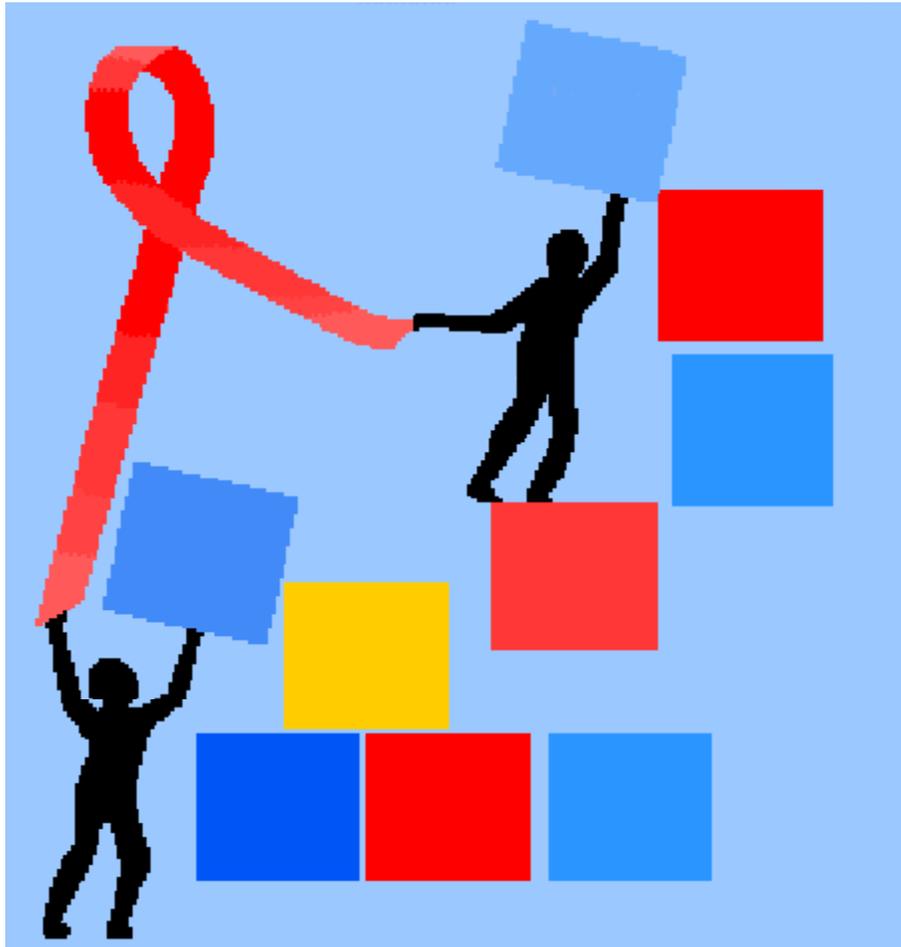


## CHAPTER 3

# Community Services Assessment and Prioritization of Target Populations



## **COMMUNITY SERVICES ASSESSMENT AND PRIORITIZATION OF TARGET POPULATIONS**

### **Data Collection Methods**

The Needs Assessment/Community Resources Committee, Epi Profile Committee, and the CPG as a whole completed an intensive review of inventory data. Additional data was collected through a number of processes to further the understanding of at-risk populations in Iowa. With a variety of data collection methods available, the Needs Assessment/Community Resources Committee weighed the merits of each, the available resources and expertise, and the time available to complete the data collection process before making a decision to further access qualitative data.

The Needs Assessment/Community Resources Committee used the following in completing its assessment.

- Key informant interviews
- Focus groups
- Information from the Young Adult Roundtables
- Prevention providers resource inventory
- Review of findings from contractual project reports
- Review of secondary research

## Inventory of Iowa HIV/AIDS Needs Assessment Studies

The CPG has compiled an inventory of documents for use in its review of existing needs and possible gaps in prevention services. The following inventory represents the current working inventory used by the CPG.

TITLE OF STUDY	DESCRIPTION
1. HIV/AIDS and STD in Iowa, 2002 <a href="http://www.idph.state.ia.us/ch/hiv_aids_programs.asp#surveillance">http://www.idph.state.ia.us/ch/hiv_aids_programs.asp#surveillance</a>	IDPH annual report on the epidemiology of HIV/AIDS and sexually transmitted diseases in Iowa. See Chapter 2.
2. HIV/AIDS Prevention Program Contract and Yearly Summary Reports, 2002	Reports from contract recipients of HIV/AIDS prevention activities that describes interventions, challenges, positive accomplishments, and creative solutions.
3. Reports from Counseling, Testing and Referral (CTR) Sites, 2002	Compiled from University of Iowa Hygienic Laboratory and the IDPH. Epidemiological data on persons being counseled and tested through CTR Sites. <ul style="list-style-type: none"> <li>• 9,844 tests were performed.</li> <li>• 15.2% of the people tested were self-identified as part of a target population. This is an increase from 14.5% in 2001.</li> <li>• 23.2% of testing was conducted in an outreach setting.</li> <li>• The overall return rate from all CTR sites was 70%. For those clients specifically testing for HIV, the return rate was 83.2%.</li> </ul>
4. STD/HIV Clinic Risk Assessments from CTR sites and substance abuse facilities, 2002	This summary reflects questions asked on a risk assessment that clients complete at the CTR sites and some substance abuse facilities. 12,820 surveys were reviewed (7,031 males, 5,787 females and 2 not indicated). Of the 12,820 surveys: <ul style="list-style-type: none"> <li>• 56.7% indicated they had been tested for HIV before.</li> <li>• 30.4% indicated they had an STD.</li> <li>• 2.3% indicated they had sex with a person who had HIV/AIDS.</li> <li>• 8.7% indicated they had used drugs with a needle.</li> <li>• 71% indicated they had sex while using alcohol.</li> <li>• 34.7% indicated they had sex when using drugs.</li> <li>• 4.7% indicated they had sex in return for drugs, money or favors.</li> <li>• 18.7% indicated their partner had an STD.</li> <li>• 1.6% indicated their partner had sex with a person who had HIV/AIDS.</li> <li>• 8.1% indicated their partner had used drugs with a needle.</li> <li>• 65.4% indicated their partner had sex when using alcohol.</li> <li>• 32.6% indicated their partner had sex when using drugs.</li> <li>• 3.5% indicated their partner had sex in return for drugs, money or favors.</li> <li>• 51% indicated they had sex with 2-5 partners in the past year.</li> <li>• 6.8% indicated they had sex with 6-9 partners in the past year.</li> <li>• 4.9% indicated they had sex with ten or more partners in the past year.</li> </ul>

TITLE OF STUDY	DESCRIPTION
5. STD/HIV Clinic Risk Assessments from CTR sites and substance abuse facilities, 2002	<ul style="list-style-type: none"> <li>• 13.8% indicated they used condoms every time.</li> <li>• 47.5% indicated they used condoms sometimes. This is a 23.1% drop since 1999.</li> </ul> <p>34.8% indicated they never used condoms. This is a 15.6% increase since 1999.</p>
6. Substance Abuse Treatment Data, 2002	<p>This data is based on 42,911 people that were admitted into treatment programs in 2002. Key findings regarding prevalence and patterns of substance use are presented for alcohol, tobacco, and other drugs.</p> <ul style="list-style-type: none"> <li>• 11.2% of people reported past IV drug use.</li> <li>• Alcohol was the most commonly used substance among adult Iowans, and the substance responsible for most treatment needs.</li> <li>• Marijuana was the most commonly reported illegal drug used by adult Iowans.</li> <li>• Stimulants (including methamphetamine) were the third most common category of drugs used by adult Iowans.</li> <li>• The most substance abuse occurred in the age range from 25-34.</li> </ul>
7. Ryan White Statewide Coordinated Statement of Need (SCSN), 2002	<p>The SCSN is a jointly prepared declaration by Ryan White CARE Act grantees, persons living with HIV/AIDS, and other interested parties within Iowa. The document serves to identify the epidemiological trends, common needs and barriers for persons living with HIV/AIDS, emerging needs, and overarching issues within Iowa.</p>
8. Iowa HIV/AIDS Project School Health Education Profile (SHEP), 2002	<p>CDC sponsored survey for school principals and lead health education teachers. Focuses on implementation of comprehensive school health education including sexual behaviors, sexually transmitted diseases, unintended pregnancies, and alcohol and other drug use, improper nutrition, sedentary lifestyle, intentional and unintentional injuries, and violent activities.</p> <p>Students are required to take one year or less of health education in 86% of Iowa's middle schools, in 88% of the state's junior/senior high schools, and in 71% of its senior high schools.</p> <ul style="list-style-type: none"> <li>• Most schools taught separate courses in health education.</li> <li>• 44% of teachers taught how to correctly use a condom.</li> <li>• 39% of staff received development courses in HIV prevention.</li> </ul> <p>Required health education is usually scheduled in grades seven or eight (middle school), eight or nine (junior/senior high school), and nine or ten (senior high school).</p> <p>During the senior year of high school, the reported incidence of sexual intercourse was highest of all 4 years and reported condom use was lowest, but only 32% of students in this classification received a health education course.</p>

TITLE OF STUDY	DESCRIPTION
9. Methamphetamine Trends, 2001-2002	<ul style="list-style-type: none"> <li>• Iowa is 6th for highest methamphetamine usage nation wide. No other mid-west state ranks higher.</li> <li>• The percent of incoming prison inmates reporting a primary use of methamphetamine has increased from 16% in 1997 to 25% in 2001.</li> <li>• By the end of 2002, the most frequent age group in female arrestees testing positive for methamphetamine was under 21.</li> <li>• For male arrestees at the end of 2002, the most common payment for methamphetamines was “non-cash,” meaning trading for other drugs, property, or sex.</li> </ul>
10. Iowa Youth Risk Behavior Survey (YRBS): Regular High School, 2001	<p>CDC sponsored; survey of students in grades 9-12 in regular public school. Self-reporting assessment to help monitor the prevalence of behaviors that put youth at risk for the most serious health and social problems that can occur during adolescence and into adulthood including drug use, sexual activity, etc.</p> <p>Focus on adolescents.</p> <ul style="list-style-type: none"> <li>• 43% of students, grades 9-12 indicated they had sexual intercourse at some time in their lives.</li> <li>• 34% of students indicated they had sexual intercourse within the last three months. An increase of 5% from 1999.</li> <li>• About 25% of students who indicated they had sexual intercourse during the last three months said they drank alcohol or used drugs before their last sexual intercourse.</li> <li>• Almost 7% of students indicated they had ever used methamphetamines. This is down from 9% in 1999.</li> </ul>
11. Iowa Youth Risk Behavior Survey (YRBS): Alternative High School, 2001	<p>CDC sponsored; survey of students in grades 9-12 in public alternative high school. Self-reporting assessment to help monitor the prevalence of behaviors that put youth at risk for the most serious health and social problems that can occur during adolescence and into adulthood including drug use, sexual activity, etc. Focus on adolescents.</p> <ul style="list-style-type: none"> <li>• 88% of students, grades 9-12 indicated they had sexual intercourse at some time in their lives.</li> <li>• 72% of students indicated they had sexual intercourse within the last three months.</li> <li>• About 34% of students who indicated they had sexual intercourse during the last three months said they drank alcohol or used drugs before their last sexual intercourse. This is down from 40% in 1999.</li> <li>• About 35% of students indicated they had ever used methamphetamines. This is down from 43% in 1999.</li> </ul>
12. Iowa Behavioral Risk Factor Surveillance System (BRFSS), 2001	<ul style="list-style-type: none"> <li>• The Iowa Behavioral Risk Factor Surveillance System is an ongoing monthly telephone survey which is financially and technically supported by the Centers for Disease Control and Prevention (CDC). The BRFSS is designed to collect</li> </ul>

TITLE OF STUDY	DESCRIPTION
<p>13. Iowa Behavioral Risk Factor Surveillance System (BRFSS), 2001 (continued)</p>	<p>information on health risk behaviors of Iowa residents age 18 and over and to monitor prevalence of these behaviors. In the 2001 BRFSS, 3,635 people participated. The risk behaviors surveyed are major contributors to illness, disability, and premature death.</p> <ul style="list-style-type: none"> <li>• 85% of respondents thought it very important to know their HIV status. Only 33% had been tested.</li> </ul> <p>12% of respondents reported they had talked to a health care provider about preventing sexually transmitted diseases other than HIV/AIDS through condom use</p>
<p>14. Survey and Analysis of the Health Needs and Disparities of the Immigrant Population, 2001 (in Iowa)</p> <p><a href="http://www.ianepca.com/reports.htm">http://www.ianepca.com/reports.htm</a></p>	<p>A total of 551 interviews were used in this study. The respondents were 18 years or older and the majority were Latino immigrants.</p> <ul style="list-style-type: none"> <li>• 50% of immigrants interviewed felt that ethnicity was a barrier to receiving health care.</li> <li>• 53% felt that transportation was a barrier and 46% reported that cost was a significant barrier.</li> <li>• 17% of immigrants interviewed have never seen a primary care doctor.</li> </ul>
<p>15. Prevalence of HIV-1 Antibody in Civilian Applicants for Military Service, 2000</p>	<p>CDC monitors HIV prevalence data provided by the U.S. Department of Defense (DOD) from their screening program for military applicants. Because of the large number of male and female applicants from all areas of the country, this population provides valuable information about the HIV epidemic.</p> <p>All persons applying for active duty or reserve military service, the service academies, or the Reserve Officer Training Corps must have high school diplomas or the equivalent. Applicants are screened for HIV infection as part of their entrance examinations.</p> <p>The prevalence of HIV-1 antibody in Iowa from October 1985 to March 2000 was 0.02% of 77,928 tested.</p>
<p>16. State Plan for Substance Abuse Prevention, 1999-2004</p>	<p>The Plan is a product of a statewide strategic planning process and serves as a guide for five years for prevention services for alcohol, tobacco, and other drug abuse and related problems. Goals included those to be addressed by state agencies and by collaborations of state agencies and goals to be addressed by local substance abuse comprehensive contracts/projects. The plan also contains needs/ issues of various communities/populations. Below are statistics from 2002 for substance abuse in Iowa.</p> <ul style="list-style-type: none"> <li>• Methamphetamine increased as the primary drug for persons entering substance abuse treatment from 1% in 1992 to 12% in 2002.</li> <li>• Marijuana increased as a primary drug from 7% in 1992 to 23% in 2002.</li> <li>• Alcohol use decreased as a primary drug from 85% in 1992 to 59% in 2002.</li> </ul>

TITLE OF STUDY	DESCRIPTION
<p>17. Homelessness in Iowa: The 1999 Summary</p>	<p>Summary of a report prepared for the state of Iowa by the University of Iowa in cooperation with the Iowa Department of Education and other state agencies. The primary purpose of the 1999 Homeless Study is estimating the size of the homeless and near-homeless population in 1999. It also provides a basic demographic profile of the homeless and near-homeless populations, investigates the causes of homelessness, and investigates service providers' perceptions of causes, barriers, and trends in number served.</p> <ul style="list-style-type: none"> <li>• Of the homeless: <ul style="list-style-type: none"> <li>• 59.7% are children</li> <li>• 33.7% are adults</li> <li>• 6.7% are unknown</li> </ul> </li> <li>• Of the near-homeless: <ul style="list-style-type: none"> <li>• 65.2% are children</li> <li>• 25.9% are adults</li> <li>• 8.9% are unknown</li> </ul> </li> <li>• The number one cause of homelessness is family break-ups.</li> <li>• Women comprise over half of the adult homeless in Iowa, no doubt related to their presence as a single parent in 80% of those households.</li> <li>• Half of all homeless households rely on income from employment. This suggests that higher paying jobs are out-of-reach or unavailable.</li> <li>• Service providers indicate that lack of living wage jobs and affordable housing were the most significant barriers to resolving homelessness in every type of community.</li> </ul>
<p>18. HIV/AIDS and Homelessness, 1999</p>	<p>This document was developed by the National Health Care for the Homeless Council in collaboration with the Bureaus of Primary Health Care, HIV/AIDS, Health Resources and Service Administration, Department of Health and Human Services in response to the following concerns.</p> <ul style="list-style-type: none"> <li>• The prevalence of HIV/AIDS is dramatically higher among homeless people than in the general population.</li> <li>• Homelessness and HIV/AIDS are widespread and intersecting problems that occur in both urban and rural populations throughout the United States.</li> <li>• Conditions associated with homelessness make HIV prevention and control especially difficult.</li> <li>• Limited access to medical care severely restricts HIV/AIDS prevention, risk reduction and treatment for homeless persons.</li> <li>• Adherence to complex HIV treatment regimens presents special challenges for homeless patients and their caregivers.</li> </ul>

