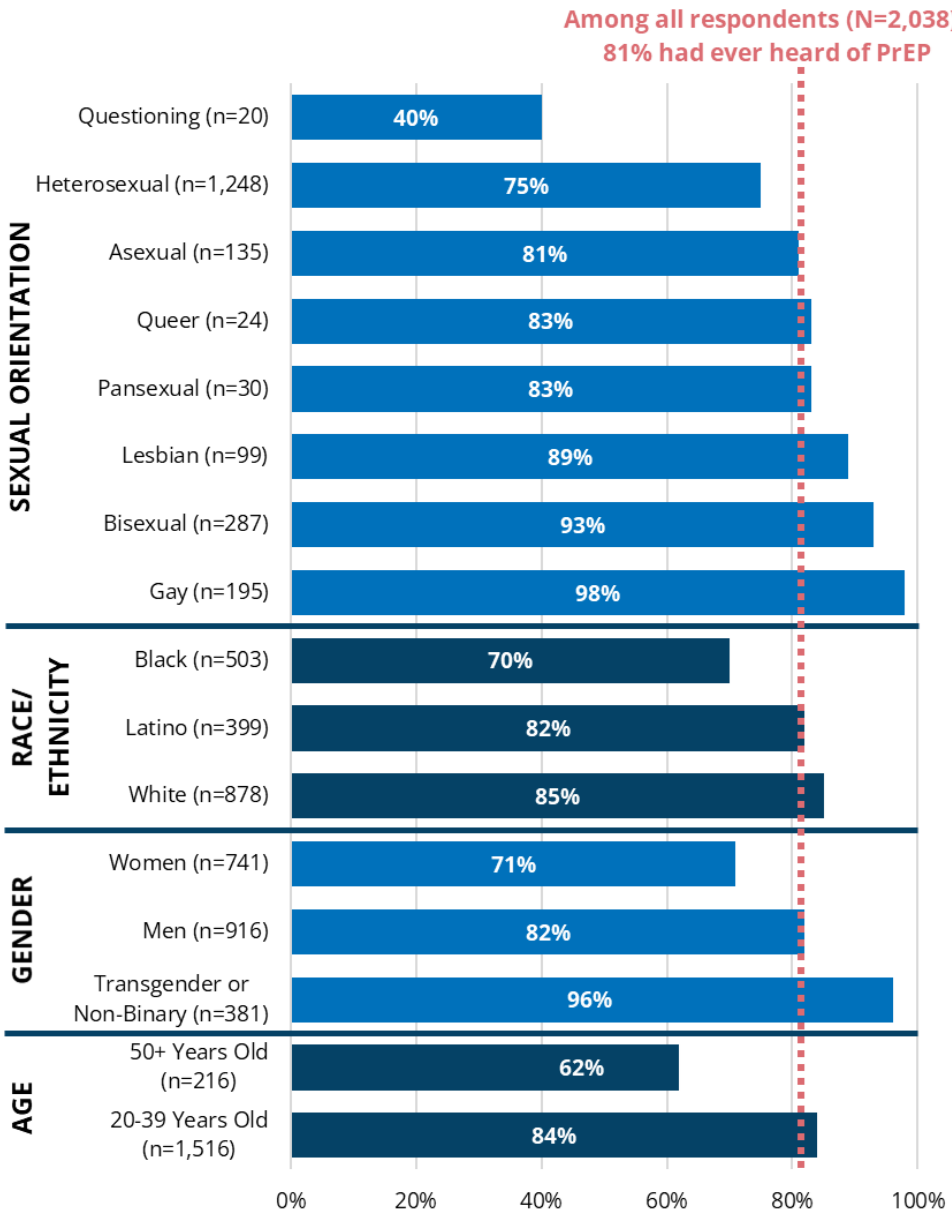

Figure 18. Disparities among respondents who had ever heard of PrEP by sexual orientation, race, ethnicity, gender, and age. *Respondents who identified as pansexual, queer, or questioning are included in the figure, however, their results should not be considered a disparity due to their small population size. The red dotted line indicates the percent of all respondents who had ever heard of PrEP (81%).*

Among respondents who were aware of PrEP but did not take it, the overwhelming majority stated they didn't think they need it (57%) as seen in Figure 19.

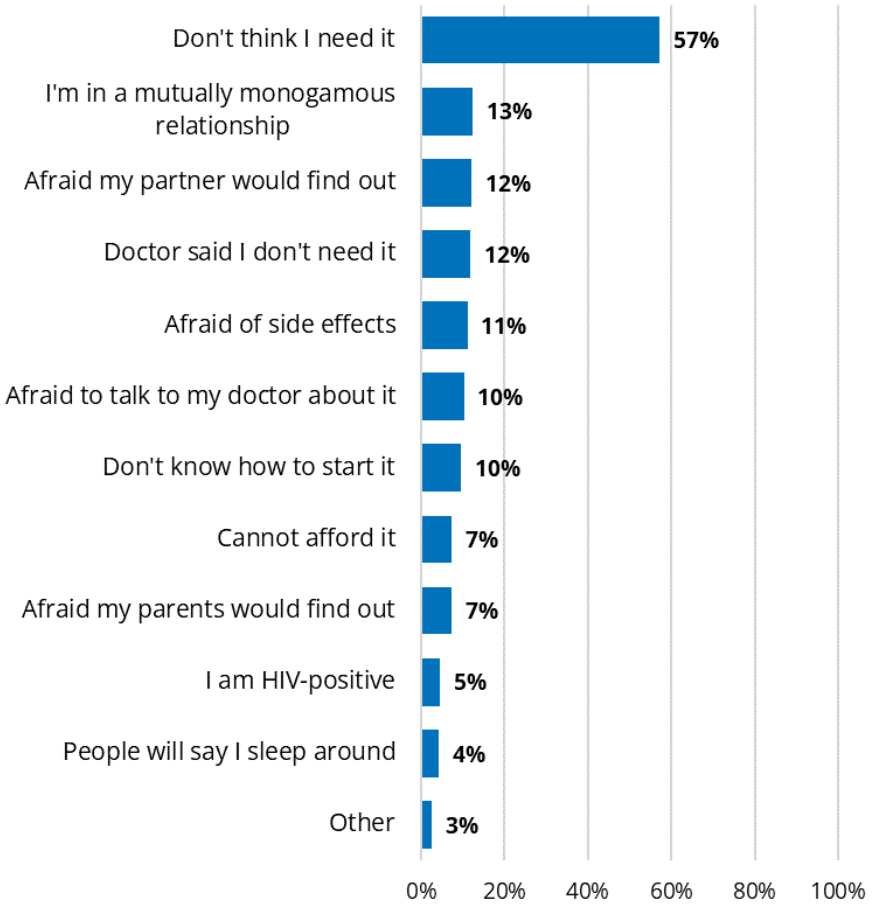

Figure 19. Reasons for not taking PrEP among respondents who were aware of PrEP but do not currently take it (n=760). *Respondents were asked to select all that apply.*

Respondents who reported that they had heard of PrEP but couldn't access it were asked about the barriers they experienced (Figure 20). The top two barriers cited by respondents were, "I can't use my insurance because of privacy concerns," (35%) and "I'm afraid to talk to my doctor about it," (35%).

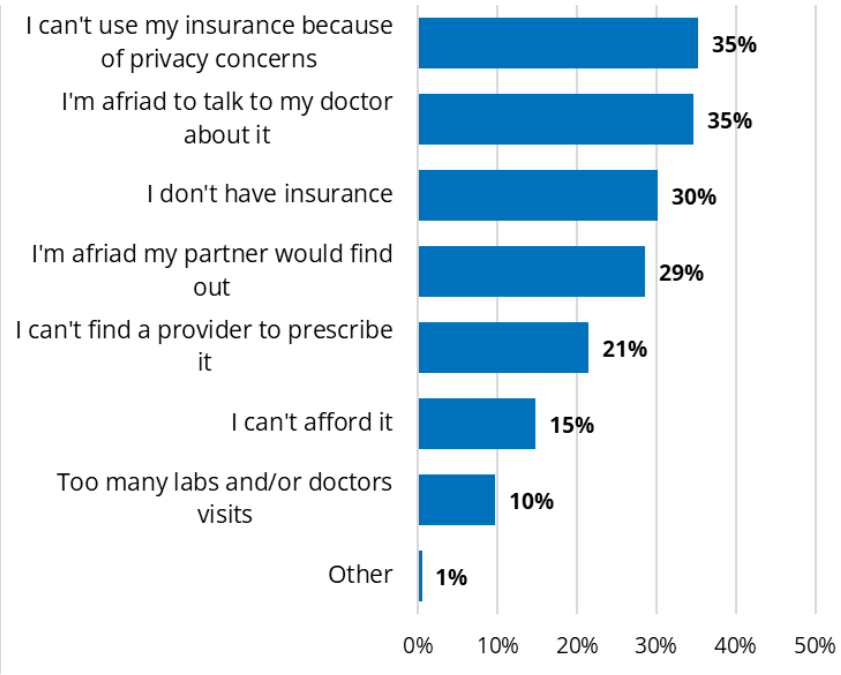

Figure 20. Barriers to PrEP among respondents who had heard of PrEP but couldn't access it (n=196). *Respondents were asked to select all that apply.*

Respondents who had taken PrEP in the past but not currently were asked why they stopped taking it (Figure 21). The number one reason respondents stopped taking PrEP was, "Too many labs and/or doctor's visits."

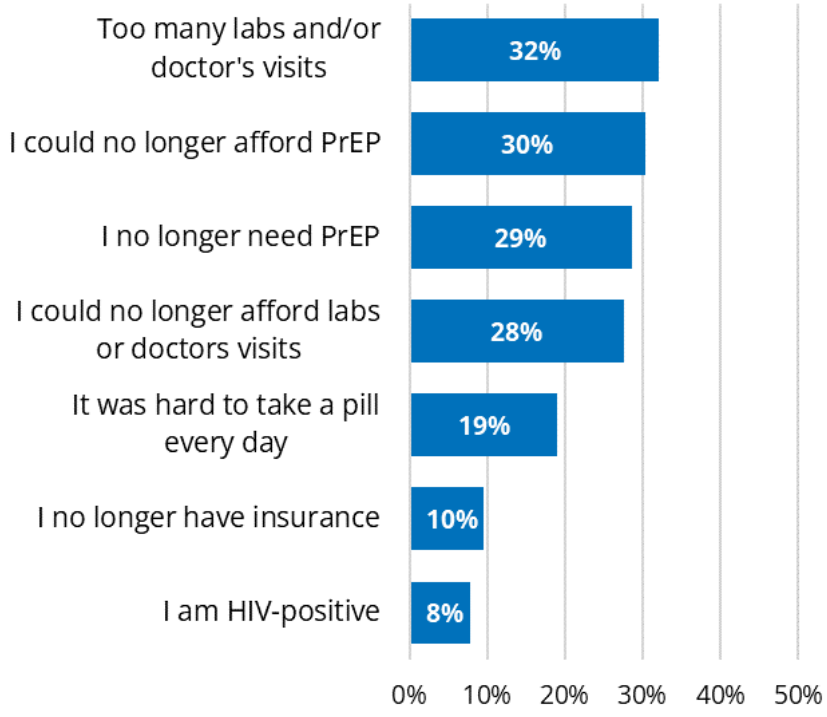

Figure 21. Reasons why respondents who previously used PrEP stopped taking it (n=399). *Respondents were asked to select all they apply.*

OPPORTUNITIES FOR IMPROVEMENT

- Increase PrEP uptake, particularly among heterosexual, Black, female, and older populations (50+).
- Explore alternative methods for accessing or funding PrEP beyond reliance on health insurance.
- Address health insurance privacy concerns, such as concerns regarding Explanation of Benefits (EOBs) sent to home addresses.
- Provide healthcare providers with education on PrEP benefits and access options for uninsured or underinsured individuals.
- Collaborate with the State Public Health Laboratory to alleviate financial burdens associated with PrEP adherence.
- Establish a PrEP Drug Assistance Program (DAP) as a payor of last resort.
- Explore potential data-sharing agreements with the Office of Health Services (OHS) for insight on PrEP and PEP prescription data.
- Increase community outreach efforts.