TITLE OF STUDY	DESCRIPTION
<p>19. Dynamics of Race, Culture and Key Indicators of Health in the Nation's 100 Largest Cities and Their Suburbs, 1998-2000  <a href="http://www.downstate.edu/healthdata">http://www.downstate.edu/healthdata</a></p>	<ul style="list-style-type: none"> <li>• 14% teen birth rate in Des Moines in 2000.</li> <li>• Des Moines was 11th in 1998-1999 for the least amount of people below the federal poverty level.</li> <li>• Des Moines is 44th in 1998-1999 for the most per capita income.</li> </ul>
<p>20. Scott County HIV/AIDS Risk Reduction Project, 1998</p>	<p>John Lewis Coffee Shop, Inc. in cooperation with staff from AIDS Project QUAD Cities, Virology Center, Center for Alcohol Services, Community Health, Scott County Health Department and the AIDS Prevention Partnership embarked on a six month assessment of HIV/AIDS Risk Factors of IDUs and homeless men in high-risk situations.</p> <ul style="list-style-type: none"> <li>• Study suggested that prevention efforts should focus on three areas including direct actions, effective dissemination, and attitudes and beliefs.</li> <li>• Respondents recommend convenient distribution of free condoms and needles/works/syringes.</li> <li>• Prevention information should be reinforced at an individual level to ensure understanding and impact.</li> <li>• Strategies should target attitudes and beliefs as well as provide information and skills building.</li> <li>• Encouragement of more user-friendly attitudes about safer sex practices.</li> </ul>
<p>21. HIV Seroprevalence in Job Corps Applicants Aged 16-21, 1997</p>	<p>The Job Corps, administered by the U.S. Department of Labor, is an occupational training program for socially and economically disadvantaged youth from rural and urban areas of all 50 states and U.S. territories. Data sent to CDC from the Job Corps provide a system for monitoring the HIV epidemic in this population, which may be at increased risk for HIV infection.</p> <p>The Job Corps recruits high school dropouts or high school graduates in need of additional education or training in order to obtain and hold meaningful jobs. The results in this report are for Job Corps entrants in Iowa who were 16 through 21 years of age. From January 1990 - December 1997, 3,625 applicants were tested with no positives identified.</p>
<p>22. Iowa Culturally-Specific Substance Abuse Treatment Needs Assessment Final Report, 1996</p>	<p>This study was conducted in 1993-96 as one of a family of treatment needs assessment studies sponsored by the Center for Substance Abuse Treatment and the Iowa Department of Public Health. The project's purposes were to: estimate substance abuse and abuse prevalence within the selected minority cultural groups, estimate treatment needs of these same groups, and identify the culturally-specific characteristics of those treatment needs.</p>
<p>23. Primary Care Essential Services Report, 1995</p>	<p>IDPH's Primary Care Program Development Group Report defining Iowa needs in:</p> <ol style="list-style-type: none"> <li>1. Acute, Urgent, and Chronic Care</li> <li>2. Case Finding, Case Management, and Transportation</li> <li>3. Health Education</li> <li>4. Communicable Disease Services</li> </ol>

TITLE OF STUDY	DESCRIPTION
24. Primary Care Essential Services Report, 1995	5. Dental Health 6. Emergency Medical Services 7. Family Planning Services 8. Home Health Care 9. Immunization 10. Maternal and Child Health 11. Mental Health 12. Nutrition Services 13. School Health Services 14. Substance Abuse Services
25. HIV Seroprevalance in Iowa Newborns by Region of Birthing Facility, 1995	Report from University of Iowa Hygienic Lab (UHL) showing geographic distribution of HIV positive births 7/1/89 - 12/31/95.
26. Director's Ad Hoc Advisory Committee on the Prevention of HIV Infection, 1993	IDPH review of existing data and their recommendations for the prevention of HIV infection.
27. AIDS Services Task Force Final Report and Recommendations Presented to the 74 <sup>th</sup> Iowa General Assembly, State of Iowa, 1991	Report of the legislative mandated task force. Describes medical and social service issues and presents nine policy options to the legislature.

## Key Informant Interviews

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The key informant interviews were conducted in 1996. The Needs Assessment Committee chose individuals whom they believed to have knowledge and expertise in HIV prevention, composition and character of Iowa communities (rural and urban), HIV/AIDS resources, and effective prevention strategies for target populations. This interview was done by telephone by the Needs Assessment Committee. Twenty-six interviews were completed. (See Attachment #3 for survey instrument.)

### SUMMARY

In an effort to obtain input from a broad spectrum of various community leaders, public officials, administrators, service providers, as well as persons living with HIV/AIDS, 26 key informant interviews were conducted over a three-month period by members of the CPG Needs Assessment Committee. Persons interviewed represented not only the four target populations as defined by the CPG, but were also chosen as a result of their involvement in the geographic regions where the epidemic is centered.

Drawing on technical assistance from the Academy for Educational Development (AED), a series of questions and probes were developed about the existing community services and various demographic characteristics. Questions were also included on both general and specific needs of the populations as well as issues of accessibility and acceptability of solutions. Members of the committee held “mock” interviews with one another, both for timing of the process as well as refining the interview instrument. These role-plays established that approximately 45 minutes would be needed to complete the interview.

The interview instrument was divided into five sections. The committee sought to determine, among other things, the impact of HIV/AIDS in each community; what prevention resources were presently available and the level of their effectiveness; what barriers were hindering prevention work; what the extent of unmet need was; and what type of prevention strategies had proven most effective.

The most revealing response was the rating of existing prevention efforts in the various communities. The work was given a cumulative rating of 3.3 on a scale of 1 to 5. There seemed to be a general consensus that present activities in the state were competent, but also agreement that a much greater emphasis was needed on those proven interventions that lead to sustained behavior change.

As would be expected in a rural state, those populations most identified as under-served were either without any recognized organizational vehicle for outreach or were isolated due to regional demographics. For instance, there seemed to be no easy answers for meeting the needs of a gay or bisexual man in a small community, while there may be an abundance of resources in the larger urban centers. While some progress is being made in urban school districts, there is still much to be desired in smaller communities where resistance to any discussion of sexuality is high. Such is the reality of prevention work in the mosaic make-up of our state.

In a state that is 96% white, there is obvious continued need for training that is both culturally specific and culturally sensitive. In addition to the lack of materials that are linguistically appropriate for certain communities, there is the absence of tools that take into account various cultural approaches to issues connected with AIDS. A better job of creating or locating curricula that are sensitive to the ethnic groups most impacted by the disease must be done. There also seemed to be a great need for education materials that address the risk to heterosexuals of every ethnic background.

There was overwhelming support for a greater emphasis on the link between substance abuse and HIV infection, and most voiced concern over the lack of condom accessibility among school-aged youth. A number of individuals prescribed the challenge to increase outreach to the “differently-abled.”

While the lack of funding was the barrier most mentioned, a number of respondents admitted that their own “lack of creativity” was impeding the programs’ effectiveness. Overall, most felt threatened by the continued sense of indifference and denial by the general population.

Lastly, there appeared to be a general need for more models of programs that emphasize behavioral change, peer education, and evaluation.

## Focus Group Surveys

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The purpose of focus group surveys was to conduct a thorough needs assessment within Iowa that would include the targeted populations. These studies were conducted in an effort to review current HIV/AIDS prevention and care strategies and services throughout the state. The results of these studies provide the HIV Community Planning Group with a vast amount of important qualitative data which is used to better serve the persons in Iowa through effective HIV prevention and care planning. (See attachment #4)

Focus groups are essentially a relaxed forum in which a facilitator and assistant meet with a small group of participants to discuss certain issues. Many advocates of focus groups suggest that these small groups are an excellent way to obtain large quantities of rich qualitative data that can be used in the Community Planning process. The focus groups were conducted in relaxed atmospheres so that persons in the study could feel comfortable and not intimidated by the subject matter or the facilitator. These groups were attended by approximately four to twelve selected participants and were held in small groups to encourage interaction and discussion.

### SUMMARY

A series of focus groups were conducted in 1995 and 1997 to collect more specific information from the target population. A protocol was designed to solicit information in five main areas:

- To determine the definition of prevention for specific target populations;
- To identify how individuals or communities have been impacted by HIV/AIDS;
- To identify what HIV/AIDS prevention needs/issues/problems/challenges exist for target populations and/or communities;
- To identify efficacy of existing HIV/AIDS prevention services; and
- To identify what prevention resources the target populations are aware of in their particular communities and what barriers exist to accessing these services.

Thirteen focus groups were conducted with the following target populations:

- Youth of color
- Youth of color in substance abuse treatment
- Youth in detention (2)
- HIV positive females (2)
- Females of color
- High-risk females

- Gay men
- Gay men of color
- Gay/bisexual youth
- Substance abusers (men & women)
- Substance abusers in corrections

An IDPH employee involved with strategic planning and having expertise on conducting focus groups facilitated the groups with the cooperation of all the CPG members in arranging the group structure, times, etc. The IDPH CPG co-chair assisted with taking notes.

In 1998 and 1999 additional focus groups were conducted with the following:

- Young gay men
- Injecting drug users in corrections
- Female Sex workers

The most recent focus groups were conducted in 2000 and 2003 with:

- HIV Positive MSM
- MSM
- High Risk Youth

The IDPH CPG Co-chair facilitated these groups.

Summaries of the most recent focus groups follow, but there also appear to be common concerns within all communities and groups, past and present, in Iowa:

- Denial still very present
- More HIV/AIDS education, the earlier the better
- Confidentiality very important
- More awareness of HIV/AIDS service agencies, especially in Rural Areas
- Easy access to condoms is important
- Increase information access to non-English speaking and reading citizens
- Address the stigma associated with living with HIV/AIDS
- Have more safer-sex workshops and risk reduction interventions; reading pamphlets just doesn't do it
- More community outreach
- Needle exchange or clean needle programs

- Great awareness of the overall needs of a specific community or group
- Educators should be open, honest, and frank and share information in a culturally appropriate manner
- Talk about HIV/AIDS more in churches and synagogues

## Injecting Drug Users in Corrections, 1999

Two focus groups (one for men and one for women) were held at the Iowa Correctional Medical Classification Center in Iowa City in June, 1999. The participants in these focus groups were ten men and twelve women who have identified themselves as having been injecting drug users. All of the participants were incarcerated. The ages of the participants ranged from 19 to 58 years old. Men and women were surveyed in separate focus groups.

The focus group began with learning more about what HIV/AIDS prevention meant to the participants. The primary response was that people who use injection drugs should have access to clean "rigs" (needles and syringes) to prevent the spread of the disease. HIV prevention means doing whatever it takes to not get infected in the first place. Many felt that larger metropolitan areas in the country were doing a better job of HIV/AIDS prevention through the use of needle exchange programs than were rural communities. One male respondent commented that injectable drugs could be found on just about any street corner in many small communities in Iowa. *"There are too many people out there that are saying we are not New York or Chicago and it's not that bad.... Well I am here to tell you that it IS that bad."*

Many men and women acknowledged that they have heard about HIV/AIDS through their local health departments or local health clinics. Others mentioned that they first learned about HIV/AIDS in school, through the media or in the Department of Corrections (DOC). Some mentioned that they learned of HIV/AIDS on the street and a couple had learned of it through personal experiences with relatives or friends that were infected. One gentleman made it a point to convey that he felt that people working in HIV prevention were at times sending the wrong message about how easy or difficult it is to become infected. He said, "It's crazy! On one hand you are telling people how difficult it is to catch HIV from someone who already has it and on the other hand they are saying that it is so easy to get through sharing rigs."

When asked if they felt they were a group at risk for HIV/AIDS, all agreed that they were at high risk. Most of the participants spoke freely about their IDU practices, often focusing on how at times they had put themselves at an even higher risk by knowingly sharing unclean rigs. For some, the reasoning was that they needed a fix so bad that at the time it didn't matter whether they were sharing needles with someone. One female, who identified herself as a former commercial sex worker, said, "If a guy wanted me to blow him without a condom, I'd say no. But if I needed drugs real bad and he had \$300 in front of my face I wouldn't hesitate to put myself at risk." She also stated that all of the massage parlors in the state of Iowa supply condoms, but whether or not the condoms are used depend on a number of factors. Many of the women interviewed were more concerned about contracting and dying of hepatitis C than HIV/AIDS.

There was a variety of opinions expressed when they were asked, "Where and when should you first start talking about HIV?" Most everyone agreed that the sooner people are educated about HIV, the better. When asked for a specific age almost all of the participants believed that HIV prevention education should begin around the age of eight. One female IDU stated she started shooting heroin at age 11. A couple of the men said that they learned more about HIV/AIDS in the DOC than anywhere else - some said that our focus group was the first chance they had to openly talk about HIV/AIDS. One of the female participants felt that people should talk about HIV/AIDS prevention everywhere and at any possible time. It seemed that the women felt more comfortable talking about prevention with friends and relatives than did the men in the focus

group. One male participant stated that he openly would talk to his girlfriends about HIV. He said, "I like my women and I like my dope but I don't want to die over either one of them."

When asked whether the participants ever talked about HIV/AIDS while shooting drugs, the overwhelming response was no.

The question was raised as to where they would go if they ever found out that they were HIV positive. Although many of them did not know for sure exactly where they would go, a number of them said they would go to a local health department or health clinic. Some mentioned that they would access a local doctor and a small minority said they would go to family or friends for support. One woman stated, "I had a brother who died of AIDS and because of the stigma associated with it he was never able to tell the family he was sick. He died and not a one of us in the family knew he was sick. Sad that he had to die that way." A couple of men and women expressed that they would probably commit suicide if they learned that they were HIV positive.

When asked "What HIV/AIDS prevention issues or problems exist for you, or in your community?" a number of participants mentioned that they just did not know. One of the biggest problems for all of them was access to clean needles and syringes. Again they stated that in larger cities there were programs to allow IDU's access to clean rigs. "Iowa needs a program like they have in Chicago or New York," said one man. Another said, "You can find people shooting drugs on every street corner in my hometown but there isn't one place in that city where any of those addicts can get a clean rig." Denial plays a role as a barrier to HIV prevention efforts. "Some people still feel that this is just a gay disease," said one female being surveyed, "and that prevents them from accepting that they themselves may be at risk."

All of the participants acknowledged that what existing prevention services are available, are better in Iowa than in some other parts of the country. One male respondent did state that if the HIV prevention service providers can't relate to the idea of him needing access to clean needles then there is no need to even begin talking about prevention. The health department continued to serve an important role in HIV prevention, as was mentioned by at least 25% of the group. It was apparent that the current level of HIV prevention services was adequate, but could use some adjustments, primarily in making clean needles and syringes available to injection drug users.

Listed below are some of the comments that the focus group participants wanted to send with the facilitators.

- "Have more of these focus groups like you are doing today."
- "I think people would learn more about AIDS prevention if they personally knew someone with it."
- "Do something like they do in London and other foreign cities. Have clinics where you can pick up clean rigs."
- "Even a junkie needs a safe place."
- "I don't have a clue. If I did I would not be shooting drugs."
- "Iowa is TOO quiet about it."
- "Good Luck! Good Luck! First thing you need to do is to become more credible to junkies. Don't scare off the people you are trying to help."
- "This is the bottom of the bottom. Keep coming back here for more information. Maybe we can help the kids. Kids can see through all the BS."

- "Make a video and show us with needles in our arms."

## Female Sex Workers, 1999

A focus group consisting of adult female commercial sex workers was held in Des Moines in August 1999. The group consisted of 10 women (6 White Non-Hispanic, 3 African-American, 1 Hispanic) who self-identified as either currently working or having previously worked in the commercial sex field. The focus group was facilitated by the IDPH CPG Co-Chair with the assistance of the CPG Community Co-Chair who is also a member of the Needs Assessment/Community Resources Committee.