Post-Exposure Prophylaxis (PEP)

Post-Exposure Prophylaxis (PEP) is a course of medication that can be administered as a prevention method after a recent potential exposure to HIV. When started within 72 hours of a potential exposure, PEP is highly effective in preventing the acquisition of HIV.

Respondents were asked about their awareness and use of PEP (post-exposure prophylaxis). Figure 22 below shows PEP awareness among all respondents. Over three-quarters of respondents had heard of PEP (76%).

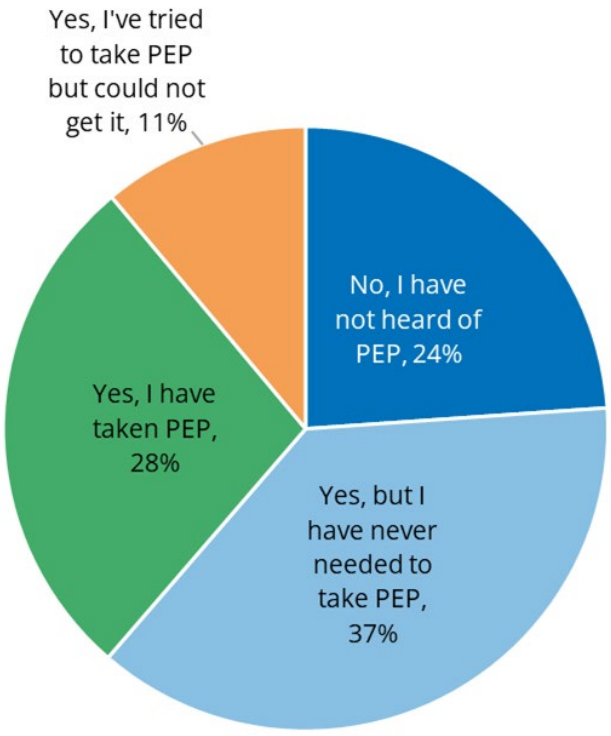

Figure 22. PEP awareness and use (N=2,038).

When evaluated for disparities (Figure 23), respondents who identified as Black (63%), women (65%), and those aged 50+ years old (55%) were less likely to have heard of PEP.

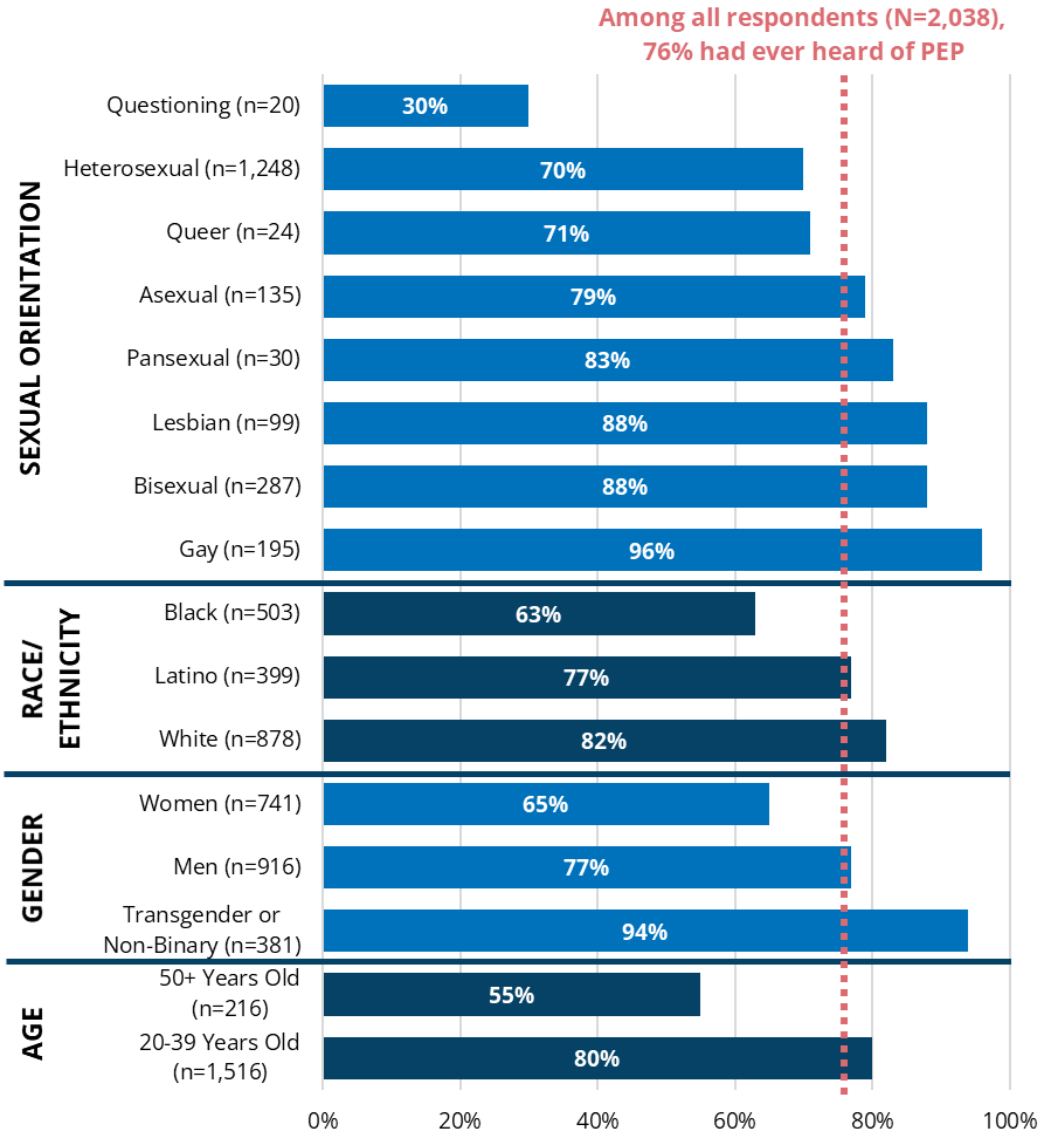

Figure 23. Disparities among respondents who had ever heard of PEP by sexual orientation, race, ethnicity, gender, and age. *Respondents who identified as pansexual, queer, or questioning are included in the figure, however, their results should not be considered a disparity due to their small population size. The red dotted line indicates the percent of all respondents who had ever heard of PEP (76%).*

Figure 24 shows where respondents had last accessed PEP among those who had used it, with the majority getting it at a clinic or hospital (42%).

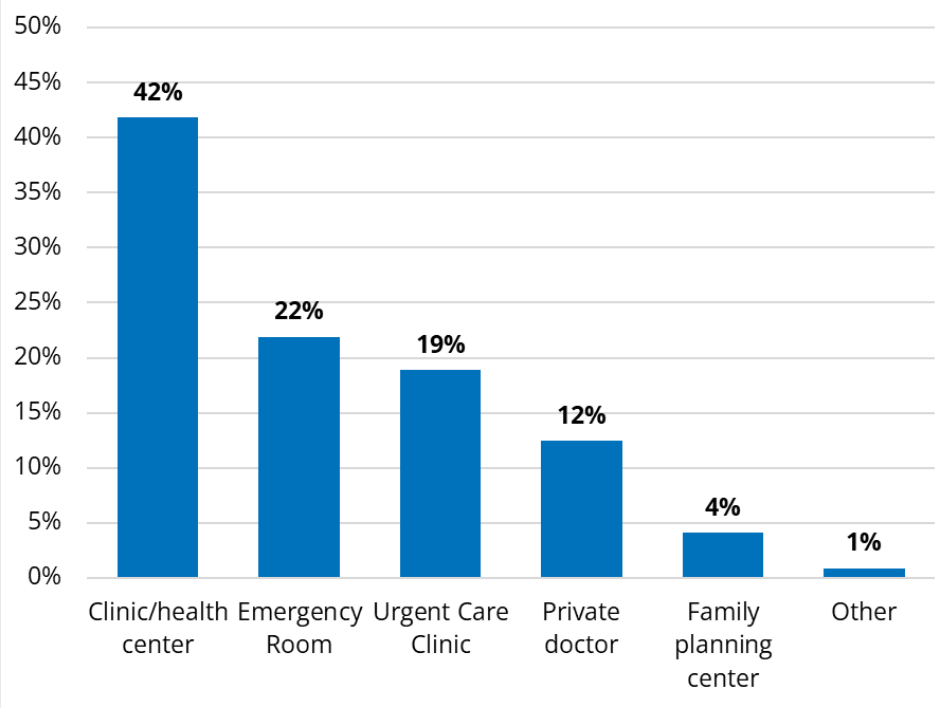

Figure 24. Location where PEP was last accessed (n=562).

Respondents were asked about their barriers to accessing PEP (Figure 25). Most respondents stated they couldn't get PEP because it was too late for them to take it (38%) or they didn't feel comfortable asking for it (28%).

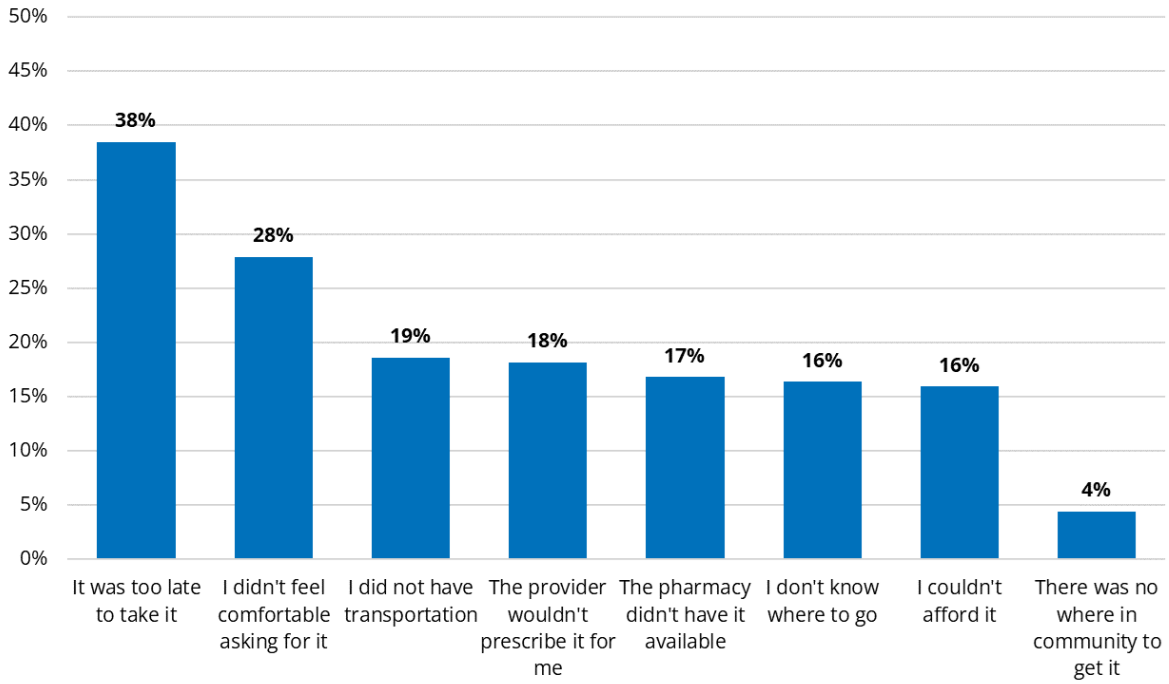

Figure 25. Barriers to accessing PEP among respondents who were aware of PEP but couldn't get it (n=226).