The group was first asked what HIV/AIDS prevention meant to them. The question was met with answers primarily concentrated on the need for ongoing safer-sex practices, increased supply and maintenance of clean needles and syringes and more public education about HIV/AIDS. One of the participants commented that it is important that HIV/AIDS educators continue to work at dispelling the myths surrounding HIV transmission and to focus on the “facts.” Another woman mentioned that HIV/AIDS Prevention may essentially mean the difference between life and death for commercial sex workers.

When asked what the group would tell someone regarding how to prevent HIV/AIDS the responses focused on telling people how important it is to use condoms and to make sure that you never share unclean straws or needles with anyone. A commercial sex worker from a smaller Iowa community stated, “If they refuse to wear a rubber then sneak it on them...because it just ain’t worth losing my life over it.”

The women, who were representative of communities throughout the state of Iowa were asked where they’ve heard about the risks of HIV/AIDS. Of the entire group it should be noted that at least 5 participants indicated that they learned about HIV/AIDS risks through the gay and lesbian community. Others mentioned they first learned of the risks through local health departments, high school and college classes, treatment, and through personal contact with friends who have HIV/AIDS.

All of the women felt that they were at risk for HIV/AIDS. There appeared to be no outright denial among this group of women. The facilitator then asked them what exactly was putting them at risk. One of the women said, “It’s simply the men we choose.” Other participants said old behaviors, the need for money, use of drugs and the very limited availability of clean needles and syringes all contributed to their increased risk of contracting HIV/AIDS. “We can have all this information but we’ll do whatever we have to when we need to get high or need the cash.” Another comment that was agreed upon by all was that HIV/AIDS is all around their work environment.

When asked what things they do that put them at risk for HIV/AIDS many of the women pointed to the fact that they have all, at some point, used drugs and/or alcohol in combination with their work. They all realized that this put them at increased risk of performing high risk behaviors which could ultimately lead to the transmission of HIV/AIDS. Someone commented that drugs and alcohol rob her of her ability to make appropriate choices. Of the 10 women present, 6 of them stated that it was the “Men” that put them at highest risk. Another participant said that “feelings of the flesh” are what put a lot of commercial sex workers at great danger and that they often confuse the high of having sex with the emotions of being loved and cared for; “When I was high I loved the entire world!”

When should you talk about HIV/AIDS prevention? All of the members of the focus group stated that the key target age for educating people would be the early teenage years. Others mentioned that starting even as early as pre-teen would possibly be even more effective. Some women felt that when kids were old enough to start to ask questions about it, no matter what age they asked, they were old enough to learn about appropriate prevention information. A woman from another small Iowa community stated, "I have a 17 year old. When he asks anything I am not going to lie to him. I'd tell him that If you ever have sex, son, please have safe sex. I didn't know about AIDS when I was shooting drugs, digging dirty needles out of the garbage but I want my son to know."

The focus group members were asked what they would do if a test showed that they were infected with HIV. Interestingly the respondents focused more on what they would do if a friend or family member had just tested positive. There was overwhelming support for each other and the newly infected. Many of the women stated they already knew people with HIV/AIDS and were aware of the struggles they faced. One respondent stated that she'd already been faced with having to deal with a fellow commercial sex worker who was diagnosed as being positive. Her response was that of support and love. She said, "I would be there for my sisters all the way, no matter what they needed."

The facilitator then asked how the women felt that HIV/AIDS would affect their community. The women expressed that there was a lot of discrimination surrounding people living with HIV/AIDS and that their community was not immune to the same type of discrimination. Almost half of the women cited examples of discrimination that they'd observed over the years. A woman who previously worked as a commercial sex worker said, "In my small town we can't tell anyone about someone who has HIV/AIDS. I have a friend that I love very much. He is an ex-marine. No one can find out about people like him in our town. As a matter of fact one time someone found out about him and he ended up with 90 stitches in his head." Another woman stated that she remembers sitting in a small hospital waiting room awaiting her test results. "I was sitting there thinking of how many people I may have affected if I am positive. I knew a guy with HIV. He was my boyfriend. At the same time he was seeing me he was also seeing 3 or 4 other girlfriends at the same time. They, too, were commercial sex workers."

The participants were asked to list what HIV prevention services are already available in their community. A woman who recently moved to a large city in Iowa commented that it was almost impossible to get clean needles and syringes in the bigger city but back in her small town it was much easier to buy them. Her comment was that there should be greater availability of clean rigs as a prevention service. Other participants commented that they recognized such organizations as gay and lesbian resource centers, local health departments, correctional facilities, community outreach workers and community health centers as being resources for HIV prevention services in their community.

The women began to talk more about condom use and the question was raised as to why people in their community do not wear condoms. The most prominent response was that men simply do not like to use condoms when having sex with commercial sex workers, especially to oral sex. They also stated that one other problem is that condoms are expensive and access to them is quite limited. "In general," one woman said, "not having access to condoms is a big problem." A woman who is currently working as a commercial sex worker said that she was with a "john"

and when she started to apply a condom he stopped and said, “Well what kind of disease do you have that we would need to use a condom?.” This ended her conversation with him and also ended the job. She reported that it ultimately has decreased communication between her and other men since that incident.

The commercial sex workers were asked what the best way to reach their community would be. There was a great deal of discussion but much of the focus was on having people, preferably women who were previously commercial sex workers, develop a relationship with these women on the street. It would be helpful for these women to see a familiar face on the street or in the bars that they could relate to and not fear. Their biggest fear would be to develop a relationship with a outreach worker and then later to find out they were working with a law enforcement officer. The women also stated that the outreach worker should know the areas where the commercial sex workers work and that it’s not always on the corner of a street in the “hood,” rather it could be a different location in town, a bar, a convenience store, etc. Often, they stated, the focus of outreach is limited to a “stereotypical area.” Another idea was to target women within the commercial sex worker population that are well know by others and to use them as a sort of gatekeepers into this population of women at risk.

## **HIV Positive Males Who Have High Risk Unprotected Sex With Other Males, 2000**

Three focus groups were held for HIV-positive Males Who Have High Risk Unprotected Sex With Males (MSMs) between October and December of 2000. Of the twenty-three participants who attended, four identified as Men of Color. Participants ranged in age from 25 to 53. The purpose of the focus groups was to have a better understanding of the prevention needs of MSM in Iowa who are living with HIV.

In order to gain information about the participants, their partners, and their relationships, the groups were asked about how they meet men. It was reported in the *New York Times* that recent studies have concluded that gay men are more likely to use the Internet to find a sexual partner than lesbians and heterosexuals, and people who use the Internet to arrange sexual encounters are more at risk for sexually transmitted diseases (*New York Times*, Nov. 9, 2000). Our participants did report that one of the most common methods was the Internet (personal ads), but they also mentioned public message phone lines (800 and 900 numbers), support groups, the GLRC social functions, gay and straight friends, the river, and parks. Participants felt it was easier to meet people in bigger cities, such as New York or Chicago, than in towns or cities in Iowa. Most no longer meet men by cruising or by going to bars. However, one participant disclosed he met his current partner in a bar. Prior to meeting his partner, he was answering e-mail on Yahoo Personals. "That was a mistake" he said. "It's amazing how many people are online. I am over the bar scene because everyone is so fake. I think for the first time in my life I am in love; I am almost afraid to say that."

Participants had different experiences in talking about their HIV status. One said, "I can relate to being open about my status, when you live in a fairly small community most people are going to know. If there is any way I think sex is in the air, I find a way to work it into the conversation. I like going to the big cities because there are more HIV-positive guys and they are more savvy and if I am going to have sex I would rather it be another pos." However, another said, "It took me awhile to say, 'Oh, by the way, I am positive.' I have friends that won't disclose for a long time and then tell them and can't understand why then people won't call them back."

When discussing the types of relationships in which they had been involved, most indicated that in the past, their partners were very controlling. Some of the men described themselves as "needy." One participant stated that many relationships could be compared to the relationship of a cat and dog; "some are aloof, like the cat, while others are very needy, like the dog." Several men stated that although they had previously been in relationships with very dominant partners, they have either taken control back or have ended relationships unless there is a 50/50 partnership. A few of the men indicated that they have never had a "relationship or date, just sex."

The participants in each of the three focus groups were asked to discuss their sexual experiences since testing HIV positive. Many said that since learning that they were positive, they felt this meant they couldn't have sex anymore. Others expressed that sex was not important anymore; having someone to hold them and love them was more important.

Several men said that they did not have a lot of experience in sexual negotiation. The situation the men are in dictates the level and outcome of negotiation. One said, "We all know what we like and where to find it and where to pursue it." Many were looking for a long-term relationship, not just casual sex. "All I really wanted was to be loved, the act of a man coming satisfied that for me. I have no interest right now and I am in a depression now and that may have something to do with it."

Most of the participants in the focus groups said that they didn't really talk about sex; it would just happen. "If you go home with a guy from the bar, you're going to have sex." Others said that they talked about who was going to do what before having sex. It appears that drugs or alcohol (substance use) play a role in safe sex and behavior. The following comment illustrates the influence substance abuse plays in relationships, communication, and negotiation. "Had a needle out of my arm, didn't talk." Another said, "I always smoke, get high - but you risk doing things you wouldn't do. Try to get high afterwards...I used to be a crack head so I didn't care."

Sexual negotiation relates to condom use and safer sex. One response to our question regarding the last time the participants had safe sex was, "Three weeks ago with my girlfriend. Since my diagnosis, I've always used condoms. (I) always assume everyone is positive." One felt that there are regional differences in condom use. "In California, it was never an issue. Just put it on and go." Even with condom use, there are still concerns. There is worry about passing on the disease if the condom breaks. One participant summed up condom use like this, "Do I like them? No. Do I use them? Yes."

An issue in working with HIV-positive individuals is identifying social networks. We asked questions about the gay community and the messages that pertain to sex and safe sex. Some felt that they are hearing the message that HIV isn't as bad now, that you don't hear that much about HIV/AIDS anymore, and that you never see anyone with a red ribbon on anymore. One individual said, "Promiscuity is still okay and I don't know if that is ever going to change." One participant even said that there is a feeling out in the gay community that "HIV is a gift." Participants discussed "rural flight" where many MSM flock to cities because there is a lack of community in rural areas, as well as a lack of social space, and fear - a lack of anonymity.

The next set of questions addressed where gay and bisexual men go for support and information about HIV transmission. At one of the focus groups, the comment was made that "support groups aren't helpful, they go over and over the same things. (They) might be useful right after diagnosis. I have my own support group." Another participant said, "This is very important. I get my support for my HIV like any other disease. I get support from everyone that is in my life; it is treated like any other disease. I treat HIV like an illness so I am out in the open about it everywhere." The most frequently mentioned sources for information on HIV transmission were TV, magazines, doctors, the Internet, and Medscape.

Participants felt that there need to be more messages about using condoms and about drug use. Group members felt HIV prevention messages need to be in schools. Parents should educate

their children. Unfortunately, many parents are unable to talk about HIV and safer sex. Many agreed about the need for more messages about using condoms. One man said, “I think you should be able to not feel like what you are doing is wrong because what everyone else is doing is different.”

Stigma was mentioned regarding condom messages, getting tested, and being open about your HIV status. One participant said, “fear kept me from testing.” Another said, “We can’t be open (about our status) because we are afraid.”

During the focus groups, it was apparent that participants were more accustomed to talking about care issues than prevention messages. There was discussion regarding case management, staying on antiretroviral medications, and payment for care. One said, “If I am aggressive and assertive, then they usually come through.” In one of the other groups, however, the statement was made that “people are not aware of the programs.”

We concluded the focus groups by asking for suggestions for HIV Prevention Planners. The foremost response was that planners need to realize that for many men, sex is sexier if they think they are at risk for getting AIDS.

It appears that the MSM HIV-positive individuals we spoke with in our focus groups had common concerns. These concerns support the research and literature emphasizing prevention efforts for HIV-positive individuals.

In summary:

- The Internet is being used in Iowa as a way to meet new partners.
- Generally, the men used condoms. However, there was still fear the condoms would fail, and they would put someone at risk.
- Most participants agreed that in their communities there is a message that HIV isn’t as bad now.
- Most of the men were more comfortable talking about care issues than about prevention or the measures they use to practice safe sex.
- All agreed Prevention Planners need to come up with new and innovative ways of approaching the topic of staying safe and living with HIV.
- Many discussed the lack of community in rural areas and the “rural flight” of MSM to cities.
- Participants felt that all doctors need to ask sexual history questions.

## High-Risk Youth Focus Group, 2003

A high-risk youth focus group took place at the Lesbian/Gay/Bisexual/Transgender (LGBT) Community Center in Des Moines on February 27, 2003. Seven males were in attendance. Each participant completed an anonymous questionnaire. The questionnaire asked about demographics as well as personal behaviors and attitudes. All of the participants reported feeling “comfortable” or “very comfortable” completing the anonymous questionnaire.

The seven males were white, non-Hispanic, and gay. Four of the participants were partnered and three were single. Ages ranged from 17 to 21 years. Five of the participants live with their parents and two live either in their own apartments or away at school. One participant reported that he had been homeless at some point in his life. Five of the participants go to high school, one attends college, and one works full-time.

One participant knew people with HIV/AIDS. Participants got most of their information about HIV/AIDS from the LGBT Community Center, the Internet, Planned Parenthood, TV, friends, and school. Four participants rated their level of HIV knowledge as “high,” two said “average,” and one reported his level was “low.” Four reported that their personal risk of acquiring HIV was “very low,” one reported “low,” and two reported “average.” Two of the participants have been tested for HIV; one of those had been tested multiple times. Two participants always used condoms. Five participants reported they “sometimes” or “often” had unsafe sexual encounters. Four of the participants had two or more sex partners in the last 12 months; all had been sexually active at some point. One participant reported ever having any sexually transmitted disease (pubic lice). Five have used marijuana and one has used drugs while engaging in sexual activity. One participant had shared a needle while injecting methamphetamine.

When asked where the participants most often met new partners, a variety of responses were given, including clubs, the Internet, at work, coffee shops, at the mall, the LGBT Community Center, and through mutual friends. Some do not actively seek out partners. When these youth decide to have sex with someone, many find it important to find common interests, to be on the same wavelength, and to ask about their HIV status. Some do not want to talk at all because it makes having sex “weird.” This most often happens in casual sexual relationships in which conversations about backgrounds are not spoken of. When asked about what the youth talked about before having sex, one replied that, “I think it (asking about HIV status before sex) would be kind of a mood killer, but you know what, I’m sorry, if your test came back positive it would probably be quite the mood killer as well.”

None of the youth reported being in a relationship in which one person was more in control than the other. The youth discussed long-term relationships and mentioned that sex is not brought up right away because conversation about backgrounds and family is more important. Expectations in a longer-term relationship include monogamy and honesty about sexual history. For many of the youth, sex is an expression of love in a long-term relationship while an orgasm is an expression of love in a short-term relationship. Sex is thought about a lot but life does not revolve around the actual act of sex for these youth. Before engaging in sexual activity, some of the participants decided where to have sex based upon whose parents were home. None of the participants had ever been pressured to have sex with anyone.

When asked about condom use, one youth reported the last time he had used a condom during sex was seven months ago. The youth explained that if he is having sex with someone who is high-risk, such as a homeless person, a condom must be worn. Before the youth have

unprotected sex, they consider their STD status, the STD status of the partner, and whether that person is a virgin. If they are in monogamous relationships, condoms are not used. The youth said that condom availability is very good and they always wear condoms if their partners want them to. But the youth do not want to offend sexual partners by asking them to wear condoms. Condoms are used more often for anal sex than for oral sex but some feel that they should be used for any part of the body at all times. Alcohol and other drugs are obstacles to having safer sex because the participants said these inhibit a person's ability to make sound decisions regarding condoms. They also said that when people use these substances, they do not think about acquiring HIV/AIDS. The last time the youth wanted to use condoms but did not, they were under the influence of drugs or too scared to say anything. The youth feel comfortable stopping the use of condoms when they are in monogamous relationships, when there is mutual trust, or when they know the HIV statuses of themselves and their partners.

The youth said safer sex meant using condoms, talking about having sex, stopping the spread of disease, getting tested, having a monogamous relationship, knowing your partner as well as possible, being open and honest, knowing your risk level, and being abstinent. The most difficult aspects about practicing safer sex are that it ruins the mood and that it is hard to be consistent when not in monogamous relationships. Maintenance of practicing safer sex is hard because some people are more educated than others, some people have mental health issues and do not care, and some people think that different practices ("oral"/"on top") are not a great risk.

When asked about the gay community, the youth responded that open gay communities are not prevalent in rural areas and that it is easier to come out in a bigger city. Family is one of the biggest obstacles youth face when coming out. Family often slows the process of coming out. Most of the youth are very comfortable being out. Most said that they keep it from their extended families for fear of confrontation or rejection but are comfortable coming out to their immediate families. There are many pressures in clubs to have sex but not in many other places. The youth expressed that many people think there is violence in gay relationships but they pointed out that they have seen violence in all relationships, even among their high school peers. The Internet is helping rural gay youth to come out and connect with people from all over the world.

Many youth go to Safe Space (the LGBT Community Center) to receive information about HIV/AIDS. They also get information from schools and trusted adults. The youth suggested that in the future more comprehensive sex education needs to be brought into the schools to reach all different types of people. They believe schools can reach every type of person and they need to do more to try and teach kids about the risks of sexual behavior. When the youth were asked about their thoughts on how schools teach safer sex, they had very strong opinions. They felt the schools and media do not talk about STDs enough. They want schools to show them how to use condoms, not just have them provided in some areas. They also do not want schools to be so serious when talking about sexual issues. They want to be able to laugh or make a joke out of an uncomfortable topic. They will be more likely to ask questions if things are discussed in a lighter manner and they will be more likely to remember it. Support is found on the Internet, in bigger cities, in the gay community, and in Youth Alliance. Also, Internet sites that are more geared toward gay youth would be helpful because they want to be able to chat, get information about HIV, receive online counseling, get lists of where they can get tested, and find out the laws surrounding getting tested. Marketing for Internet sites and for information in schools is something that should be done to better reach more kids.

## Men Who Have Sex With Men Focus Group, 2003

A focus group with men who have sex with men (MSM) took place in Dubuque with 10 males in attendance. All were white, non-Hispanic and self-identified as gay. Three of the participants were partnered and seven were single. Ages ranged from 21 to mid-forties. Two participants indicated they were living with HIV.

There was some discussion of the term “queer;” however, none of the participants identified themselves as queer. Most participants said they were 100 percent “out,” but don’t feel the need to “announce it to everyone.” It was common for participants to have an equal mixture of gay and straight friends. It was agreed that work settings tend to be a difficult place to be “out.”

When asked about the gay community in Dubuque, participants said it is a small community with no formal gay, lesbian, bisexual, transgender (GLBT) center. There have been attempts to create an organization to support GLBT residents, but participants cite difficulty in organizing, lack of interest, and no consistent effort. Participants said such organization is more difficult in rural areas because people are afraid to be “out.” One participant summarized by saying, “Dubuque is a cultural bubble and people don’t want to change.”

The central meeting venue for men who have sex with men in Dubuque is a specific bar that has become known as Dubuque’s only gay bar. Men and women, including people who do not identify as GLBT, frequent it. . Since there is only one identified meeting venue, there seems to be a crossover of ages; all age ranges mix at the bar.

The participants reported meeting other MSM at the bar through friends, the Internet, adult bookstores, parks and when visiting other communities. When meeting new guys, alcohol seemed to be part of the dynamic. Meeting someone at a bar, drinking, and then deciding to go home together was mentioned as a typical situation in Dubuque and other communities.

Participants report that the following issues arise when meeting a new partner and deciding to have sex:

- Who is top and who is bottom;
- Where to go;
- Whether protection will be used;
- The relationship status of each person;
- Whether the other person is looking for a relationship or a one night stand;
- The HIV status of each person;
- The availability of condoms (the unavailability of condoms would deem sex not an option);
- Erotic talk and clarification of what is going to happen.

Communicating about having sex included comments such as:

- Simply telling partner what you would like to do.
- Trying different things rather than discussing them.

When an unsafe encounter occurred, participants identified impairment from drugs/alcohol as the reason. When asked if there were times they had sex when they didn’t want to, several

participants indicated they had engaged in sex to please their partner, or when they were under the influence of drugs and/or alcohol.

When asked about safer sex and the use of condoms, the general response was that the participants didn't like using them but felt it was necessary to be safe. The process of discussing safer sex with a partner, having condoms available when needed, and stopping to put the condoms on, were viewed as barriers to having safer sex. Other comments were that condoms desensitize the experience and taste bad. When asked in what situations they felt they need to use condoms, participants said it was important to use them all the time when you don't know the HIV status of your partner. A discussion of monogamy and the use of condoms highlighted the important factor of trust in a relationship, and how people determine when they can trust their partners.

Situations in which participants wanted to use a condom, but did not included: when they were in a new relationship, didn't have one available, partner had a latex allergy or they were too drunk or high. There was a lot of discussion about the ability to negotiate safer sex, or to use condoms when one or both partners were under the influence of drugs and/or alcohol. Several participants reported they had unprotected sex as a result of being drunk or high.

Some HIV+ people may be more willing to engage in risky behavior because they are already infected and may not have the concern of contracting it, they said. The belief seemed to be that if the HIV+ person were the receptive partner, there was no risk of transmitting HIV to the insertive partner. It was a common belief that oral sex is a fairly low risk activity and anal sex without a condom is not safe.

Participants cite fear of HIV (unknown status of partner), partners that are too young, and fear of consequences as reasons they have abstained from sex in the past.

Messages related to sex in the Dubuque gay community are unspoken according to participants. One participant felt the overall feeling is "one of desperation, or get it when you can." However, participants agreed there is no real pressure to have sex. There is a presumption that if you are seen with someone more than once, you must be dating or having sex.

When asked about HIV prevention messages, participants reported the following:

- There is much less knowledge among the gay community now than in the 80's when many people were dying of AIDS.
- Advertisements showing people with HIV as buff and healthy make living with HIV seem like not a big deal.
- More money needs to be spent on advertising HIV prevention messages in the media.
- Men who have sex with men have lapsed into denial about the deadliness of HIV/AIDS.

Barriers to reaching men who have sex with men include social stigma about being gay and religious barriers.

MSM are often motivated by personal experiences, such as someone in the family or a friend who has died from HIV.

Participants were adamant that the message needs to be that HIV is not just a gay disease. Consequently, they believe, everyone should have access to prevention messages. They said HIV prevention messages should be stressed more in school, including elementary, middle and high schools. Participants also want to see positive messages about alternative lifestyles in schools to perhaps lessen the pressure for kids struggling with their sexual orientation.

The group suggested ideas for marketing prevention messages to men who have sex with men. They included:

- Advertising in magazines and newspapers within both the gay and straight communities as a method of reaching a broad GLBT base.
- A campaign using parents (specifically mothers of gay men) who have children with HIV/AIDS. Participants felt this would be effective.
- A newspaper article on people living with HIV/AIDS in Dubuque. It has been done before with great response from the community and GLBT residents.
- Using radio announcements, which reach more people than other forms of media.
- Having booths where HIV information is disseminated at community events.
- Using television shows to promote behaviors.
- Making information available where MSM meet for sex.
- Billboard advertising.

Final thoughts and discussions included reaching men when they are sober, individually reaching out to peer groups, and being an advocate for HIV awareness.

## Iowa Young Adult Roundtables

### 2003 Summary

In 2003, 60 young people participated in the Young Adult Roundtables (YARTs) in Davenport, Mason City, Sioux City, and Des Moines.

YARTs participants represent a variety of backgrounds, cultures, identities, and experiences. Each YART has a facilitator and a mentor. The mentor is a CPG member. The youth participate in CPG work primarily to assure that youth voices are heard and youth needs addressed. The youth meet every other month for three hours. Youth completed an anonymous questionnaire during their first meeting of the year. The results are summarized below.

#### DEMOGRAPHICS

	<b>2003</b>
Average Age	16 (range 14-23)
Youth of Color	21%
Female	73%
Male	27%
Gay/bisexual or questioning	7%

#### Results of Questionnaire

	<b>2003</b>
Consider self at-risk for HIV	23%
Self-reported level of HIV knowledge	
Very Low	2%
Low	2%
Average	36%
High	46%
Very High	16%
Ever tested for HIV	36%
Sexually active	50%
Knows someone living with HIV or AIDS	36%
Knows someone who has died from AIDS	18%
Uses condoms	32%
Has "unsafe" encounters	
Never	16%
Sometimes	32%
Often	7%
Smokes on a regular basis	21%
Uses drugs or alcohol	55%
Has been in drug treatment	5%
Has been pregnant/ has gotten someone pregnant	25%
Are the parent of one or more children	23%
Living Arrangements	
With parents/guardians	73%
Foster Home	5%
Own apartment	16%
At school	5%
Currently a student	73%
Currently working full-time	21%
Currently working part-time	16%

Sources of HIV/AIDS Information

Information Source	Percent
Friends	84%
Family	36%
Church/Synagogue	2%
TV	48%
Radio	9%
Newspaper	5%
Magazines	30%
School	34%
Other Sources (YARTs, Maternal Health Center, Peer leadership/counselor)	59%

The youth held discussions on obstacles to effective HIV prevention in Iowa. Brainstorming was centered on the top ten barriers to reaching youth. These barriers, and strategies to overcome them, are summarized below. The young people also developed the action steps to implement the strategies.

**SCHOOLS**

<u>Feelings/Beliefs</u>	<u>Strategies</u>	<u>Action Steps</u>
<ul style="list-style-type: none"> <li>■ HIV/STD prevention is not taught before 8<sup>th</sup> grade in most schools.</li> <li>■ Faculties in schools tend to be uncomfortable when talking about sex with students and usually don't have up-to-date information.</li> <li>■ Schools don't allow you to talk openly about everything (sex, condoms).</li> </ul>	<ul style="list-style-type: none"> <li>■ Start teaching prevention methods at an earlier age.</li> <li>■ Cover HIV/ STD prevention in mandatory health classes and other classes that could integrate prevention into their curricula.</li> <li>■ Peer educators.</li> </ul>	<ul style="list-style-type: none"> <li>■ Set up peer-education programs in the schools.</li> <li>■ Make it a point to educate teachers and give them up-to-date information on HIV/AIDS.</li> <li>■ Parent involvement is a must.</li> <li>■ Need a comprehensive health program.</li> </ul>

**PARENTS**

<u>Feelings/Beliefs</u>	<u>Strategies</u>	<u>Action Steps</u>
<ul style="list-style-type: none"> <li>■ Feel that parents take the wrong approach when discussing sex with children.</li> <li>■ Many parents don't have information regarding HIV/ STD prevention.</li> <li>■ Many thought that dads were harder to talk to about sex.</li> <li>■ Parents don't talk about it; it is taboo.</li> </ul>	<ul style="list-style-type: none"> <li>■ Open discussions between parents and children.</li> <li>■ Educate parents so they feel comfortable talking to their children.</li> <li>■ HIV/ STD programs.</li> <li>■ Parents must have discussions with their children about sex and character.</li> <li>■ Parents need to be more involved in youth's education; COMMUNICATION.</li> </ul>	<ul style="list-style-type: none"> <li>■ Education is the key to getting full support from parents.</li> <li>■ Encourage parents to have open communication with their children.</li> <li>■ Have conferences so parents can learn about HIV/AIDS.</li> <li>■ Make it a requirement for any parent(s) who has a child going through the program to come and participate in the program before the child does.</li> </ul>

### ATTITUDES/BELIEFS

<u>Feelings/Beliefs</u>	<u>Strategies</u>	<u>Action Steps*</u>
<ul style="list-style-type: none"> <li>■ From a religious viewpoint, there should be no sex before marriage.</li> <li>■ Looked down upon when talking about sex.</li> <li>■ HIV/AIDS not prevalent in north Iowa.</li> <li>■ If you are on the pill you don't have to worry about HIV.</li> </ul>	<ul style="list-style-type: none"> <li>■ Having people living with HIV speak to youth.</li> <li>■ Knowledge that sex is a very small part of a relationship and that protecting yourself is very important.</li> </ul>	

### CULTURE

<u>Feelings/Beliefs</u>	<u>Strategies</u>	<u>Action Steps*</u>
<ul style="list-style-type: none"> <li>■ Our culture sends a message to youth about what is acceptable and what is not.</li> <li>■ Hispanic cultures are usually from a Catholic faith.</li> <li>■ Cultural beliefs get in the way of using protection.</li> <li>■ Northern Iowa has a conservative culture.</li> </ul>	<ul style="list-style-type: none"> <li>■ Talk to any adult who has an open mind and will listen to your questions about sex.</li> <li>■ Give information to elders in the community to show how important education is for the youth.</li> </ul>	

### LANGUAGE

<u>Feelings/Beliefs</u>	<u>Strategies</u>	<u>Action Steps</u>
<ul style="list-style-type: none"> <li>■ The use of slang words tends to drive adults away from conversations and may keep them from understanding what is being said.</li> <li>■ Teachers need to talk to you and not down to you.</li> <li>■ Reach people by talking their language.</li> </ul>	<ul style="list-style-type: none"> <li>■ Make sure that information is in all languages.</li> </ul>	<ul style="list-style-type: none"> <li>■ Make all documents in the top four languages in that community.</li> <li>■ Know when to use slang.</li> <li>■ Talk "to" youth and not down, above, or at them.</li> </ul>

### SOCIETY (In general and/or Peers)

<u>Feelings/Beliefs</u>	<u>Strategies</u>	<u>Action Steps*</u>
<ul style="list-style-type: none"> <li>■ Contributes to how youth feel and act towards sex.</li> <li>■ Videos, music, and movies all promote sexual behaviors.</li> <li>■ If society wants it to happen, it will. If it doesn't, then it</li> </ul>	<ul style="list-style-type: none"> <li>■ Make it harder for youth to be permitted into "R" rated movies and to buy music containing messages about sex.</li> <li>■ People need to accept that times have changed; just because it used</li> </ul>	

<p>won't.</p> <ul style="list-style-type: none"> <li>■ Scared of the stigma about HIV/AIDS.</li> <li>■ People are stigmatized if they are having sex.</li> <li>■ People don't want to believe premarital sex happens.</li> </ul>	<p>to be like that, doesn't mean that it is now.</p>	
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**RURAL AREAS**

<p><b><u>Feelings/Beliefs</u></b></p> <ul style="list-style-type: none"> <li>■ Seem to be isolated.</li> <li>■ Have less funding for HIV/STD prevention.</li> <li>■ Fewer testing services.</li> <li>■ Schools are uncomfortable with condom distribution.</li> </ul>	<p><b><u>Strategies</u></b></p> <ul style="list-style-type: none"> <li>■ Use of Internet prevention sites.</li> <li>■ Choose someone who would be willing to learn and keep up on new HIV/STD prevention information.</li> <li>■ Increase services for testing.</li> </ul>	<p><b><u>Action Steps</u></b></p> <ul style="list-style-type: none"> <li>■ Use popular media when available.</li> <li>■ Internet peer education as a resource.</li> <li>■ Health fairs put on by local agencies.</li> <li>■ Media campaign focusing on rural residents.</li> </ul>
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**AGE DIFFERENCE IN PARTNERS**

<p><b><u>Feelings/Beliefs</u></b></p> <ul style="list-style-type: none"> <li>■ Girls mature faster than boys and tend to date older men.</li> <li>■ Older men and younger women are more acceptable than older women and younger men.</li> <li>■ The older the person is that the young person is dating, the less likely the young person is to find out about the partner's history.</li> </ul>	<p><b><u>Strategies</u></b></p> <ul style="list-style-type: none"> <li>■ Encourage youth to date in their own age range.</li> <li>■ Talk about the publication called a <u>Mother's Voice</u> and what Carol and David Ellingsworth have done for prevention.</li> <li>■ Talk to older men and find out why they would want to date younger women.</li> </ul>	<p><b><u>Action Steps*</u></b></p>
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**RELIGION**