OPPORTUNITIES FOR IMPROVEMENT

- Increase PEP awareness and uptake, particularly among heterosexual, Black, female, and older (50+) populations.
- Explore additional facilities capable of offering on-demand PEP services.
- Foster collaboration with other agencies, such as the Connecticut Alliance to End Sexual Violence and others, to bolster PEP access and support initiatives.
- Increase community outreach efforts.

Condom Use

Condoms are still one of the most effective methods of HIV prevention, and the only method that also protects against STDs and unintended pregnancies. The Connecticut Community Distribution Center (located in Hartford and an integral component of the CT DPH) is dedicated to increasing the availability of harm reduction, education, and medical resources with a specific focus on preventing the transmission of HIV and other STDs. The center facilitates access to essential resources by enabling eligible individuals and organizations to request free internal and external condoms, personal lubricant, dental dams, finger cots, and educational materials, subject to availability. Moreover, it extends support to agencies, providing them with access to bulk prevention supplies, print materials, and campaign and outreach resources. This strategic approach ensures the widespread dissemination of preventive measures among individuals and communities, thereby reinforcing the mission to reduce the transmission of HIV and STDs.

In this section of the survey, respondents were asked about their condom use. Over three-quarters of respondents reported using condoms (79%). Only 12% reported never using condoms.

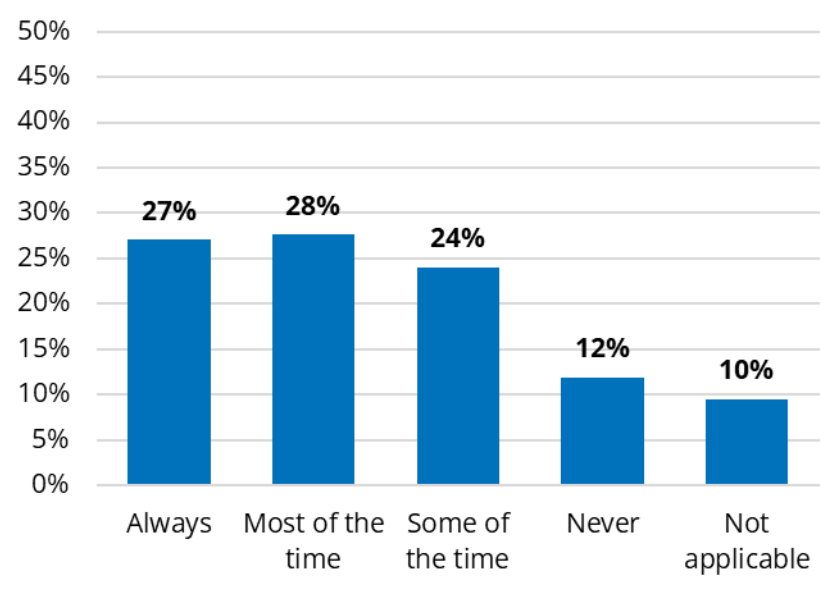

Figure 26. Condom use among all respondents (N=2,038).

Respondents who used a condom most of the time, some of the time, or never, were asked why they didn't use one (Figure 27). The top three reasons these respondents didn't use a condom were because they were having sex with their regular partner (42%), they were having sex with someone they know (26%), and they already had sex with that person without a condom (20%).

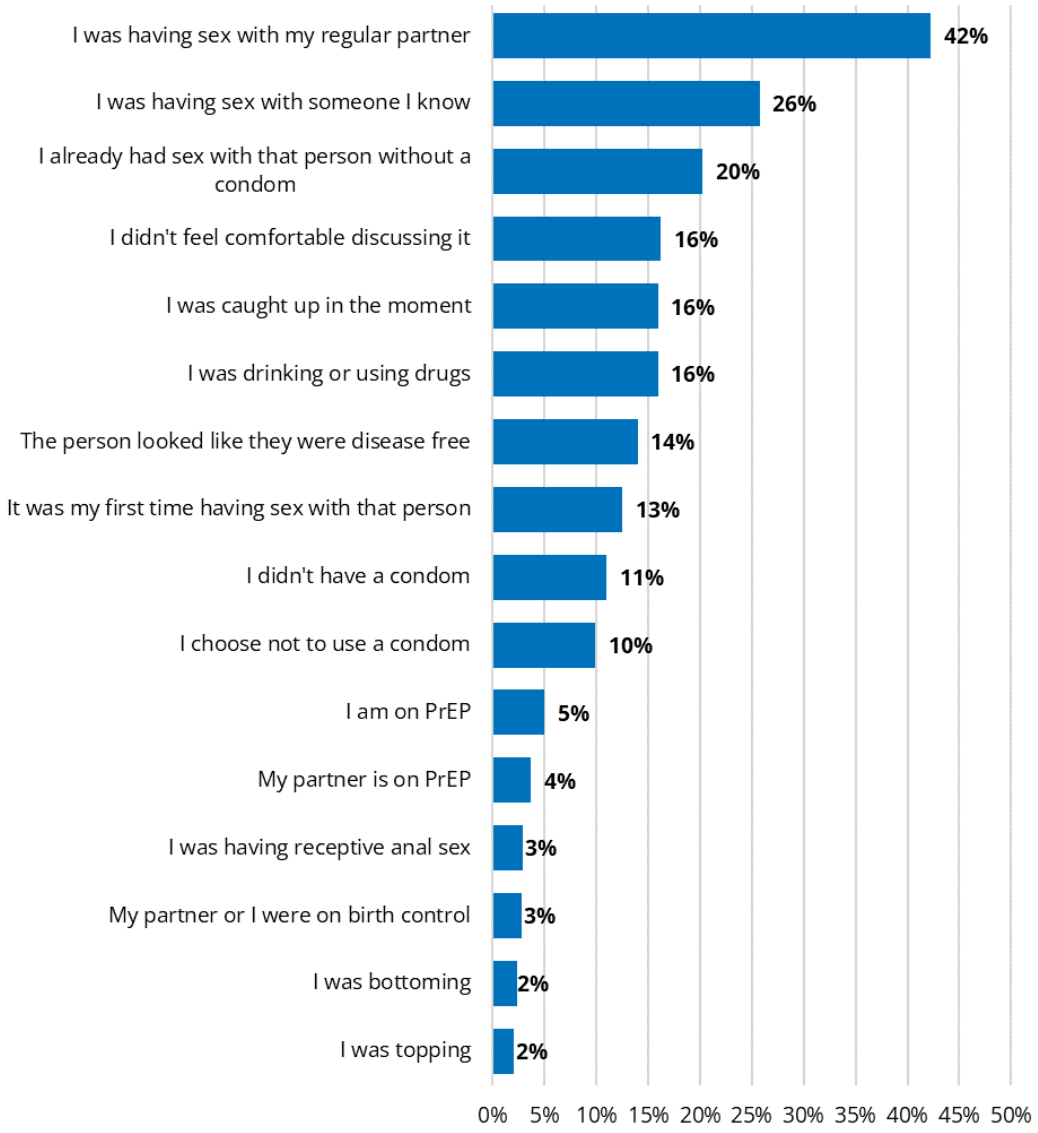

Figure 27. Reasons condoms were not used among respondents who only used a condom most of the time, some of the time, or never (n=1,293). *Respondents were asked to select their top three reasons.*

OPPORTUNITIES FOR IMPROVEMENT

- Provide education on the increasing prevalence of STDs and stress the importance of condom use when either partner has not been tested for HIV and STDs, regardless of past sexual history.
- Expand condom distribution programs in various settings such as healthcare facilities, community centers, schools, and public events to ensure easy access to condoms for individuals of all ages.
- Increase the variety of available condoms to include different sizes, textures, and materials to cater to diverse preferences and needs, thereby encouraging consistent use.
- Establish peer-led initiatives where trained individuals within communities educate their peers on the importance of condom use, correct usage techniques, and overcoming barriers to consistent use.

STD Testing

Sexually transmitted diseases (STDs) are a set of infections that are transmitted through vaginal, anal, and oral sex. Frequently asymptomatic, STDs without symptoms are typically undiagnosed and untreated. This can result in damage to the reproductive system, along with other body systems. People who have been diagnosed with an STD have an increased likelihood of acquiring HIV.

Respondents were asked about the STDs they've been tested for. Over half of respondents reported being tested for STDs in the past 12 months (61%), while 34% reported not being tested, and only 5% didn't know if they had been tested (Figure 28).

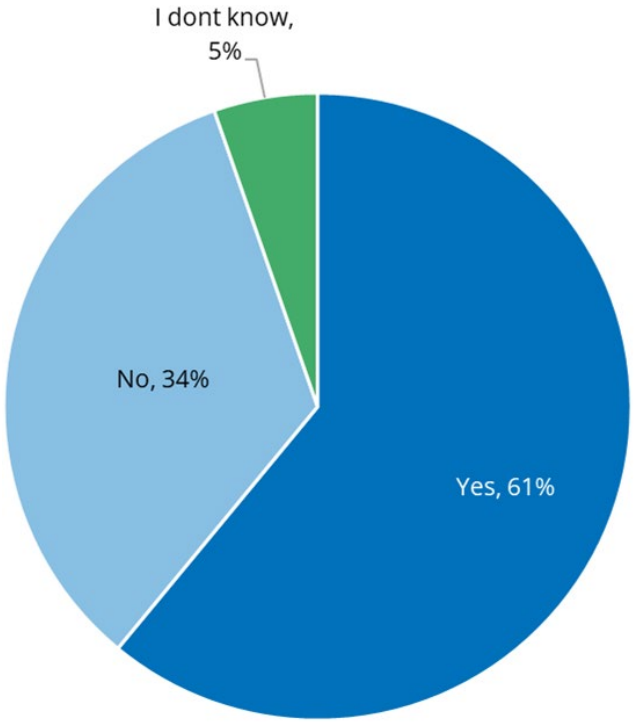

Figure 28. Tested for STDs in the last 12 months (N=2,038).

Figure 29 below displays the disparity evaluation among respondents who were tested for STDs within the past 12 months. Respondents who identified as heterosexual (54%), Black (57%), women (54%), men (57%), and those aged 50+ years old (33%) were less likely to have been tested for STDs compared to all respondents. Gay respondents (87%), and transgender or non-binary respondents (84%) were significantly more likely to have been tested for STDs compared to all respondents.