<p><b><u>Feelings/Beliefs</u></b></p> <ul style="list-style-type: none"> <li>■ Premarital sex is a no-no, but no one is doing anything to stop it.</li> <li>■ Abortion – no one wants to talk about.</li> <li>■ No birth control/not protecting themselves.</li> </ul>	<p><b><u>Strategies</u></b></p> <ul style="list-style-type: none"> <li>■ Improvements in communication.</li> </ul>	<p><b><u>Action Steps</u></b></p> <ul style="list-style-type: none"> <li>■ Be realistic and don't preach "just say no."</li> <li>■ Tell the entire story and let the youth decide.</li> <li>■ Continue the dialog even if you don't like what is being said.</li> </ul>
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**PEOPLE WHO ARE MENTALLY CHALLENGED**

<u>Feelings/Beliefs</u>	<u>Strategies</u>	<u>Action Steps</u>
<ul style="list-style-type: none"> <li>■ What you see in movies is not what occurs in real life.</li> <li>■ Are trusting and vulnerable; can have sex and not know what happened.</li> </ul>	<ul style="list-style-type: none"> <li>■ Educate</li> <li>■ Explain in a simple and repetitive manner.</li> </ul>	<ul style="list-style-type: none"> <li>■ Specific classes that are geared toward their learning ability.</li> <li>■ Posters that they can relate to.</li> <li>■ Use language that they understand.</li> <li>■ Hands-on activities would be helpful.</li> </ul>

**PERSONAL RESPONSIBILITY**

<u>Feelings/Beliefs</u>	<u>Strategies</u>	<u>Action Steps*</u>
<ul style="list-style-type: none"> <li>■ Responsible for only your behaviors.</li> <li>■ Never assume anything.</li> <li>■ Handling pressure to drink and engage in sexual activities is a challenge.</li> <li>■ Only the guy's responsibility to remember condoms.</li> </ul>	<ul style="list-style-type: none"> <li>■ Educate youth on how to assess risks, recognize risks, and prevent transmissions.</li> <li>■ Let others know of your beliefs and values from the start.</li> <li>■ Take care of yourself.</li> <li>■ Set limits.</li> </ul>	

**GOVERNMENT**

<u>Feelings/Beliefs</u>	<u>Strategies</u>	<u>Action Steps</u>
<ul style="list-style-type: none"> <li>■ Not getting enough HIV information to people.</li> <li>■ Not enough access to free condoms.</li> <li>■ Lack of funding for education.</li> <li>■ Lack of trust in the government.</li> </ul>	<ul style="list-style-type: none"> <li>■ Get word out that HIV infection can happen to anyone.</li> </ul>	<ul style="list-style-type: none"> <li>■ Lobbying.</li> <li>■ Consider programs beyond abstinence-only.</li> <li>■ Increase funding for HIV prevention programs.</li> <li>■ Get Comprehensive Family Care Act passed.</li> </ul>

**REALISM**

<u>Feelings/Beliefs</u>	<u>Strategies</u>	<u>Action Steps</u>
<ul style="list-style-type: none"> <li>■ Only evident when it affects someone close.</li> <li>■ The realization that HIV/AIDS is here.</li> </ul>	<ul style="list-style-type: none"> <li>■ It could happen to anyone.</li> </ul>	<ul style="list-style-type: none"> <li>■ Educate the community that HIV/AIDS is in Iowa.</li> <li>■ It can happen to anyone.</li> <li>■ Meeting people living with HIV/AIDS in their community.</li> </ul>

\*The young people expressed difficulty developing action steps in these categories for some of the strategies. They felt that topics like “Personal Responsibility” and “Age Difference in

Partners” had to do with moral judgment. Consequently, they felt it was hard to say what was right for others. It is probably better to help young people understand that their actions have consequences, and what those consequences might be.

### **Examining HIV Risk and Attitudes**

The youth examined various opinions about HIV risk and attitudes. They were asked to complete an anonymous questionnaire about eight statements. They could strongly disagree, strongly agree, disagree, or agree.

The statements were:

1. It is hard for me to understand why people who know how HIV is transmitted continue to risk infection.
2. Anal intercourse is a normal behavior.
3. I would personally trust a condom to protect me in sexual intercourse with a person whom I know was HIV infected.
4. IV drug users should be given free clean needles.
5. Heterosexuals are at a low risk of contracting AIDS.
6. I would refuse to go to school with someone who has AIDS.
7. AIDS is a punishment for promiscuity.
8. People with AIDS should not have sex.

The youth then were given each other’s anonymous questionnaires and told to give supportive responses to the answers. Later, they were asked how they felt about defending an opinion not their own.

The youth were asked what they observed during this exercise. They were asked about how it felt to defend an opinion that was not their own. They said it was very hard and they wanted to argue against the opinion they were given. Some also found that though they listened to other’s opinions, they rarely changed their minds. Others noted they thought all young people were open-minded, but instead found that some young people thought more like their parents. The youth were asked how it felt when someone perceives their opinions to be in the minority and one responded that it made them feel “out of place and wrong.” Others said it made them feel like they didn’t fit in. The youth thought it “took a lot” to stand alone and keep friends when they saw an issue differently than the majority. They got a feel for what it is like to “be different.”

The youth thought the point of the activity was to learn how to be more open, non-judgmental, respectful, and to accept differences in opinion. They thought they could achieve a more non-judgmental behavior by learning what their own strongly held opinions are and learning how to communicate openly.

## Sexuality and Relationships

Another activity involved getting the youths' ideas about relationships and safer sex. They were queried about what was being taught about sex in school, and if more or less should be taught. Most responded that they remembered being taught "something about sex" at some point. They reported that most teachers talked only about abstinence and used videos without accompanying discussion. The youth in all four cities agreed that more needs to be taught about sex in school. They suggested that peers speak about STDs and HIV/AIDS. They suggested that people their own age educate them with facts and consequences of their actions. The youth would like a balance between abstinence education and comprehensive health education.

When asked how parents handle the topic of sex, most responded that their parents are scared to discuss sex and expected the schools to teach their children about it. They suggested a class for parents and their children to learn about sex and different ways to talk about it.

YARTs participants believe that "safer sex" means using protection, being monogamous, being abstinent, being educated about consequences, and knowing and communicating with partners. They said young people do not practice safer sex because of the stress of buying condoms, the challenges around learning how to use them, being "caught-up in the moment," difficulties in communicating about protection with their partners, and challenges in setting boundaries. They said it is not easy to practice safer sex, especially when the partner is not willing.

All agreed that drugs and alcohol play a "big role" in sexual relationships. They felt that when people drink they do not think straight and do not want to stop to use a condom. They also noted that alcohol lowers inhibitions and many people feel guilty and have regrets about what they did while under the influence. Youth discussed the fact that people can "black out" while drinking and often do not remember what they did or whom they did it with.

When asked how they felt about using condoms, they expressed many different views. Some said that "if you have a monogamous partner and are on birth control you do not need to use condoms." Others said that "condoms are a necessity every time you have sex." Some also said they did not like condoms at all since they diminish pleasure. They were asked what they would think about when considering having unprotected sex. Topics voiced included: pregnancy, getting an STD/HIV, how well they know the person, if they can trust the person they were going to have sex with, and the availability of emergency contraception pills. One participant said she considered using a condom but did not and became pregnant and now has a baby. Others said they take a chance on pregnancy or do not care if they get pregnant. Some youth said they would talk about birth control, condoms, or their past sexual experiences before they would have sex. Others said they did not discuss anything before having sex. Most said youth do not take responsibility for their actions and the younger the age the less responsible they are. They were asked if they had ever been pressured, or heard of someone being pressured, to have sex. Some responded that "guys pressure girls all the time and girls just have to learn to say no." When asked if youth would change anything about their relationships, some responded by saying men need to be more mature, women need to have just one partner, both sexes need to argue less, need to communicate more, and be more supportive.

Participants were asked to give suggestions to HIV planners on how to educate youth about sex and HIV. They said more reality situations are needed. Educators should show HIV as "real"

and teach that sex has consequences. Youth suggested more outreach and education about sex by their peers. Participants want peers to be able to hand out condoms and disseminate real information about sex. They want help to understand and know the consequences of behaviors without being judged.

## **Youth–Adult Partnerships**

YARTs held a discussion about how young people want adults to treat them in regards to HIV and sex education. Responses varied; most felt that educators were uncomfortable talking about sex and often videos were shown without any accompanying discussion. The young people felt that their regular teachers in schools were very open and that school guidelines, at times, make it difficult to cover topics in a comprehensive way. They stressed that teachers should not insert their personal values/biases into their educational experience. They felt that ongoing HIV/AIDS and sex education for teachers would be beneficial.

YARTs were asked to say what the ideal HIV and sex education messages should be. Responses included:

- Candid discussions about risks and information about safe sex.
- Contraceptives: their effectiveness and how to use them.
- Session should be interactive (not lecturing).
- Groups should be small enough so youth feel comfortable asking questions.
- Guest speakers who have real life information about living with HIV should be included.

Although others may worry that discussing sex, condoms, and/or HIV make young people more likely to have sex, the YARTs felt this was not the case. They felt knowledge about sex, condoms, and HIV does not promote sexual activity. In support of the young people’s opinions, Douglas Kirby, Ph.D., reported in Emerging Answers in May 2001, that “a large body of evaluation research clearly shows that sex and HIV education programs do not increase sexual activity. These programs do not hasten the onset of sex, increase the frequency of sex, nor increase the number of sexual partners. To the contrary, some sex and HIV education programs delay the onset of sex, reduce the frequency of sex, and/or reduce the number of sexual partners.”

The YARTs summarized what they would like adults to do regarding HIV and sexuality in their schools. They felt they needed more information, more interactions with personal stories to increase the effectiveness of the message, and options that go beyond “abstinence-only” education. They overwhelmingly felt that HIV education should be required in schools. The YARTs felt that the best places to have sex education are in health, family and consumer science, social studies, and parenting classes.

The specifics topics to be covered should include:

1. HIV/AIDS transmission on the following issues:
  - Childbirth
  - Types of sex
  - Peer pressure
  - Date rape
2. Testing, treatment, and signs and symptoms.
3. Contraceptives (how to use, cost, and effectiveness).
4. Sexuality (heterosexual, gay, and bisexual).

YARTs felt that the following should be avoided:

1. Religious connections discussing only abstinence (“sex is a sin, burn in hell”).
2. “Cheesy” teaching methods.
3. Videos covering HIV/AIDS without accompanying discussion.
4. Separation of the sexes.

The youth were asked how much freedom they would like. Their answers varied greatly depending on age. One responded they want total freedom to make all of their own decisions. Most wanted their parents to trust them more and allow them to make more decisions on their own. Some responded that more freedom brings more responsibility and that as they gain more freedom it is not as big of a deal as it once was.

They were asked how adults could assist young people in advocating for their needs. They responded that adults need to be open-minded, trusting, supportive, and non-judgmental. They also wanted adults to challenge their thoughts, respect their opinions, talk and listen to them, and provide necessary resources.

When asked to describe successful relationships they have had with adults, the general response was when the adults are non-judgmental, respectful, and accepting they have a successful relationship. Other qualities of successful relationships included adults showing care, trust, and treating the youth as equals.

### **Risk Reduction Interventions**

The youth discussed different prevention methods for reducing STD and HIV risk in youth. They thought that youth would respond most to individual level, group level, outreach programs, health communication and public information, electronic media, and print media. They discussed each intervention in detail and concluded that each can be effective, depending on the situation.

Following are YARTs’ views on each intervention:

- Individual-level interventions are effective because “it is easier to talk about private things with just one person.” They also thought that individual-level discussions might be scary for some because they may not trust the other person, but they provide a chance to ask private questions. Prevention case management is effective because it can teach youth how to talk about protection and how to use a condom. It would be more effective with humor.
- Group-level interventions are effective in settings such as churches, schools, and support groups. They thought it may be hard to get a point across or ask questions in a larger group but follow-up meetings for questions would be helpful.
- Outreach programs are effective because they go to the high-risk people and can facilitate support groups.
- Health communication and public information interventions include activities such as *We Care Weekend*, *National HIV Testing Day*, and *Red Ribbon Dinner*. Youth felt that TV programs young people watch would be good places to provide information. In addition, they felt that more ads should be placed in teen magazines and on radio stations. Some participants thought hotlines were outdated and that young people would rather use the Internet to get information.
- Electronic media is effective because it reaches a large audience and is private. The Internet is useful but can be dangerous if the proper precautions are not used.
- Print media includes news articles about HIV/AIDS, billboards, and public buses. Hotlines/clearinghouses are used for the public to get printed material from the state department of health, CDC, and other federal agencies. These venues can get people thinking about reducing the risk of HIV/AIDS.

Other interventions that youth commented on:

- Community-level interventions are designed to reach a defined community with the intention of altering social norms to influence high-risk behavior. This can happen when groups want a risk-reduction message and ask educators for help. They can also be mass media or peer-education groups. Due to different “learning styles,” youth were unsure of this intervention’s effectiveness.
- Community organizing takes place when people persons within or outside a community identify a problem and education to alleviate it. The organizing may be by volunteers, professional groups, or a specific group of supporters. Youth felt that these workers need to be from the same community that they’re trying to serve.
- Social marketing can use surveys to assess need and effectiveness of products and can support youth and adults to help delay high-risk behaviors. Youth felt that, to be effective, this intervention should be done subtly. If too aggressive, the intended target will just “blow it off.”
- Public events can include the *Red Ribbon Dinner* and plays. Youth thought that “theater type events” are good ways to raise HIV awareness.

- Policy interventions are activities designed to reduce or eliminate barriers to HIV prevention. They include laws allowing syringe exchange, proper disposal of used needles and comprehensive health education. Participants felt that policy should focus on “safe sex,” not abstinence. The youth discussed challenges in getting policies passed in a bureaucratic system.

## Summary

Youth had a variety of feelings about their participation on the Young Adult Round Tables during the last year. Participants generally felt comfortable discussing the topics. Reinforcement of the ground rules that were established for the YARTs contributed to this comfort level. The four YARTs continue to meet bi-monthly to address the HIV/AIDS prevention needs of Iowa’s youth.

The YART participants completed an evaluation of the process. Seventy-eight (78) percent of the youth believed that the information from their groups is used in the statewide HIV prevention planning process. A summary of the evaluation follows:

- Youth want to make a difference; participation in the YARTs gives them the chance.
- Youth felt affirmation from the HIV/AIDS Program.
- Some want to have a YART meeting every month, instead of bi-monthly.
- They want the community to be more aware of YARTs.
- Youth felt that YARTs provide an opportunity for youth to access information about HIV prevention and broaden their knowledge about where to go for more information.
- Concerns were voiced about abstinence-only education. Youth want comprehensive information so they can make good choices.
- The youth felt that the separate track at the October 2002 Iowa HIV/AIDS Conference was a great opportunity to bring youth together to discuss their issues.

## STD/HIV/AIDS Provider Services Survey

The Community Planning Group developed a survey to assess what STD/HIV/AIDS prevention and care services are being provided by organizations throughout Iowa, which populations are being targeted, and whether the level of services is adequate for each of those populations. The survey included questions about the provider agencies, services provided, populations served, sources of funding, barriers encountered, and training and capacity building needs of the agency staffs. The survey also solicited opinions about what service gaps existed. The results of the 2002 survey are described below. (See Attachment #5 for survey instrument.)

### Methods

The survey was limited to 323 organizations that were likely to be providing STD/HIV/AIDS services. These organizations included HIV/AIDS prevention and care providers, community-based organizations, and counseling, testing, and referral sites funded by the Iowa Department of Public Health's HIV/AIDS and STD Prevention Programs. Also included were gay/lesbian/bisexual/transgender resource centers, family planning organizations, mental health centers, migrant worker service providers, community health centers, government social service agencies, housing/shelter programs, public health departments, substance abuse programs, Red Cross affiliates, student health centers, maternal and child health clinics, STD clinics, youth-serving agencies, and correctional facilities.

Surveys were mailed in November 2002. A postage-paid envelope was included to increase the rate of return of completed surveys. Several of the providers were contacted to remind them to return their surveys or to clarify specific responses. A total of 144 surveys were returned, for a response rate of 45%.

Because over half of the providers did not return the survey, the responses reported here may not be representative of all prevention and care providers in Iowa. In addition, they may not reflect all services or service gaps present in the state.