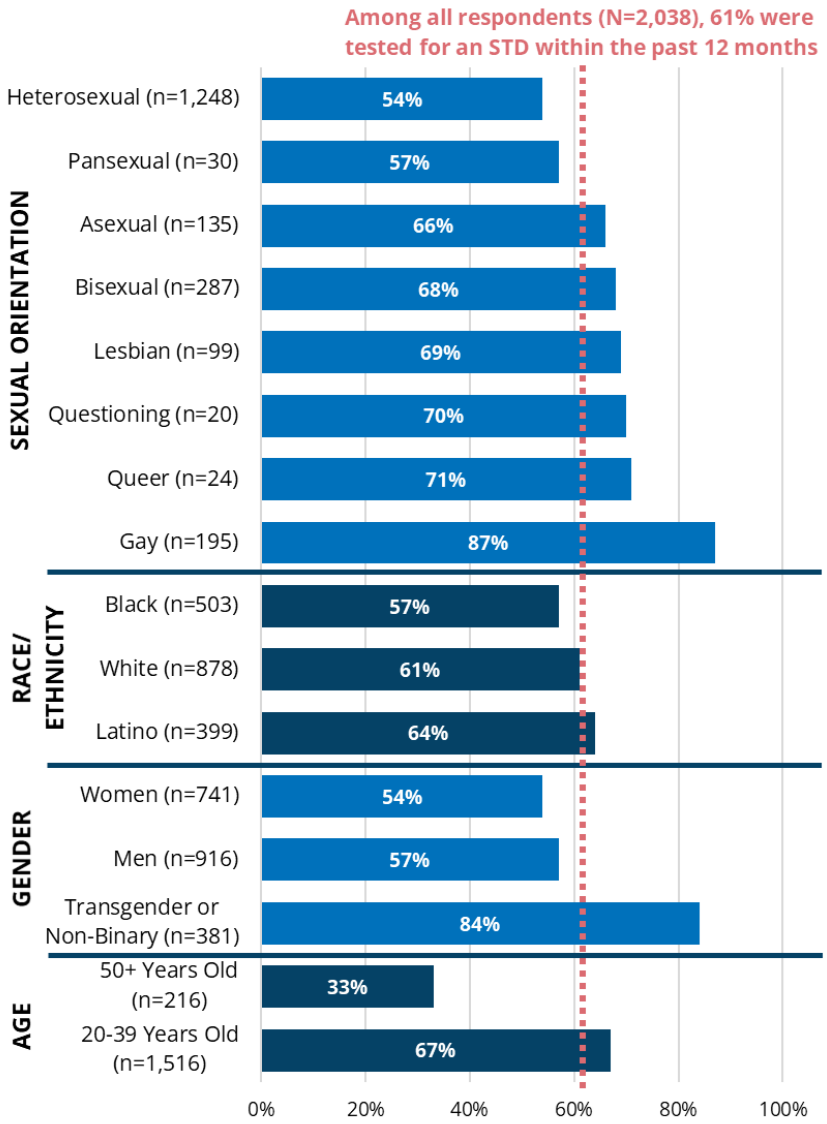

Figure 29. Disparities among respondents who were tested for an STD within the past 12 months by sexual orientation, race, ethnicity, gender, and age. *Respondents who identified as pansexual, queer, or questioning are included in the figure, however, their results should not be considered a disparity due to their small population size. The red dotted line indicates the percent of all respondents who were tested for an STD within the past 12 months (61%).*

Respondents who received an STD test within the last 12 months were asked where they were tested. About a third of respondents (31%) reported being tested at a clinic/health center (Figure 30).

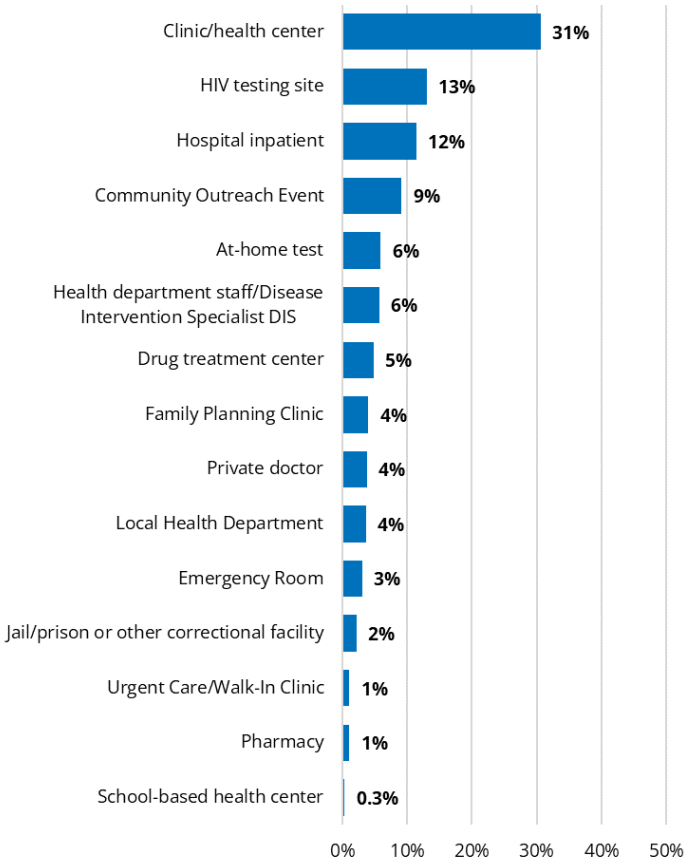

Figure 30. STD testing facility among respondents who received an STD test within the past 12 months (n=1,243).

When asked about what STDs they were tested for, over half of respondents reported being tested for syphilis (52%), followed by gonorrhea (47%), then chlamydia and human papilloma virus (HPV) each at 37%. Full results can be seen in Figure 31 below.

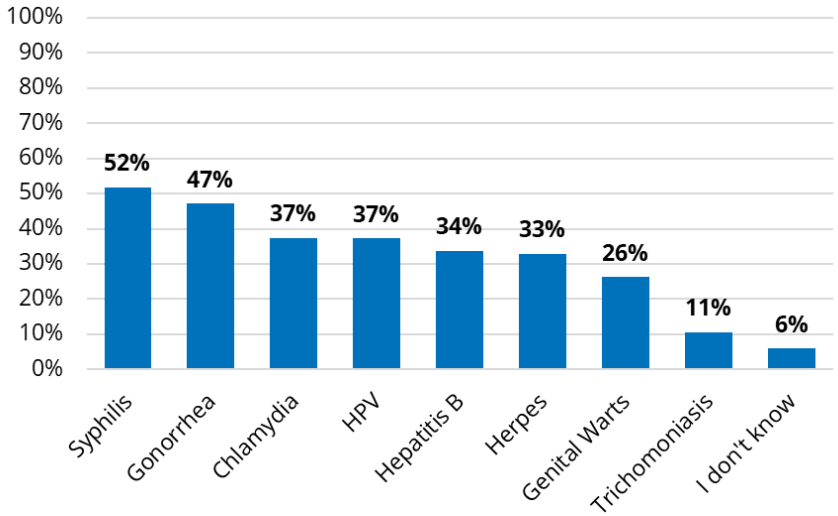

Figure 31. STDs tested for within the past 12 months (n=1,243). *Respondents were asked to select all that apply.*

Figure 32 below shows the STD testing sites reported by respondents who received a test in the last 12 months. The most common STD testing sites were blood draw (47%), followed by vaginal swab and urine test (each at 35%).

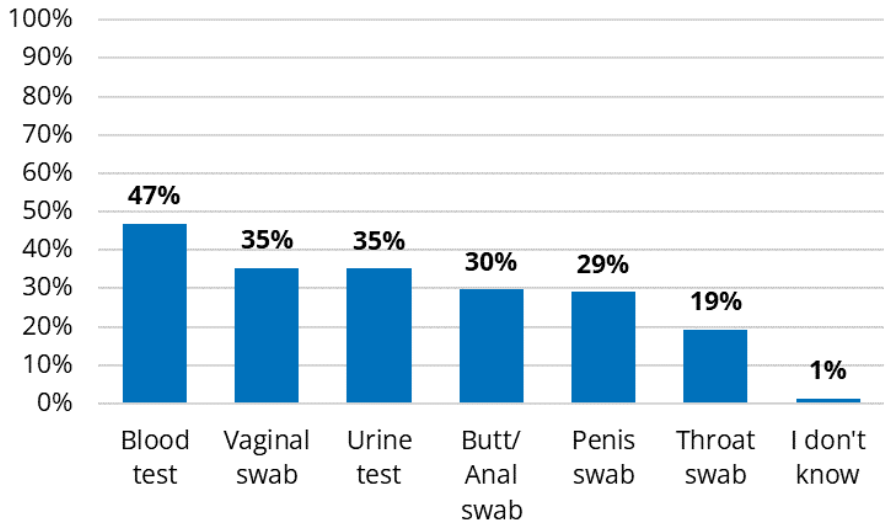

Figure 32. STD testing sites reported by respondents who were tested in the past 12 months (n=1,243). *Respondents were asked to select all that apply.*

Respondents were asked to indicate the STDs they tested positive for (Figure 33).

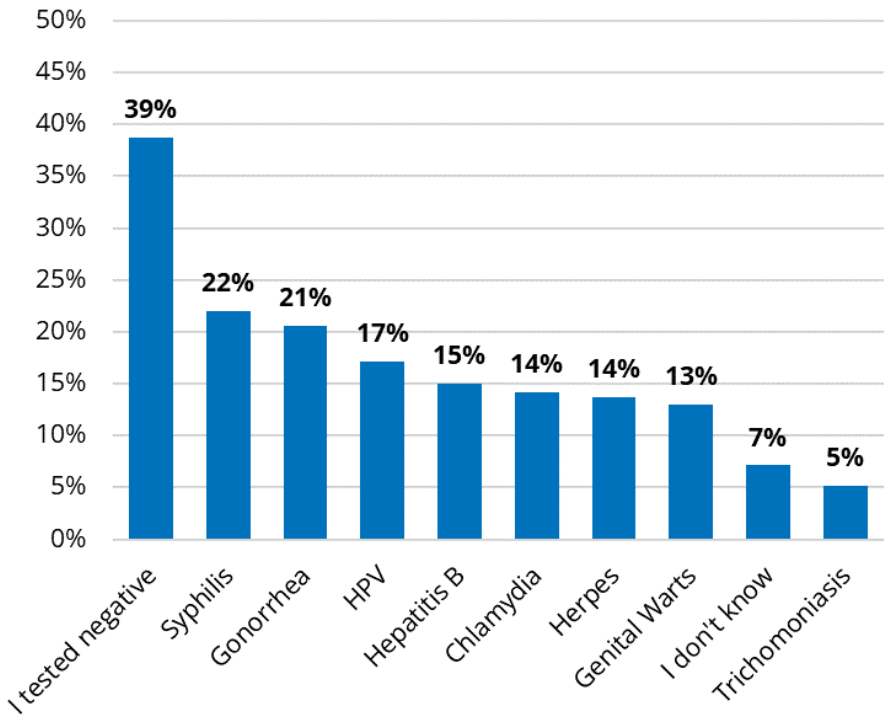

Figure 33. Positive STD results within the past 12 months (n=1,243). *Respondents were asked to select all that apply.*

Thirty-nine percent (39%) of respondents tested negative, followed by 22% who tested positive for syphilis and 21% who tested positive for gonorrhea.

All respondents were asked what would make it more likely for them to get an STD test. Almost half of respondents (48%) said they would be more likely to be tested if it were free. Full results can be seen in Figure 34 below.