### Agency Descriptions

Of the 144 respondents, 94 (65%) indicated that their agency provides prevention services that help prevent transmission of HIV and other STDs (Table 1). Thirty-one (22%) indicated that their agency provided care services to HIV-infected or HIV-affected persons. Seventy agencies (49%) provided HIV prevention services only; 7 (5%) provided HIV care services only; and 24 (17%) provided both HIV prevention and HIV care services. Forty-three of the agencies (30%) did not provide HIV prevention or care services.

**Table 1**  
**Types of Services Provided by Responding Agencies**

Services	#	(%)
HIV/AIDS prevention	70	(49)
HIV/AIDS care	7	(5)
Both HIV/AIDS prevention and care	24	(17)
Services other than HIV/AIDS prevention and care	43	(30)
Total	144	

Respondents were asked to choose one organization type to best describe their agency. Table 2 shows the organization descriptions for each group of agencies. Community-based organizations made up the largest group of respondents. Just over 25% of the respondents overall described their agency as a community-based organization.

**Table 2**  
**Description of Agencies by Services Provided**

Organization Type	Type of Services Provided									
	HIV Prevention		HIV Care		Both HIV Prev & Care		Other		All Agencies	
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)
Community-based organizations	11	(16)	3	(43)	8	(33)	17	(40)	39	(27)
Family Planning agency	20	(29)	0	--	2	(8)	2	(5)	24	(17)
Drug and alcohol treatment service	11	(16)	2	(29)	1	(4)	9	(21)	23	(16)
Adult corrections	1	(1)	1	(14)	3	(13)	7	(16)	12	(8)
Public health agency	9	(13)	0	--	3	(13)	0	--	12	(8)
Community health center	4	(6)	0	--	2	(8)	1	(2)	7	(5)
Youth corrections	2	(3)	0	--	2	(8)	2	(5)	6	(4)
Hospital, outpatient	1	(1)	1	(14)	1	(4)	2	(5)	5	(3)
College/university/community college	3	(4)	0	--	0	--	0	--	3	(2)
Private, for-profit agency	1	(1)	0	--	0	--	2	(5)	3	(2)
Government social service agency	2	(3)	0	--	0	--	0	--	2	(1)
Maternal/child health	1	(1)	0	--	1	(4)	0	--	2	(1)
Community mental health center	4	(6)	0	--	2	(8)	1	(2)	2	(1)
Housing/shelter	1	(1)	0	--	0	--	0	--	1	(1)
Migrant worker service provider	1	(1)	0	--	0	--	0	--	1	(1)
Gay/lesbian/bisexual service org.	1	(1)	0	--	0	--	0	--	1	(1)
STD clinic	1	(1)	0	--	0	--	0	--	1	(1)
<b>TOTAL</b>	<b>70</b>		<b>7</b>		<b>24</b>		<b>43</b>		<b>144</b>	

HIV prevention providers are most likely to be family planning agencies, community-based organizations, drug and alcohol treatment centers, or public health agencies. Although

community-based organizations comprise the largest number of HIV care providers (n = 8), nearly 2/3 of the 31 care providers were not community-based organizations.

While only one organization chose “STD clinic” as an agency descriptor, 60 agencies provided these services. The largest number of these, 21, chose “family planning agency” as the primary organization descriptor. Other descriptors included “public health agency” (n = 8), “community health center” (n = 5), “community-based organization” (n = 5), “drug and alcohol treatment center” (n = 5), and “adult correctional facility” (n = 5).

### PREVENTION SERVICES

Analysis of the following questions was limited to those 94 agencies that provided HIV/AIDS prevention services. Each respondent was asked to describe the agency’s geographical service area and the population(s) it serves. Fifty-two percent of the respondents described the area served by their agency as regional, while 35% reported that their agency served a local/citywide area (Table 3). Twelve providers (13%) indicated that their agencies served the entire state.

Just over half of the HIV/AIDS prevention agencies served populations in medium or large urban areas (Table 4). Twenty-four agencies served small urban or rural populations. Sixteen agencies served institutional populations, including correctional facilities (n = 8), substance abuse treatment facilities (n = 4), college health centers (n = 3), and a federal job training program (n = 1).

**Table 3**  
**Geographical Area Served by Agency**

Area	#	(%)
Statewide	12	(13)
Regional	48	(52)
Local/Citywide	33	(35)

**Table 4**  
**Type of Population Served by Agency**

Population	#	(%)
Large Urban (Over 45,000)	37	(40)
Medium Urban (20,000-44,999)	15	(16)
Small Urban (5,000-19,999)	15	(16)
Rural (Under 5,000)	9	(10)
Institution	16	(17)

The median number of HIV/AIDS prevention clients served per year was 200, with a range from 0 to 8,259 (data not shown). Characteristics of prevention clients are presented in Table 5. Ethnicity (Hispanic or Not Hispanic) was asked separately from race. The median percentage of Hispanic clients was 5, with a range from 0 to 95. Thirty-four agencies (36%) indicated that 10% or more of their clients were Hispanic. Thirty agencies reported that at least 25% of their clients belonged to a minority racial group. One agency served only American Indian /Alaskan Native clients.

**Table 5**  
**Characteristics of Prevention Clients**

<b>Ethnicity</b>	<b>Median</b>	<b>Range</b>
Hispanic	5%	0-95%
<b>Race</b>		
American-Indian or Alaska Native	0%	0-100%
Asian	1%	0-20%
Black or African American	6%	0-60%
Native Hawaiian or Pacific Islander	0%	0-5%
Multi-racial	0%	0-20%
White	87%	0-100%

### Funding for Prevention Providers

The survey asked about amounts of funding and the sources of that funding for HIV prevention services. Only 35 providers gave specific funding amounts. The median amount of funding was \$32,000, with a maximum amount of \$242,000 (Table 6). Three agencies reported receiving over \$100,000 annually for prevention services. The largest sources of funding were state and federal grants. Few agencies utilize private sources of funding or fund-raising activities. City and county grants were received by only nine providers but these were a significant source of support (\$200,000) for one agency. Thirty-four providers listed other sources of funding but amounts were generally small.

**Table 6**  
**Sources of Funding for HIV Prevention Activities**

<b>Funding Source</b>	<b>Median Amount</b>	<b># Agencies Utilizing Source</b>	<b>Range</b>
Total Funding	\$32,000	--	\$30 - \$242,000
Private Sources	\$1,000	7	\$300 - \$25,200
City/County Grants	\$8,500	9	\$4,200 - \$200,000
State/Federal Grants	\$25,200	43	\$100 - \$225,000
Fundraising Activities	\$2,000	6	\$200 - \$19,000
Fee for Services	NA*	11	NA*
Foundation Grants	\$4,200	10	\$500 - \$15,000
Other	\$4,500	34	\$200 - \$39,000

\* Total amount not given on surveys.

## Prevention Services Offered and Populations Served

The prevention providers were asked about the specific services they provided. Table 7 shows the prevention activities offered by the type of agency. The most common prevention activities are listed first.

Community-based organizations (CBOs) were split into two groups so that CBOs that work with a high percentage of minority clients could be compared to the other CBOs. High-minority CBOs were defined as those that served a high percentage of minority clientele compared to the population of Iowa. The populations served had to meet one of the following criteria:  $\geq 20\%$  Hispanic,  $> 3\%$  Native Hawaiian/ Pacific Islander,  $> 6\%$  American Indian/ Alaska Native,  $> 7\%$  Asian,  $\geq 25\%$  Black,  $< 50\%$  White, or a combination of all minority racial and ethnic groups (including multiracial) that was greater than or equal to 25% of persons served by the agency.

HIV 101 (basic information about HIV prevention) was the most commonly available prevention activity for all providers, with 94% offering this service. Individual risk reduction counseling was the most frequently offered intervention, with 63 of the 94 providers making this service available. On-site HIV testing and counseling was available at 62% of prevention agencies.

Street outreach, multi-session groups, and prevention case management were less frequently offered. Only 17% of agencies offer groups sessions for HIV negative-persons, and only 9% for HIV-positive persons. Twelve agencies (13%) offered HIV prevention case management as a prevention activity.

CBOs with a high percentage of minority clients differed somewhat from other CBOs. High-minority CBOs were more likely to offer HIV testing and counseling (on- or off-site), mass media campaigns, street outreach, prevention case management, and multi-session group interventions for HIV-positive persons.

Family Planning agencies make up the largest group of HIV prevention providers who responded to the survey. As a group, most of these agencies offer information and educational materials, individual risk reduction counseling, on-site HIV testing, and STD screening and treatment. Three-fourths of them offer condom skills training but only half teach condom negotiation skills. Few, if any, offer prioritized interventions, such as outreach, multi-session group interventions, or prevention case management.

Only 25% of drug treatment centers that offer HIV prevention have on-site HIV testing and counseling, although 50% offered multi-session group interventions for HIV-negative persons. Only one offered multi-session group interventions for HIV-positive persons and none offers prevention case management.

**Table 7**  
**Prevention Activity by Type of Agency for Selected Agency Types**

Prevention Activity	Type of Agency <sup>1</sup>																	
	Community based Org. N = 11		High Minority CBOs N = 8		Public Health Agency N = 12		Family Planning N = 22		Drug Treatment N = 12		Community Health Center N = 6		Corrections – Youth N = 4		Corrections – Adults N = 4		All Prevention Providers N = 94	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
HIV 101 information	9	(82)	8	(100)	9	(75)	21	(95)	10	(83)	3	(50)	4	(100)	4	(100)	78	(94)
Educational materials	9	(82)	6	(75)	11	(92)	19	(86)	8	(67)	5	(83)	3	(75)	4	(100)	75	(80)
Indiv. risk reduction couns.	7	(64)	6	(75)	11	(92)	19	(86)	7	(58)	2	(33)	1	(25)	2	(50)	63	(67)
On-site HIV test. / counseling	3	(27)	3	(34)	11	(92)	19	(86)	3	(25)	4	(67)	2	(50)	4	(100)	58	(62)
HIV referrals	7	(64)	5	(63)	11	(92)	11	(50)	5	(42)	4	(67)	1	(25)	3	(75)	54	(57)
STD screening and treatment	2	(18)	1	(13)	7	(58)	22	(100)	2	(17)	5	(83)	2	(50)	4	(100)	52	(55)
Condom distribution	7	(64)	6	(75)	9	(75)	15	(68)	2	(17)	4	(67)	0	--	1	(25)	50	(53)
Condom skills training	7	(64)	5	(63)	7	(58)	17	(77)	3	(25)	1	(17)	1	(25)	1	(25)	47	(50)
Condom negotiation skills	6	(55)	5	(63)	6	(50)	11	(50)	3	(25)	1	(17)	2	(50)	0	--	37	(39)
School-based education	6	(55)	6	(75)	4	(33)	13	(59)	1	(8)	0	--	0	--	1	(25)	36	(38)
Telephone info./ counseling	6	(55)	4	(50)	7	(58)	12	(55)	0	--	4	(67)	0	--	1	(25)	36	(38)
Hepatitis B vaccine	1	(9)	1	(13)	6	(50)	13	(59)	3	(25)	3	(50)	1	(25)	1	(25)	35	(37)
Hepatitis C test. / counseling	1	(9)	2	(25)	3	(25)	2	(9)	3	(25)	4	(67)	1	(25)	2	(50)	22	(23)
Off-site HIV test./ counseling	2	(18)	4	(50)	9	(75)	1	(5)	2	(17)	0	--	0	--	1	(25)	21	(22)

<sup>1</sup> Not all agency types are presented separately. The following agency types are represented only in the “All Prevention Providers” column: college/university/community college; community mental health center; housing/shelter; outpatient hospital; governmental social service agency; private, for-profit agency; migrant worker service provider; and gay/lesbian/bisexual service organization.

**Table 7 (continued)  
Prevention Activity by Type of Agency<sup>1</sup>**

Prevention Activity	Type of Agency <sup>1</sup>																	
	Community based Org. N = 11		High Minority CBOs N = 8		Public Health Agency N = 12		Family Planning N = 22		Drug Treatment N = 12		Community Health Center N = 6		Corrections – Youth N = 4		Corrections – Adults N = 4		All Prevention Providers N = 94	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Peer education programs	8	(42)	3	(38)	1	(8)	5	(23)	0	--	0	--	1	(25)	2	(50)	20	(21)
Mass media campaigns	3	(27)	5	(63)	3	(25)	5	(23)	0	--	0	--	0	--	2	(50)	19	(20)
Street outreach	3	(27)	4	(50)	4	(33)	3	(14)	0	--	0	--	0	--	1	(25)	17	(18)
Multi-session groups for HIV-	4	(36)	2	(25)	3	(25)	0	--	4	(50)	0	--	0	--	1	(25)	16	(17)
Hepatitis A vaccine	0	--	1	(13)	6	(50)	0	--	0	--	2	(33)	1	(25)	0	--	13	(14)
Prevention case management	2	(18)	4	(50)	3	(25)	1	(5)	0	--	0	--	1	(25)	1	(25)	12	(13)
Multi-session groups for HIV+	2	(18)	3	(38)	1	(8)	0	--	1	(8)	0	--	0	--	1	(25)	8	(9)

<sup>1</sup> Not all agency types are presented separately. The following agency types are represented only in the “All Prevention Providers” column: college/university/community college; community mental health center; housing/shelter; outpatient hospital; governmental social service agency; private, for-profit agency; migrant worker service provider; and gay/lesbian/bisexual service organization.

**Table 8**  
**Prevention Populations Served by Type of Agency**

Prevention Population	Type of Agency <sup>1</sup>																	
	Community - based Org. N = 11		High Minority CBOs N = 8		Public Health Agency N = 12		Family Planning N = 22		Drug Treatment N = 12		Community Health Center N = 6		Corrections – Youth N = 4		Corrections - Adults N = 4		All Prevention Providers N = 94	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Young adults (13-24)	9	(81)	6	(75)	11	(92)	21	(95)	8	(67)	4	(67)	3	(75)	1	(25)	74	(79)
General population	11	(100)	7	(88)	11	(92)	20	(91)	9	(75)	5	(83)	1	(25)	1	(25)	73	(78)
Low socio-economic status	6	(55)	6	(75)	10	(83)	14	(64)	8	(67)	4	(67)	2	(50)	1	(25)	58	(62)
Substance abusers	7	(64)	5	(63)	8	(67)	9	(41)	12	(100)	3	(50)	2	(50)	1	(25)	53	(56)
High-risk Heterosexual	4	(36)	6	(75)	9	(75)	15	(68)	9	(75)	2	(33)	1	(25)	0	--	51	(54)
IDU	3	(27)	5	(63)	9	(75)	8	(36)	9	(75)	3	(50)	2	(50)	2	(50)	46	(49)
Women at risk	5	(45)	6	(75)	7	(58)	14	(64)	6	(50)	2	(33)	0	--	0	--	46	(49)
MSM	5	(45)	5	(63)	8	(67)	11	(50)	6	(50)	3	(50)	1	(25)	1	(25)	45	(48)
Persons with STDs	3	(27)	3	(38)	7	(58)	17	(77)	6	(50)	1	(17)	1	(25)	0	--	44	(47)
Pregnant women	4	(36)	4	(50)	7	(58)	8	(36)	6	(50)	3	(50)	1	(25)	0	--	40	(43)
Bisexuals	4	(36)	4	(50)	7	(58)	11	(50)	6	(50)	1	(17)	1	(25)	0	--	39	(41)
Incarcerated persons	4	(36)	4	(50)	8	(67)	6	(27)	3	(25)	1	(17)	4	(100)	4	(100)	38	(40)
MSM/IDU	3	(27)	4	(50)	7	(58)	8	(36)	6	(50)	2	(33)	1	(25)	1	(25)	36	(38)
Lesbians	3	(27)	1	(13)	7	(58)	11	(50)	7	(58)	2	(33)	0	--	0	--	36	(38)
Persons with HIV/AIDS	4	(36)	5	(63)	6	(50)	5	(23)	6	(50)	3	(50)	1	(25)	1	(25)	34	(36)
Homeless persons	5	(45)	5	(63)	6	(50)	5	(23)	6	(50)	2	(33)	1	(25)	0	--	33	(35)

<sup>1</sup> Not all agency types are presented separately. The following agency types are represented only in the “All Prevention Providers” column: college/university/community college; community mental health center; housing/shelter; outpatient hospital; governmental social service agency; private, for-profit agency; migrant worker service provider; and gay/lesbian/bisexual service organization.