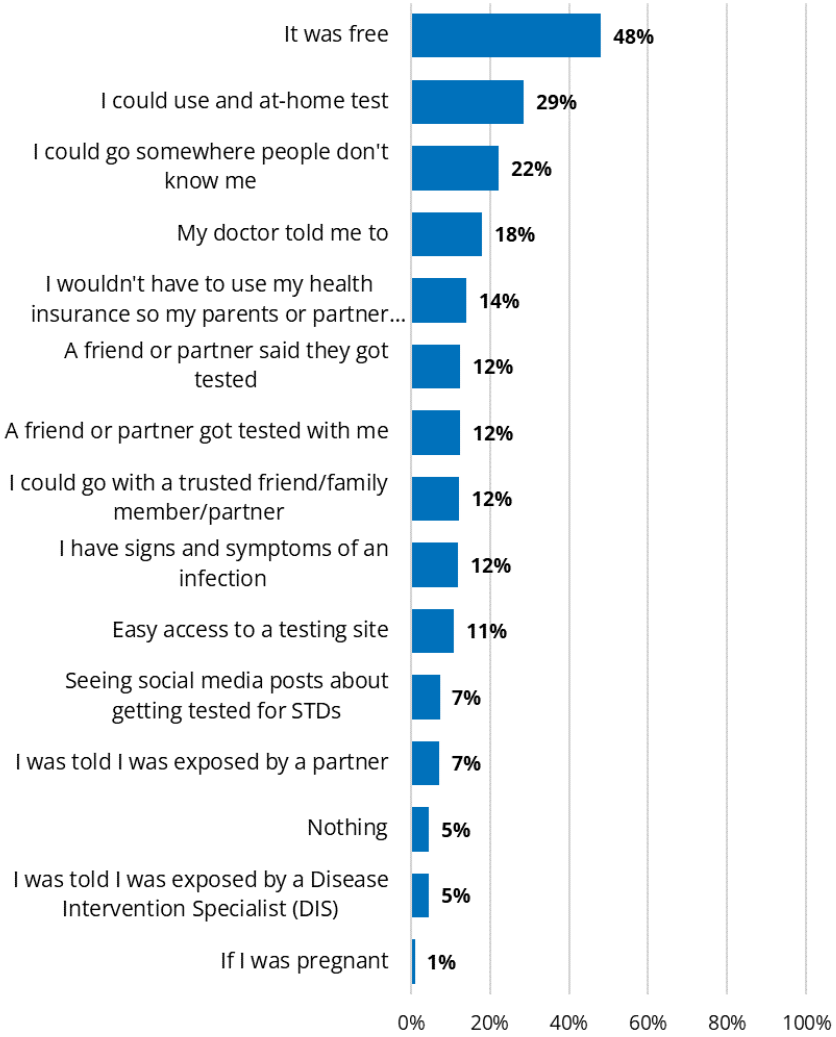

Figure 34. Things that would make it more likely for respondents to receive an STD test (N=2,038).

OPPORTUNITIES FOR IMPROVEMENT

- Increase routine STD testing, particularly among heterosexual, Black, women, men, and individuals aged 50 and older.
- Explore broadening access to point-of-care STD testing.
- Increase awareness of and linkage to organizations offering free or low-cost testing services.
- Implement routine STD testing and integrate with other preventative screenings (i.e., HIV, HCV, Mpox).
- Increase community outreach efforts.

Hepatitis C (HCV) Testing

Hepatitis C (HCV) is a virus that affects the liver and can cause serious damage. Most people who acquire HCV suffer from a long-term chronic infection. A small portion of people diagnosed with HCV clear the virus on their own, but most will need treatment to be cured. At this time, there is no vaccine for HCV.

A new Viral Hepatitis Testing Law (HB6733) became effective in Connecticut on October 1, 2023 It, "requires all primary care providers to offer a hepatitis C testing to each patient over the age of 18, at least once, all pregnant women during each pregnancy, and persons with known risk factors for hepatitis C should be tested more frequently."

All respondents were asked about their experience with HCV testing. Over half of respondents had received an HCV test within the past 12 months, while 40% had not received a test, and 6% were unsure if they had received a test (Figure 35).

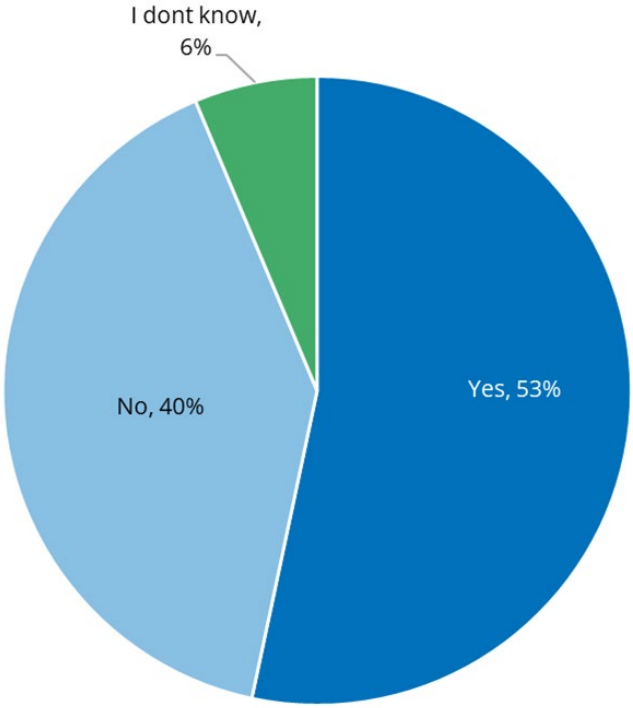

Figure 35. Tested for HCV within the past 12 months (N=2,038).

Comparatively, 68% of respondents reported ever being tested for HCV (Figure 36), and only one quarter (25%) were never tested.

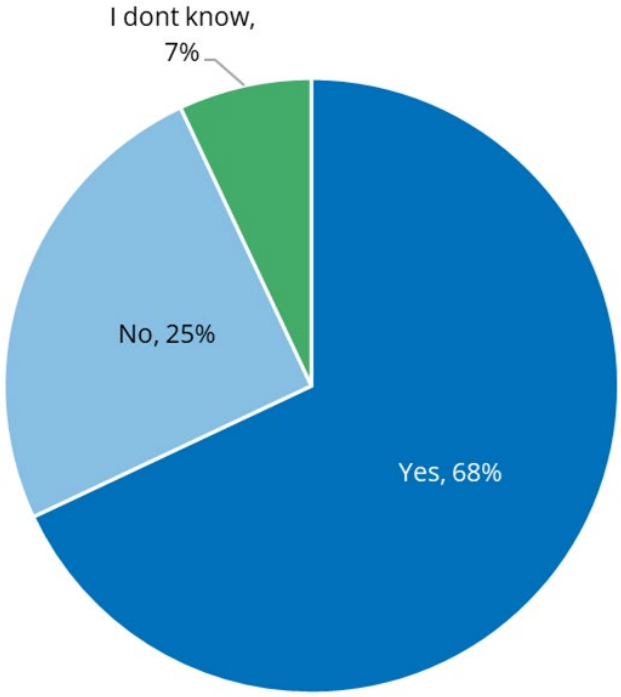

Figure 36. Ever tested for HCV (N=2,038).

When evaluated for disparities (Figure 37), respondents who identified as lesbian (75%, n=99), gay (87%, n=195), and transgender or non-binary (89%, n=381) were more likely to have ever been tested for HCV.

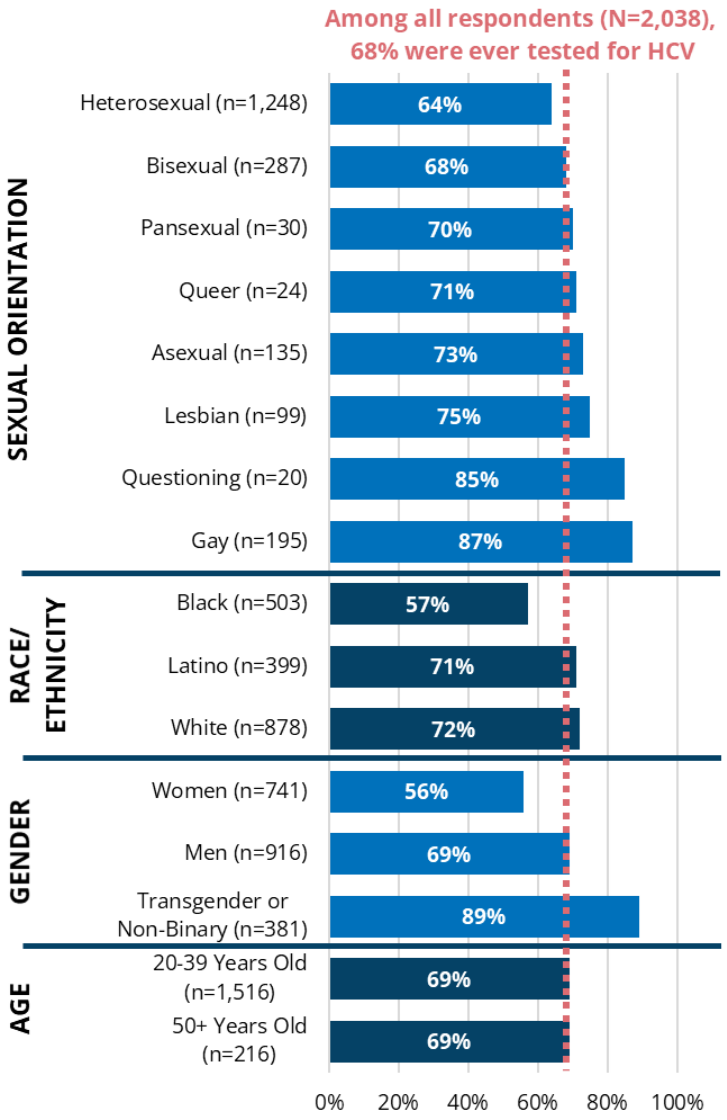

Figure 37. Disparities among respondents who were ever tested for HCV by sexual orientation, race, ethnicity, gender, and age. *Respondents who identified as pansexual, queer, or questioning are included in the figure, however, their results should not be considered a disparity due to their small population size. The red dotted line indicates the percent of all respondents who were ever tested for HCV (68%).*

Among respondents who had ever been tested for HCV, 54% had ever tested positive, with 38% testing positive within the past 12 months (Figure 38).

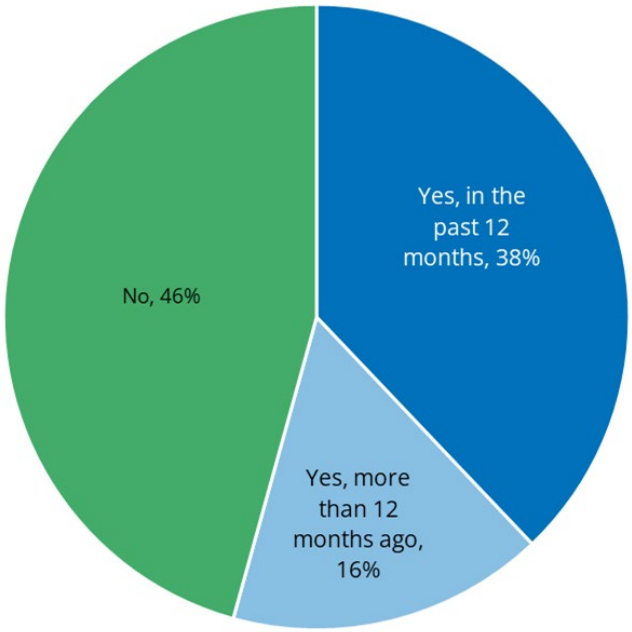

Figure 38. Positive HCV test result among respondents who had ever received an HCV test (n=1,385).

There were 752 respondents who had ever tested positive for HCV. Of those, 85% had received treatment (Figure 39). Forty-two percent (42%) were currently being treated, 24% were treated and cured, and 20% were treated, cured, and reinfected. Twelve percent (12%) of respondents had never been treated.

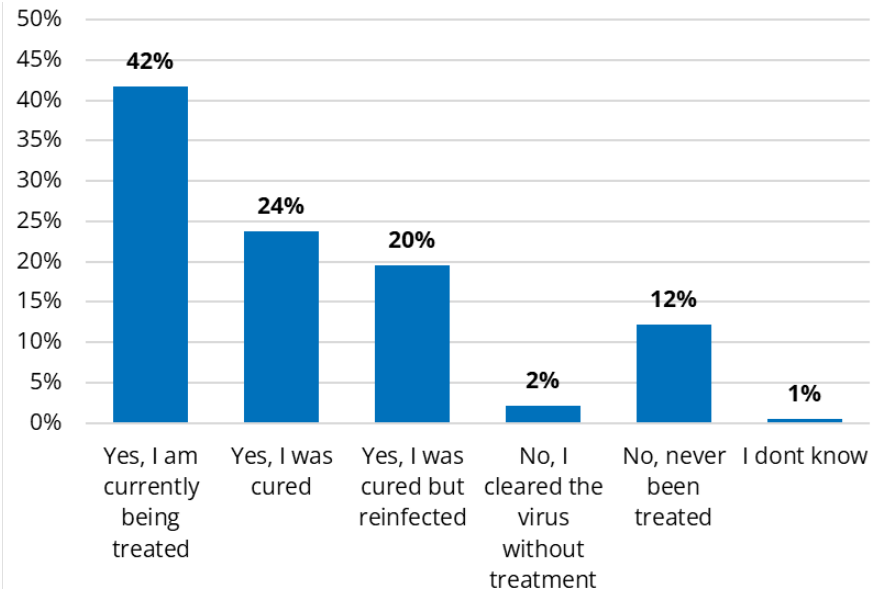

Figure 39. HCV treatment among respondents who had ever tested positive for HCV (n=752).

Respondents who had never been treated for HCV were asked the reasons why they hadn't received treatment (Figure 40). About one third of respondents indicated they didn't know where to go (33%),

and another third said they didn't have insurance (30%). One quarter of respondents stated they didn't want treatment (25%).

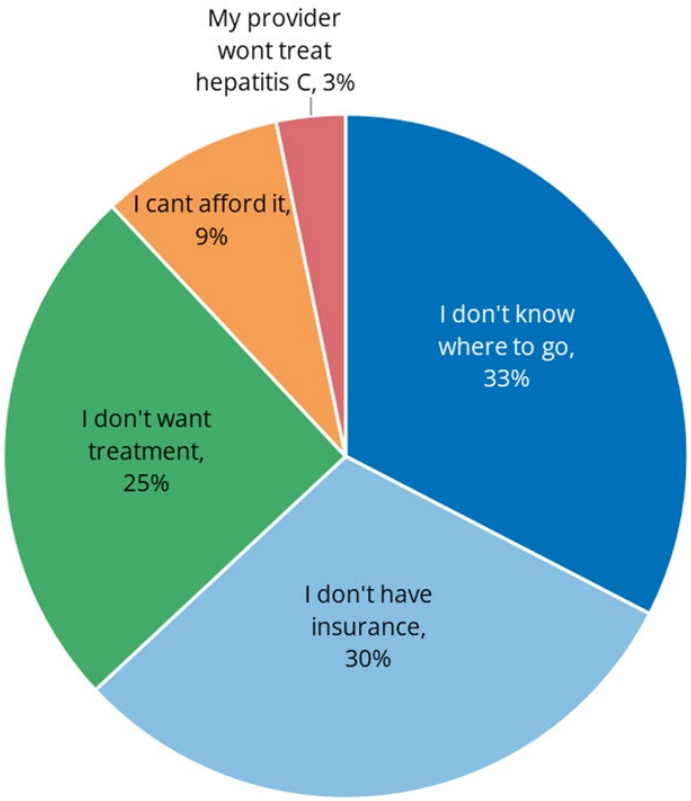

Figure 40. Reasons why respondents didn't receive HCV treatment (n=92).

OPPORTUNITIES FOR IMPROVEMENT

- Increase HCV testing, especially among populations that identify as heterosexual, Black, and women.
- Create and disseminate a fact sheet outlining the new viral hepatitis testing law to both providers and patients.
- Increase patient awareness of available HCV treatment locations, including primary care providers (PCPs) and federally qualified health centers (FQHCs).
- Increase HCV treatment engagement by employing patient navigators for enhanced linkage to care.
- Increase community outreach efforts

Mental Health

Mental health encompasses a person's emotional, psychological, and social well-being, influencing how they think, feel, and act in daily life. It encompasses a broad spectrum of conditions ranging from mood disorders like depression and anxiety to severe mental illnesses such as schizophrenia. Mental health is interconnected with physical health, and conditions like HIV and STDs can significantly impact it. Individuals living with HIV or STDs may experience heightened levels of stress, anxiety, and depression due to the stigma, fear of disclosure, and potential impact on relationships and self-esteem. Additionally, the complex medical management of these conditions can further

exacerbate mental health challenges, underscoring the importance of integrated care approaches that address both physical and psychological needs for optimal well-being.

In this section of the survey, respondents were asked about any mental health challenges they experienced. Figure 41 below shows the number of days respondents felt stressed, depressed, hopeless, isolated, anxious, or had other emotional problems over the past 30 days. About one quarter of respondents reported feeling like this for zero days (12%). The majority of respondents (31%) reported these feelings for 3-6 days. Eleven percent (11%) of respondents reported these feelings for all 30 days.

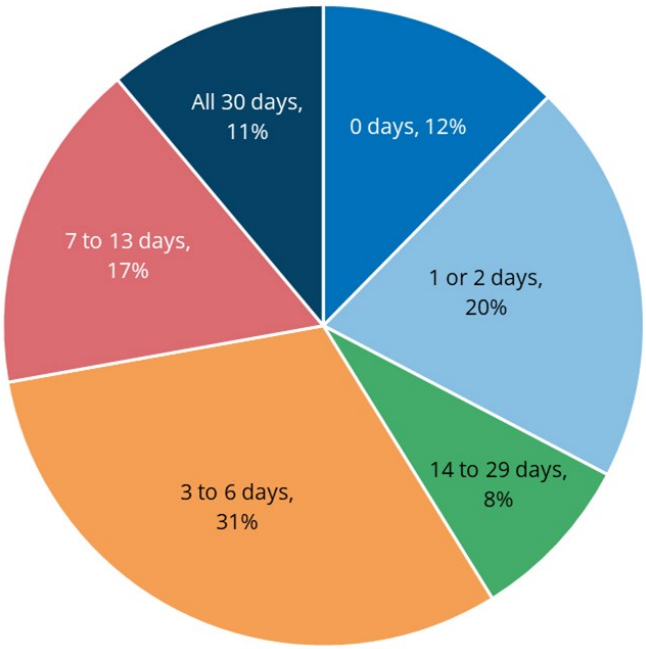

Figure 41. Number of days respondents felt stressed, depressed, hopeless, isolated, anxious, or had other emotional problems over the past 30 days (N=2,038).

Thirty-five percent (35%) of respondents reported feeling suicidal within the past 12 months. Figure 42 shows the disparity evaluation for suicidal thoughts in the past 12 months. Respondents who identified as heterosexual (20%, n=1,248), Black (27%, n=503), women (21%, n=741), men (29%, n=916), and those aged 50+ years old (5%, n=216) were less likely to have had suicidal thoughts. All other populations were more likely to have experienced suicidal thoughts compared to all respondents.

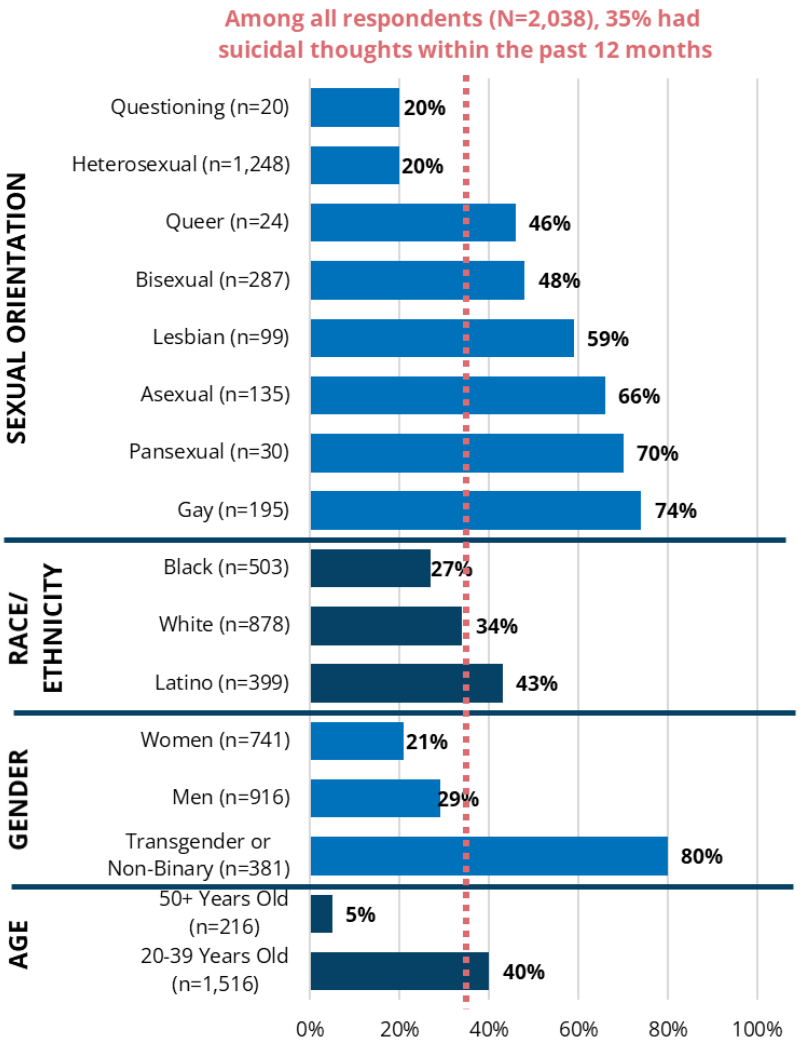

Figure 42. Disparities among respondents who had suicidal thoughts within the past 12 months by sexual orientation, race, ethnicity, gender, and age. *Respondents who identified as pansexual, queer, or questioning are included in the figure, however, their results should not be considered a disparity due to their small population size. The red dotted line indicates the percent of all respondents who had suicidal thoughts within the past 12 months (35%).*

OPPORTUNITIES FOR IMPROVEMENT

- Enhance mental health screening, particularly among bisexual, lesbian, asexual, gay, Hispanic, transgender, non-binary, and 20-39-year-old populations.
- Raise awareness of the 9-8-8 suicide hotline.
- Implement a Syndemic screening tool for comprehensive health assessments.
- Enhance accessibility to mental health services by expanding service locations, offering teletherapy options, and reducing wait times for appointments.
- Explore ways to integrate mental health services with primary care and other healthcare settings to provide holistic care and improve coordination between mental health providers and other healthcare professionals.
- Implement cultural humility training to better meet the needs of diverse populations and ensure effective referrals and linkages for mental health services.

- Collaborate with other state agencies such as DMHAS.
- Improve services by hiring staff that reflects the focus population, including racial and ethnic minorities, LGBTQ+ individuals, and those with different cultural backgrounds.
- Increase community outreach efforts to raise awareness about mental health issues, reduce stigma, and promote help-seeking behaviors.
- Increase community outreach efforts.

Substance Use

Respondents were asked about past and present drug use. Exactly half of respondents reported never injecting drugs (Figure 43). Thirty-four percent (34%) reported injecting drugs within the past 12 months, while the remaining 16% reported injecting drugs more than 12 months ago.