**Table 8 (continued)**  
**Prevention Populations Served by Type of Agency**

Prevention Population	Type of Agency <sup>1</sup>																	
	Community - based Org. N = 11		High Minority CBOs N = 8		Public Health Agency N = 12		Family Planning N = 22		Drug Treatment N = 12		Community Health Center N = 6		Corrections – Youth N = 4		Corrections - Adults N = 4		All Prevention Providers N = 94	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Trade sex for money/drugs	2	(18)	3	(38)	6	(50)	6	(27)	7	(58)	1	(17)	1	(25)	1	(25)	30	(32)
Mentally ill persons	2	(18)	4	(50)	3	(25)	4	(18)	5	(42)	1	(17)	2	(50)	1	(25)	26	(28)
Sex workers	2	(18)	3	(38)	5	(42)	4	(18)	6	(50)	0	--	1	(25)	1	(25)	24	(26)
Medical professionals	4	(36)	4	(50)	2	(17)	5	(23)	4	(33)	2	(33)	1	(25)	0	--	24	(26)
Transgendered persons	2	(18)	2	(25)	5	(42)	5	(23)	2	(17)	2	(33)	1	(25)	0	--	23	(24)
Migrant workers	2	(18)	2	(25)	3	(25)	7	(32)	2	(17)	1	(17)	1	(25)	0	--	19	(20)
Developmentally disabled	1	(9)	1	(13)	1	(8)	7	(32)	3	(25)	0	--	1	(25)	0	--	17	(18)
Visual/hearing impaired	1	(9)	1	(13)	3	(25)	4	(18)	5	(42)	0	--	1	(25)	0	--	16	(17)

<sup>1</sup> Not all agency types are presented separately. The following agency types are represented only in the “All Prevention Providers” column: college/university/community college; community mental health center; housing/shelter; outpatient hospital; governmental social service agency; private, for-profit agency; migrant worker service provider; and gay/lesbian/bisexual service organization.

Table 8 summarizes the prevention populations served by the various prevention agencies. The populations are listed from most commonly to least commonly served. Young adults and the general population are the most served populations, with nearly 80% of the agencies providing services to them. Substance abusers, high-risk heterosexuals, and injection drug users were also widely served populations.

Men who have sex with men, the community planning group's highest priority population, were served by less than half of the prevention providers. HIV-positive people (i.e., persons with HIV/AIDS), another priority group, were served by 36% of the prevention providers.

CBOs with large minority clientele bases were more likely than other CBOs to serve high priority populations, including MSM, IDU, women at risk, HIV-positive persons, and MSM/IDU. They were also less likely to serve lower priority populations, such as youth and the general population.

Among populations least likely to be served were transgendered persons and migrant workers. Fewer than 25% of prevention providers served these populations.

### **Perceptions of Service Gaps to Selected Populations**

All prevention providers were asked to assess how well services are provided to selected populations in their area. They rated services on the following scale:

0 = "Not provided at all/ potential service gap;" 1 = "Somewhat provided but not in sufficient quantity to meet demand;" 2 = "Adequately provided;" 3 = "Well provided;" and 4 = "Excessive; duplication of services." Table 9 shows, for each of the populations, the average score assigned by the providers. Scores below 1.0 are italicized and indicate a perceived service gap.

Individual-level interventions for high-risk youth were the only prevention services to receive a rating of "adequately provided." All other interventions were rated as lacking for all populations. For that reason, scores below 1.0 will be highlighted as indicating service gaps.

Only two types of prevention services were rated as inadequate (< 1.0) for all populations. HIV prevention capacity building activities, those services that strengthen public health infrastructure for HIV prevention, were rated as the most inadequate prevention services for all populations except HIV-positive persons. Outreach was rated as the second most inadequate prevention service, with an average score of 0.88. At-risk women, IDUs, and HIV-positive persons were rated as most in need of outreach services.

Prevention case management was the only other prevention service to have an overall rating below 1.0. Only two populations, however, scored below 1.0. At-risk women and injecting drug users were rated as most in need of prevention case management services.

**Table 9**  
**Perception of Adequacy of Prevention Services**

TYPE OF PREVENTION SERVICE	MSM	IDU	POPULATION			Total
			High Risk Youth	HIV +	At-Risk Women	
(Mean Score <sup>1</sup> )						
<b>Individual Level Intervention:</b> Health education and risk reduction counseling for individuals.	1.8	1.8	2.0	1.8	1.7	1.8
<b>Group Level Intervention:</b> Health education and risk reduction education for groups of individuals.	1.2	1.3	1.6	1.3	1.3	1.3
<b>Community Level Interventions:</b> Programs that target the selected community, involve community members in the design and delivery, and attempt to change community norms, attitudes, values, and behaviors.	<i>0.97</i>	<i>0.87</i>	1.2	<i>0.97</i>	<i>0.98</i>	1.0
<b>Health Communication/Public Information Programs:</b> The delivery of planned HIV/AIDS prevention messages that target selected populations and aim to dispel myths about HIV transmission.	<i>0.98</i>	<i>0.89</i>	1.2	<i>0.98</i>	<i>0.96</i>	1.0
<b>Prevention Case Management:</b> Client-centered, with the goal of promoting the adoption of HIV risk-reduction behaviors by clients who display multiple, complex problems and risk reduction needs. Provides intensive, ongoing, and individualized prevention counseling support and service brokerage.	1.0	<i>0.95</i>	1.0	1.0	<i>0.90</i>	<i>0.97</i>
<b>Outreach:</b> Defined as HIV prevention, education, counseling, and referrals for persons who engage in high-risk activities, delivered at informal sites (e.g., bars, parks, shooting galleries, bathhouses, beauty parlors, or other community congregation sites).	<i>0.92</i>	<i>0.82</i>	<i>0.98</i>	<i>0.85</i>	<i>0.81</i>	<i>0.88</i>
<b>HIV Prevention Capacity Building:</b> Services that strengthen governmental and non-governmental public health infrastructure in support of HIV prevention, implement systems to ensure the quality of services delivered, improve the ability to assess community needs, and provide technical assistance in all aspects of program planning and operations.	<i>0.84</i>	<i>0.80</i>	<i>0.94</i>	<i>0.89</i>	<i>0.75</i>	<i>0.84</i>

<sup>1</sup> Scores were as follows: 0 = "Not provided at all/ potential service gap;" 1 = "Somewhat provided but not in sufficient quantity to meet demand;" 2 = "Adequately provided;" 3 = "Well provided;" and 4 = "Excessive; duplication of services." Scores below 1.0 are italicized and indicate a perceived service gap.

High-risk youth consistently received the highest scores, regardless of the intervention type. Youth scored below 1.0 only for HIV prevention capacity building and outreach.

Overall, at-risk women and injecting drug users were rated as most in need of prevention services. Injecting drug users were rated as significantly lacking in community-level interventions, health communication and public information programs, HIV prevention capacity building, and outreach. At-risk women were most in need of HIV prevention capacity building and outreach.

### Barriers to Providing HIV Prevention Services

Table 10 indicates which barriers were most frequently encountered by prevention providers.

**Table 10**  
**Barriers/Difficulties in Providing HIV Prevention Services**

Barriers	(%)
Limited funding	(77)
Limited staffing	(71)
Lack of culturally and ethnically appropriate staff	(58)
Target population not aware of services	(49)
Lack of bilingual materials	(45)
Training for staff	(43)
Problems of accessibility for the target population	(41)
Small size of target population	(38)
Recruiting qualified staff	(38)
Insufficient coordination, collaboration between providers	(31)
Staff retention	(16)

Limited funding and staffing were listed as barriers for over 70% of prevention providers. Recruiting and retaining staff do not seem to be significant barriers, although 58% mentioned a lack of culturally and ethnically appropriate staff. Nearly half of the providers mentioned that the target populations were not aware of their services and over one-third cited the small size of the target population as a barrier.

### Access to Services

Accessibility to services is another potential barrier that was assessed. Each provider was asked to rate their agency on the provision of a number of features that enhance accessibility to their services.

Most providers rated their agencies highly on handicap accessibility, availability of parking, and location (Table 11). Almost two-thirds of the providers said that providing transportation tokens did not apply to their agencies. Of the remaining one-third, 32% did a poor job of providing the

tokens. Over a fourth of the providers said they did a poor job of providing interpreters and half rated their agencies poorly for providing sign language interpreters. Twenty-seven percent of the providers said their staffs poorly represented their target population(s). Child care was the lowest-rated feature. Almost 60% of the agencies said this service did not apply to them. Two-thirds of those who rated the feature said their agencies did a poor job of providing child care. Only two providers said their agency did a good job of providing this service.

**Table 11**  
**Availability of Specific Accessibility Features**

Accessibility Feature	Availability Rating	
	Mean Score <sup>1</sup>	% Rating "Poor"
Building is handicap accessible	4.7	0
Parking is readily available	4.6	4
Agency is near public transportation	4.4	11
Agency is located near target population(s)	4.2	6
Agency is located near other agencies to which clients are referred	3.9	8
Agency is located near hospitals/clinics that clients use	3.8	13
Transportation tokens are provided to clients	3.4	32
Interpreters/translators are available	3.0	28
Staff is representative of the target population(s)	3.0	27
Sign language interpreters are available	2.2	50
Child care is available for clients	1.8	66

<sup>1</sup> Rated on scale of 5 = Good; 3 = Fair; 1 = Poor.

## SUMMARY OF PREVENTION SERVICE NEEDS

- While the CPG has identified Men Who Have Sex with Men and Injecting Drug Users as the highest priority groups for HIV prevention interventions in Iowa, the survey indicates that young adults, women, and the general population are the groups most frequently reached by prevention providers.
- HIV 101, education, individual risk reduction counseling, and on-site HIV counseling, testing, and referral were the most frequently reported prevention services provided. However, off-site testing, street outreach, prevention case management, and multi-session groups for both positive and negative persons were less frequently offered.
- Over 70% of the providers indicated that the most significant barriers to providing services were limited funding and staffing.

### Perception of Adequacy of Prevention Services

- Individual-level interventions for high-risk youth were the only prevention services to receive a rating of “adequately provided.” All other interventions were rated as lacking for all populations.
- Only two types of prevention services were rated as inadequate (<1.0) for all populations: HIV prevention capacity building activities and Outreach. At-risk women, IDUs, and HIV-positive persons were rated as most in need of outreach services. In addition, prevention case management was given an overall rating below 1.0. However, only two populations scored below 1.0. At-risk women and injecting drug users were rated as most in need of prevention case management services.
- High-risk youth consistently received the highest scores, regardless of intervention type.

Overall, at-risk women and injecting drug users were rated as most in need of prevention services.

## CARE SERVICES

Thirty-one agencies reported providing essential health and support services for persons with HIV/AIDS. Each agency was asked to describe its geographical service area and the populations it serves. Sixty-five percent of the respondents described the area served by their agency as regional, 16% indicated that their agency served a statewide area, and 19% reported that their agency served a local/citywide area (Table 12).

Just over 40% of the care agencies served populations in medium or large urban areas (Table 13). Four agencies served medium urban areas and seven agencies served small urban or rural populations. Seven agencies served institutional populations, all associated with correctional facilities.

**Table 12**  
**Geographical Area Served by Agency**

Area	#	(%)
Statewide	5	(16)
Regional	20	(65)
Local/Citywide	6	(19)

**Table 13**  
**Type of Population Served by Agency**

Population	#	(%)
Large Urban (Over 45,000)	13	(42)
Medium Urban (20,000-44,999)	4	(13)
Small Urban (5,000-19,999)	5	(16)
Rural (Under 5,000)	2	(6)
Institution	7	(23)

The median number of HIV/AIDS care clients served per year was 40, with a range from 0 to 344 (data not shown). Seven providers served more than 100 clients; most of these were Ryan White Title II or Title III providers.

Characteristics of care clients are presented in Table 14. Ethnicity (Hispanic or Not Hispanic) was asked separately from race. The median percentage of Hispanic clients was 6, with a range from 0 to 25. Eleven agencies (35%) indicated that 10% or more of their clients were Hispanic. Fourteen agencies reported that at least 25% of their clients belonged to a minority racial group.

**Table 14**  
**Characteristics of Care Clients**

Race/Ethnicity	Median	Range
Hispanic	6%	0-25%
American-Indian or Alaska Native	0%	0-21%
Asian	1%	0-27%
Black or African American	17%	0-60%
Native Hawaiian or Pacific Islander	0%	0-5%
Multi-racial	0%	0-10%
White	80%	0-100%

## Funding for Care Providers

Twenty agencies answered questions about funding sources, and only 12 gave total dollar amounts (Table 15). Of those, the median total funding was \$79,800, with maximum funding just over \$500,000. Six agencies received more than \$100,000 in care funding. All were Ryan White Title II or Title III providers, and the major sources of funding were state and federal grants. Three agencies received foundation grants of \$12,000 or more. Only six agencies engaged in fundraising for care activities. Generally, this accounted for \$2,000 or less. Eight agencies reported private sources of care funding, with a median of \$4,700 from this source.

**Table 15**  
**Sources of Funding for Care Activities**

<b>Funding Source</b>	<b>Median Amount</b>	<b># Agencies Utilizing Source</b>	<b>Range</b>
Total Funding	\$79,800	---	\$23,875 - \$500,500
Private Sources	\$4,700	8	\$300 - \$19,500
City/County Grants	\$2,500	5	\$2,000 - \$10,000
State/Federal Grants	\$46,000	20	\$319 - \$500,000
Fundraising Activities	\$1,500	6	\$200 - \$19,000
Fee for Services	NA*	3	NA*
Foundation Grants	\$13,000	3	\$12,000 - \$85,000
Other	\$6,600	12	\$850 - \$20,000

\* Total amount not given on surveys.

Survey respondents were asked what services their agencies provide and what services are available in their community through other agencies. Table 16 lists these services according to their availability in the communities.

Health education and risk reduction services were the most available care services. Over 90% of the providers said this service was available in their community; 84% offered it through their agency. Substance abuse counseling, mental health care, outpatient care, information referral, and case management services are also widely available in communities. Over 60% of the responding agencies offered case management at their agencies, and over half offered access to support groups. Fewer than 20% of the agencies offered a food bank, health insurance, home health care, hospice, respite care, or legal services. With the exception of health insurance, these services were reported to be available, for the most part, from other sources.

Only 52% of care providers said they offer access to the state's drug assistance program. This program is available to HIV-infected persons in all communities of the state despite the fact that 26% of the care providers did not indicate that the service was available in their communities. This may indicate that this and other services are more available than the survey results show. At the same time, it illustrates that availability may not be a good indicator of utilization. If providers are unaware of services available in their communities, their clients may not be either.

To determine potential service gaps, provision of services was examined by region. The western region includes Sioux City and Council Bluffs, north central includes Ft. Dodge, Mason City, Ames, and Marshalltown; south central includes Des Moines; northeast includes Cedar Rapids, Dubuque, and Waterloo; and south east includes Iowa City, Davenport, and Burlington. No differences in services available by region were noted. However, it was apparent that respondents from agencies located outside of the major metropolitan areas were less often able to answer questions about whether specific services were available in their communities or regions.

**Table 16**  
**Services Offered for HIV-infected Persons**

Service for HIV infected	Provided By the Surveyed Agency		Provided By At Least One Agency in the Community <sup>1</sup>	
	#	(%)	#	(%)
HIV Health Education/Risk Reduction	26	(84)	29	(94)
Substance Abuse Counseling	14	(45)	28	(90)
Mental Health Care	14	(45)	28	(90)
Outpatient Health Care Services	10	(32)	28	(90)
Information Referral	22	(71)	26	(84)
Client Case Management/Planning	19	(61)	26	(84)
Oral Care	13	(42)	25	(81)
Nutrition Education	13	(42)	23	(74)
Anti-Retroviral Drug Assistance	16	(52)	23	(74)
Home Health Care	4	(13)	23	(74)
Hospice Care	2	(6)	23	(74)
Support Group	16	(52)	22	(71)
Emergency Financial Assistance	14	(45)	22	(71)
Client Advocacy	14	(45)	22	(71)
Outreach	14	(45)	22	(71)
Food Bank	6	(19)	22	(71)
Legal Services	2	(6)	22	(71)
Transportation	12	(39)	21	(68)
Housing Assistance	9	(29)	21	(68)
Treatment Adherence Services	10	(32)	19	(61)
Buddy/Volunteer Group	10	(32)	19	(61)
Respite Care	2	(6)	19	(61)
Health Insurance	5	(16)	14	(45)

<sup>1</sup> Includes the responding agency.