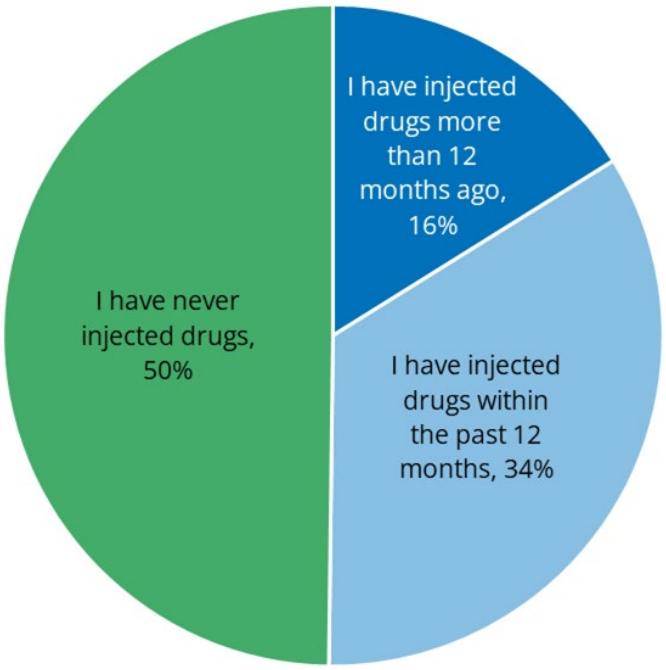

Figure 43. Injection drug use among all respondents (N=2,038).

When evaluated for disparities (Figure 44), respondents who identified as heterosexual (37%, n=1,248), Black (36%, n=503), women (34%, n=741), and those aged 50+ years old (29%, n=216) were less likely to have ever injected drugs.

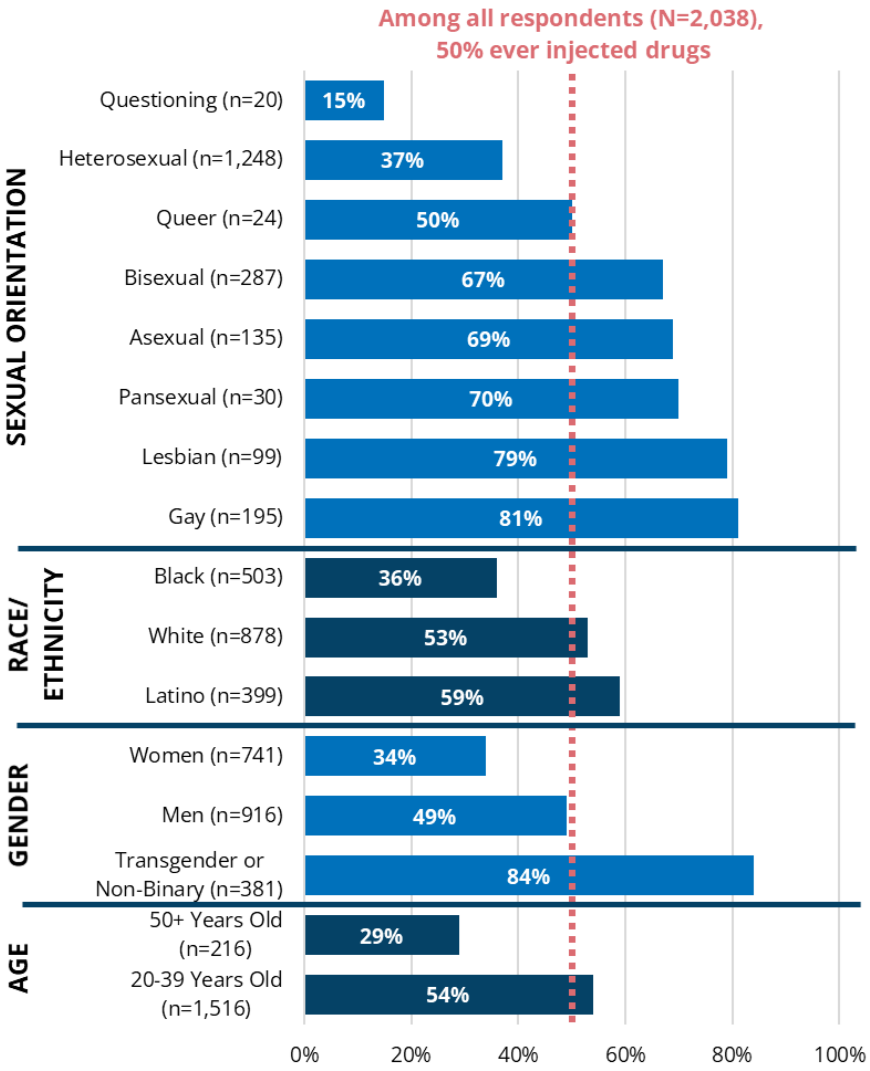

Figure 44. Disparities among respondents who had ever injected drugs by sexual orientation, race, ethnicity, gender, and age. *Respondents who identified as pansexual, queer, or questioning are included in the figure, however, their results should not be considered a disparity due to their small population size. The red dotted line indicates the percent of all respondents who had ever injected drugs (50%).*

About three quarters of respondents (74%) who had ever injected drugs (n=1,023) reported sharing needles or works, and 93% said they knew where to get new needles or syringes. In addition, 90% reported knowing where to dispose of used needles.

Figure 45 shows the locations where they access new needles or syringes. Syringe service programs were most utilized to get new needles or syringes (44%), followed by pharmacies (38%), and family or friends (36%).

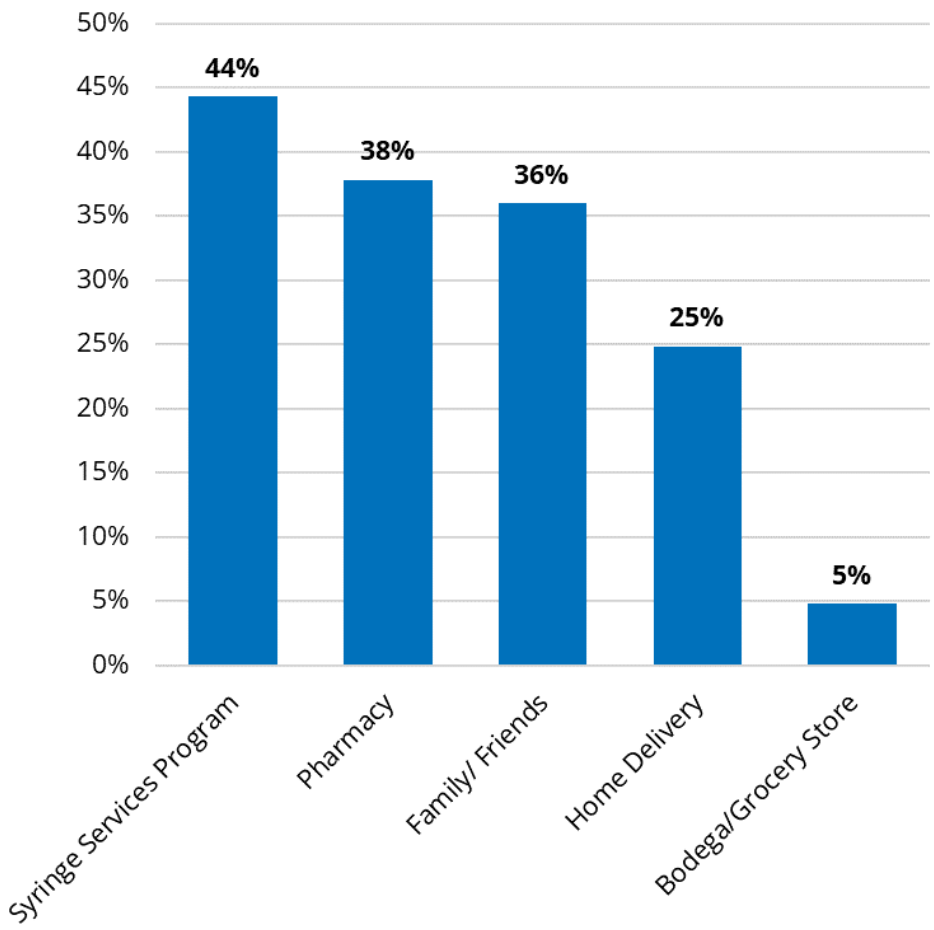

Figure 45. Locations where respondents obtain new needles or syringes (n=1,023). *Respondents were asked to select all that apply.*

All respondents were asked about drugs used in the last 12 months (Figure 46). The most frequently used drugs were cannabis (34%), followed by stimulants (30%) and opioids (24%). Forty-five percent (45%) of respondents reported not using any drugs in the last 12 months.

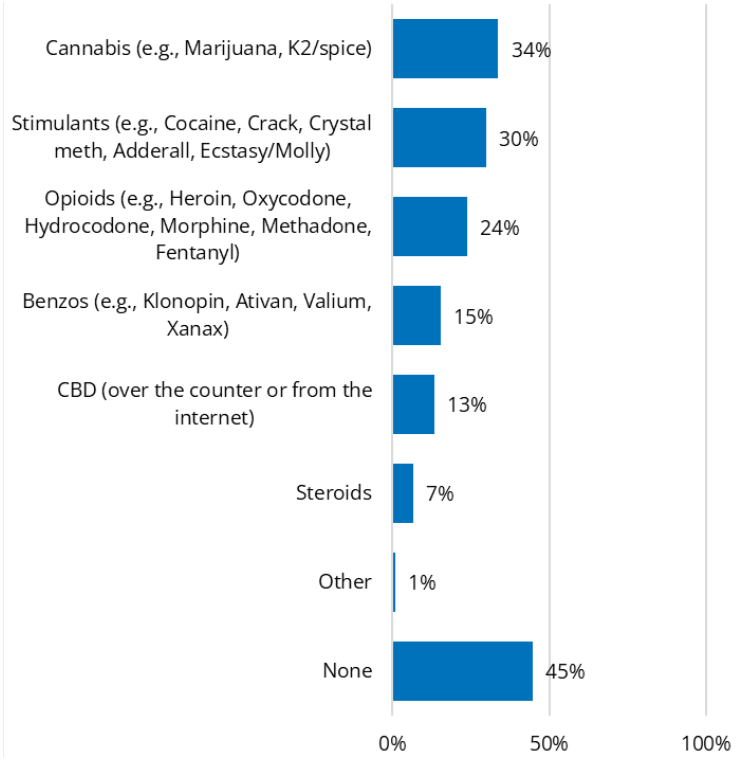

Figure 46. Drugs used within the past 12 months among all respondents (N=2,038).

Among all respondents, 48% reported that they have wanted to stop using drugs, or someone close to them asked them to stop using drugs.

OPPORTUNITIES FOR IMPROVEMENT

- Increase linkage to medications for opioid use disorder and other drug treatment services.
- Expand bundled services for opioid use disorder.
- Increase education around Harm Reduction.
- Reduce wait times for enrollment in treatment facilities.
- Eliminate barriers to accessing care (e.g., requirement of being in recovery).
- Increase the availability of MAT options in correctional facilities.
- Increase community outreach efforts.

Service Improvement

Respondents were asked about the best way services could be improved. Figure 47-49 show the ways HIV, STD, and HCV prevention services could be improved. More education was the most frequently selected improvement opportunity for all three prevention services types at 33%, 34%, and 28% respectively.

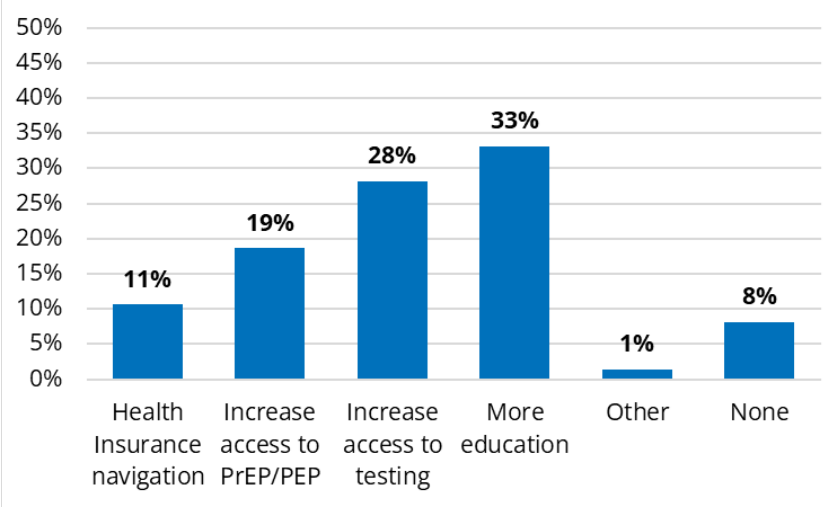

Figure 47. HIV prevention services improvement opportunities (N=2,038).

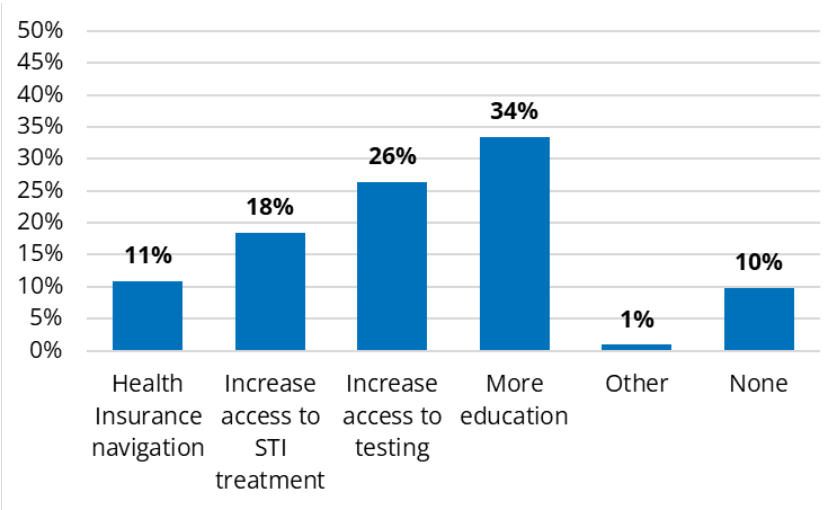

Figure 48. STD prevention services improvement opportunities (N=2,038).

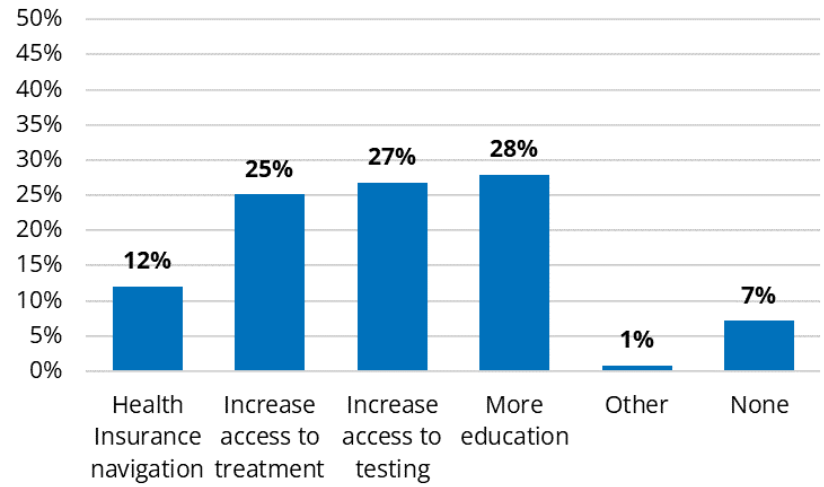

Figure 49. HCV prevention services improvement opportunities (N=2,038).

Figure 50 shows the ways substance use disorder (SUD) could be improved. One quarter of respondents (25%) said increased access to substance use treatment was the best way to improve SUD.

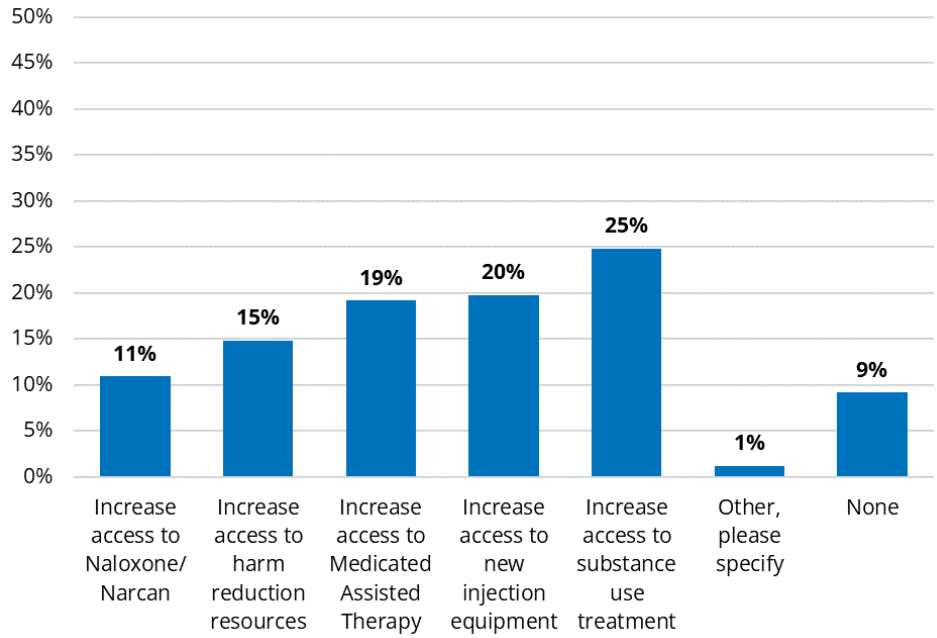

Figure 50. Substance use disorder improvement opportunities (N=2,038).

CONNECTICUT
Public Health

Improvement Opportunities

Prevention Needs Assessment 2022

Prevention Needs Assessment

The Prevention Needs Assessment (PNA) survey was conducted in 2022 and assessed various aspects of HIV prevention needs among Connecticut residents. A total of 2,038 individuals completed the survey. The PNA collected information about respondents' demographics, HIV testing history, pre and post-exposure prophylaxis awareness and use, STD and hepatitis C (HCV) testing and treatment, substance use, mental health, sexual practices, marketing of services, and opportunities for improvement in prevention services.

Improvement Opportunities

Opportunities for improvement were identified for each topic area in the survey.

Marketing

- Maintain emphasis on social media campaigns for outreach, while identifying the most effective platforms for each audience.
- Foster engagement with the population through focus groups or listening sessions to gather diverse perspectives.
- Implement academic detailing through personalized educational sessions with healthcare professionals and utilize provider toolkits and fact sheets to deliver tailored information and resources to facilitate informed decision-making and optimize patient care.
- Obtain additional resources for a local Public Service Announcement (PSA) promoting HIV prevention services and how to access them.

Service Delivery

- Explore ways to increase client satisfaction.
- Investigate variations in wait times across different prevention services (e.g., HIV, STD, PrEP, HCV, etc.).
- Improve provider capacity and reduce wait times to enable comprehensive care within a single visit using the Status Neutral model of care.
- Explore bundled testing modalities to increase service provisions.
- Explore other bundled service opportunities such as mobile pharmacies, mobile SSP services, and mobile testing services.
- Explore ways to integrate prevention services with other state entities (i.e., DMHAS, DOC, DCF, DSS, and DDS)

HIV Testing

- Encourage providers to prioritize PrEP and more frequent testing for high-risk individuals.
- Educate both providers and consumers about routine testing laws for HIV and HCV.
- Enhance understanding of gender-affirming care, provider bias, stigma, health equity, and anti-racism through trainings and capacity-building assistance.
- Implement syndemic screening tools to improve comprehensive health assessments.
- Expand sexual health clinics to increase accessibility to services.
- Recruit staff members who represent populations affected by the epidemic.
- Conduct focus groups with individuals who have been denied an HIV test, particularly transgender or non-binary individuals.

Pre-Exposure Prophylaxis (PrEP)

- Increase PrEP uptake, particularly among heterosexual, Black, female, and older populations (50+).
- Explore alternative methods for accessing or funding PrEP beyond reliance on health insurance.
- Address health insurance privacy concerns, such as concerns regarding Explanation of Benefits (EOBs) sent to home addresses.
- Provide healthcare providers with education on PrEP benefits and access options for uninsured or underinsured individuals.
- Collaborate with the State Public Health Laboratory to alleviate financial burdens associated with PrEP adherence.
- Establish a PrEP Drug Assistance Program (DAP) as a payor of last resort.
- Explore potential data sharing agreements with the Office of Health Services (OHS) for insight on PrEP and PEP prescription data.

Post-Exposure Prophylaxis (PEP)

- Increase PEP awareness and uptake, particularly among heterosexual, Black, female, and older (50+) populations.
- Explore additional facilities capable of offering on-demand PEP services.
- Foster collaboration with other agencies, such as the Connecticut Alliance to End Sexual Violence and others, to bolster PEP access and support initiatives.

Condom Use

- Provide education on the increasing prevalence of STDs and stress the importance of condom use when

either partner has not been tested for HIV and STDs, regardless of past sexual history.
- Expand condom distribution programs in various settings such as healthcare facilities, community centers, schools, and public events to ensure easy access to condoms for individuals of all ages.
- Increase the variety of available condoms to include different sizes, textures, and materials to cater to diverse preferences and needs, thereby encouraging consistent use.
- Establish peer-led initiatives where trained individuals within communities educate their peers on the importance of condom use, correct usage techniques, and overcoming barriers to consistent use.

STD Testing

- Increase routine STD testing, particularly among heterosexual, Black, women, men, and individuals aged 50 and older.
- Explore broadening access to point-of-care STD testing.
- Increase awareness of and linkage to organizations offering free or low-cost testing services.
- Implement routine STD testing and integrate with other preventative screenings (i.e., HIV, HCV, Mpox).

Hepatitis C (HCV) Testing

- Increase HCV testing, especially among populations that identify as heterosexual, Black, and women.
- Create and disseminate a fact sheet outlining the new viral hepatitis testing law to both providers and patients.
- Increase patient awareness of available HCV treatment locations, including primary care providers (PCPs) and federally qualified health centers (FQHCs).
- Increase HCV treatment engagement by employing patient navigators for enhanced linkage to care.

Mental Health

- Enhance mental health screening, particularly among bisexual, lesbian, asexual, gay, Hispanic, transgender, non-binary, and 20-39-year-old populations.
- Raise awareness of the 9-8-8 suicide hotline.
- Implement a Syndemic screening tool for comprehensive health assessments.
- Enhance accessibility to mental health services by expanding service locations, offering teletherapy options, and reducing wait times for appointments.
- Explore ways to integrate mental health services with primary care and other healthcare settings to provide holistic care and improve coordination between mental health providers and other healthcare professionals.
- Implement cultural humility training to better meet the needs of diverse populations and ensure effective referrals and linkages for mental health services.
- Collaborate with other state agencies such as DMHAS.
- Improve services by hiring staff that reflects the focus population, including racial and ethnic minorities, LGBTQ+ individuals, and those with different cultural backgrounds.
- Increase community outreach efforts to raise awareness about mental health issues, reduce stigma, and promote help-seeking behaviors.

Substance Use

- Increase linkage to medications for opioid use disorder and other drug treatment services.
- Expand bundled services for opioid use disorder.
- Increase education around Harm Reduction.
- Reduce wait times for enrollment in treatment facilities.
- Eliminate barriers to accessing care (e.g., requirement of being in recovery).
- Increase the availability of MAT options in correctional facilities.

For help interpreting results, please contact:
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