The survey did not ask how widely accessed or utilized the services were by specific populations. Despite the availability of some services, care providers noted in their comments that there were still unmet needs for those services. Transportation, dental services, and substance abuse treatment were listed as services for which need exists in spite of relatively high availability.

Nearly half of the providers listed specific unmet needs. These included:

- Services for minority populations
- Vocational services
- Support groups for women and youth
- Transportation, especially for those in rural areas
- Programs for inmates who are returning to the community
- Dental services
- HIV testing and case management services
- Programs for youth and minorities in corrections
- More accessible substance abuse treatment programs
- Affordable housing
- Food/grocery services
- Utility assistance
- Co-pays for medications/insurance
- Group education and counseling programs
- More staff to specialize in areas such as community health, HIV prevention, and STD services

**Barriers to the provision of HIV/AIDS Care Services**

Survey respondents were asked to list significant barriers to providing care services. Limited funding was the barrier most frequently cited by care providers (Table 17). Eighty-five percent of the providers indicated this as a barrier. Limited staffing was cited by 65% of the providers.

**Table 17  
Barriers/Difficulties in Providing Care Services**

Barriers	(%)
Limited funding	(85)
Limited staffing	(65)
Target population not aware of services	(48)
Lack of culturally and ethnically appropriate staff	(46)
Problems of accessibility for the target population	(40)
Lack of bilingual materials	(40)
Training for staff	(32)
Recruiting qualified staff	(28)
Small Size of target population	(24)
Insufficient coordination, collaboration between providers	(16)
Staff retention	(13)

Lack of culturally and ethnically appropriate staff was cited much more frequently by care providers than by prevention providers, 58% versus 46%, respectively (see Table 10), while staff training needs and small target population size were cited less often than by prevention providers. Insufficient coordination and collaboration was also much less of a problem for care providers than for prevention providers. Staff retention was not a significant barrier for either care or prevention providers.

**Access to Care Services**

Care providers were asked to rate their agency on the provision of a number of features that enhance accessibility to their services.

Ratings did not differ significantly from those of the HIV prevention providers, although fewer care agencies rated themselves as “poor” on most accessibility features. Most care providers rated their agencies highly on handicap accessibility, availability of parking, and location, although 15% rated their agency’s proximity to public transportation as “poor” (Table 18). Just over 60% of the providers said that providing transportation tokens did not apply to their agencies. Of the remaining agencies, 25% did a poor job of providing the tokens. Only 14% of care agencies rated their provision of interpreters as “poor,” but nearly 40% rated their provision of sign language interpreters as “poor.” Nineteen percent of the providers said their staffs poorly represented their target population(s). Child care was the lowest rated feature. Approximately half of the agencies said this service did not apply to them. Nearly 90% of those who rated the feature said their agencies did a poor job of providing child care. Only two providers said their agency did a good job of providing this service.

**Table 18**  
**Availability of Specific Accessibility Features**

Accessibility Feature	Availability Rating	
	Mean Score <sup>1</sup>	% Rating “Poor”
Building is handicap accessible	4.7	0
Parking is readily available	4.7	0
Agency is near public transportation	4.3	15
Agency is located near target population(s)	4.2	7
Agency is located near hospitals/clinics that clients use	4.2	11
Agency is located near other agencies to which clients are referred	4.1	7
Transportation tokens are provided to clients	3.7	25
Interpreters/translators are available	3.4	14
Staff is representative of the target population(s)	3.0	19
Sign language interpreters are available	2.6	39
Child care is available for clients	1.5	87

<sup>1</sup> Rated on scale of 5 = Good; 3 = Fair; 1 = Poor.

**SUMMARY OF CARE SERVICE NEEDS**

- Health education and risk reduction services were the most available care services. Eighty-four percent of the care providers offer these services through their own agencies. Client case management/planning was available at 61% of the care agencies. Another 23% said some other agency provided this service in their community. Substance abuse counseling, mental health care, and outpatient health care services were reported to be widely available, but were more often offered through another agency in the community than by the care provider. Health insurance was the service that was least likely to be available.
- The survey does not provide information as to whether the widely available care services are actually being utilized by all populations. Transportation, substance abuse treatment, and dental services were still cited as unmet needs despite being rated as available services.
- Other unmet needs included services for minority populations, vocational services, support groups for women and youth, programs for inmates returning to the community, HIV testing, case management services, programs for youth and minorities in corrections, affordable housing, food/grocery services, utility assistance, copays for medications/insurance, group education and counseling programs, and more specialized staff.
- Limited funding and limited staffing were cited as the most significant barriers to providing care services.
- Providers rated the provision of several clinic accessibility features as fair or poor. The availability of interpreters/translators was rated as “fair” overall at care agencies while the availability of child care was rated as “poor” by 87% of care providers.

## UNMET TRAINING AND CAPACITY BUILDING NEEDS

All respondents were asked to rate the need for training of staff or volunteers as well as the need for agency/management capacity building. Table 19 shows the training needs for prevention providers only, care providers only, agencies that provide both prevention and care services, and agencies that provided services other than HIV prevention and care. The score was rated on a scale from 1-5, with 1 being the least need and 5 being the greatest need.

**Table 19**  
**Training Needs for Staff and Volunteers**  
**By Type of Services Provided by Agency**

Training Needs	Agencies that Provide:			
	HIV Prevention Only (N=70)	HIV Prevention and Care (N=24)	HIV Care Only (N=7)	Other Prevention / Care (N=43)
	Score <sup>1</sup>	Score <sup>1</sup>	Score <sup>1</sup>	Score <sup>1</sup>
Cultural competence programs	3.2	2.7	1.6	2.7
Risk reduction/behavior change	3.0	3.0	2.3	3.0
Program development/evaluation	2.9	3.0	2.6	2.6
Effective prevention intervention strategies	2.9	2.9	2.2	2.9
Prevention counseling	2.9	2.9	2.0	2.8
HIV/AIDS treatment information	2.9	2.3	2.8	2.8
HIV/HCV co-infection	2.9	2.7	2.8	2.6
Data collection and analysis	2.8	2.7	1.0	2.4
Living with HIV/AIDS	2.8	2.3	3.2	2.4
Human sexuality	2.7	2.3	1.5	2.7
HIV/AIDS 101 (Basic Information)	2.7	1.8	2.3	3.2
Prevention and care linkages	2.7	2.7	2.2	2.0
How to work with the media	2.6	2.1	2.2	2.1
Prevention with sero-discordant couples	2.6	2.5	2.0	1.8
Writing measurable goals and objectives	2.6	2.9	1.0	2.0
Program implementation	2.5	2.4	1.8	1.9
Treatment adherence	2.5	2.4	1.6	1.8
Care case management	2.5	2.7	1.8	1.9
Prevention case management	2.5	3.0	2.0	1.9
Clinical STD services	2.4	2.2	1.0	2.1
Sexual history taking	2.4	2.2	1.4	2.3
Clinician specimen collection technique	2.2	1.5	1.0	1.8
Vaccine administration, scheduling, and storage (Hepatitis A and B)	2.2	2.0	1.0	1.6

<sup>1</sup> Mean score based on scale of 1 = least need and 5 = greatest need.

Those providers that only provided HIV prevention services rated cultural competence programs as the greatest training need, followed by programmatic theory, design, and evaluation. Agencies that provided both HIV prevention and care services differed somewhat in their training needs from those agencies that only provide HIV prevention services. Prevention case management was included among their greatest training needs, along with programmatic theory, design, and evaluation. Among their lowest training needs was HIV/AIDS 101, which they ranked substantially lower than those that provide only HIV prevention services.

Care providers were much less likely than prevention providers to want training in cultural competence. The highest-rated training need for care providers was for living with HIV/AIDS. After that, training for HIV/AIDS treatment information and HIV/Hepatitis C co-infection was most highly rated. In general, care providers rated the need for training lower than prevention providers.

Agencies that did not provide HIV prevention or care services ranked HIV/AIDS 101 as their highest training need. After that, risk reduction/behavior change and prevention intervention strategies were most highly rated as needs.

The providers were also asked to rank capacity building needs for their agencies on a scale of 1 to 5, 5 being the highest need. Prevention providers rated resource development and grant writing training as their highest need, followed by marketing and public relations trainings (Table 20). Care providers, however, ranked volunteer recruitment and training as their greatest capacity building need, although the score was only 2.2. The agencies that provided services other than HIV prevention and care ranked marketing and public relations highest, but there was little deviation in scores for these providers.

**Table 20**  
**Capacity Building Needs for Agencies**  
**By Type of Services Provided by Agency**

Capacity Building Needs	Agencies that Provide:			
	HIV Prevention Only (N=70)	HIV Prevention and Care (N=24)	HIV Care Only (N=7)	Other Prevention / Care (N=43)
	Score <sup>1</sup>	Score <sup>1</sup>	Score <sup>1</sup>	Score <sup>1</sup>
Resource development and grant writing	3.0	2.7	1.7	1.9
Marketing/public relations	2.9	2.5	1.7	2.1
Organizational development	2.7	2.4	1.8	1.9
Volunteer recruitment and training	2.6	2.4	2.2	1.9
Board development	2.4	2.2	1.7	2.0
Fiscal management	2.4	2.3	1.7	1.9

<sup>1</sup> Mean score based on scale of 1 = least need and 5 = greatest need.

Finally, the survey asked for additional comments regarding unmet needs to stop the transmission of STDs and HIV in Iowa. The following are selected comments:

- Concentrate on high-risk youth and take into account demographic differences.
- Expand hours for free HIV screening. This could be offered at family planning centers as part of gynecological exams or regular check-ups.
- Prevention of staff burnout. Retreats. More care and training for staff, especially case managers.
- Implement services in more places like schools.
- More funding for large, collaborative efforts between health care providers.

## Gap Analysis

HIV Prevention Needs have been defined as the following:

- A **met need** is a need for HIV prevention services within a specific target population that is currently addressed through resources that are available, appropriate, and accessible.
- An **unmet need** is a need for HIV prevention services within a specific target population that is not currently addressed because no services are currently available, or available services are inappropriate or inaccessible.

A gap analysis is a description of the unmet HIV prevention needs, or service gaps, for the high-risk populations. The gap analysis also shows how and where the resources are being used. It helps to identify areas where resources may need to be redirected, or areas where more resources are needed and new interventions should be implemented. Determining unmet needs helps in the process of prioritizing populations and interventions by identifying which interventions are successful and which population's needs have and have not been met.

Based on a review of epidemiological data, availability of local resources and assessment of statewide needs and services from the Provider Resource Survey (Community Services Assessment), and a summary of the currently funded HIV Prevention Projects a gap analysis was conducted to identify:

- Populations at highest risk for future HIV infection and with the highest need for services to prevent future infections;
- Barriers to accessing the services that do exist; and
- The degree to which the needs of high-risk populations are currently being met.

To supply the Community Planning Group with an idea of the level of services currently being provided for the identified populations comparisons were made between the perception of the level of services identified in the Provider Services Survey and the results of the evaluation and summary of the CDC-funded HIV Prevention Projects.

The Provider Services Survey showed that individual level interventions for high-risk youth were the only prevention services to receive a rating of "adequately provided." All other interventions were rated as lacking for all populations. Two types of interventions were rated as inadequate (<1.0) for all populations: HIV prevention capacity building activities and Outreach. At-risk women, IDU's, and HIV-positive persons were rated as most in need of outreach services. In addition, prevention case management was given an overall rating below (1.0); however only two populations scored below 1.0. At-risk women and injecting drug users were rated as most in need of prevention case management services. High-risk youth consistently received the highest scores, regardless of intervention type. Overall, at-risk women and injecting drug users were perceived as most in need of prevention services.

In 2002, the HIV Prevention Projects summary was broken down by priority populations and by intervention. There was a 64 percent increase in the number of people reached in 2002 over 2001. Providers reached 134 percent of their projected intervention plan numbers.

The results of the presentation to the Community Planning Group before Priority Setting by the Epi-Profile Committee and the Needs Assessment/Community Resources Committee follows.

Potential Target Populations	Need	Met Need	Unmet Need
HIV + Persons	The CDC has identified as the number one priority.	<ul style="list-style-type: none"> <li>Total of 8 projects funded to do PCM with HIV+ MSM, IDU and High-risk Heterosexuals</li> <li>Total of 4 projects funded to do GLI with HIV+ MSM</li> <li>Good relationships with Title III agencies, HIV Doctors, drug rehab centers</li> <li>Offered testing to partners of HIV+ people</li> <li>Involved HIV- partners, who brought in HIV+ partners</li> <li>Needs assessment showed that 36% of Prevention Providers serve persons with HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>Needs assessment showed that the perception of the adequacy of prevention services for HIV+ for all interventions was that of “Somewhat provided but not sufficient to meet demand.”</li> <li>There was a perception on the needs assessment that HIV+ were receiving ILI interventions, however there were no ILI projects funded for the last time.</li> <li>Challenges included: recruitment issues, program compliance, and staffing issues.</li> <li><b>Estimate: Unmet need</b></li> </ul>
MSM	<p>Diagnoses are declining but they still represent the largest portion of new cases overall.</p> <p>AIDS Incidence - Avg. # of diagnoses/yr. (2000-2002) – 40                      Diagnosed HIV cases (3 yr. Average) – 49                      Diagnosed HIV cases per 100,000 pop (3 yr. Average) – 217/100,000                      Diagnosed HIV Prevalence (including AIDS) - 576</p>	<ul style="list-style-type: none"> <li>4 Projects funded to do PCM with HIV+ MSM, 2 projects funded to do PCM with MSM with HIV+ partners, 5 projects funded to do Outreach with MSM Substance Users, 3 projects funded to do Outreach with Young MSM, 4 projects funded to do GLI with HIV+MSM, 3 projects funded to do GLI with MSM Substance Users, and 1 project funded to do GLI with Young MSM</li> <li>Interventions worked when had consistently high visibility at gathering places (bars, events, parks, etc.)</li> <li>The Needs Assessment showed that 48% of all prevention providers are serving MSM</li> <li>According to the Needs Assessment CBO’s with large minority clientele were more</li> </ul>	<ul style="list-style-type: none"> <li>On the Needs Assessment, the overall perception of prevention services for all interventions was that “Services were provided but not in sufficient quantity to meet demand.”</li> <li>Men who have sex with men, the CPG’s highest priority population were served by less than half of the prevention providers.</li> <li>Challenges include lack of interest on the part of clients – MSM burnout.</li> <li>Apathy and disinterest to HIV Prevention messages</li> <li>Staff turnover and shortages</li> <li><b>Estimate: Unmet need</b></li> </ul>

Potential Target Populations	Need	Met Need	Unmet Need
		<p>likely to serve high priority populations, including MSM.</p> <ul style="list-style-type: none"> <li>• Collaboration with community GLBT groups</li> </ul>	
IDU	<p>A large decrease in diagnoses has been seen recently but they still comprise the second largest category of persons living with HIV.</p> <p>AIDS Incidence – Avg. # of diagnoses/yr. (2000-2002) – 8                      Diagnosed HIV cases (3 yr. Average) – 11                      Diagnosed HIV cases per 100,000 pop (3yr. Average) – 174/100,000                      Diagnosed HIV Prevalence (including AIDS) – 213</p>	<ul style="list-style-type: none"> <li>• 1 Project funded to do PCM with IDU who are HIV+, 3 projects funded to do Outreach with IDU not in treatment, and 1 funded to do Outreach with IDU in Communities of Color. 4 projects funded to do ILI with IDU not in treatment and in correctional facilities, 11 projects funded to do GLI with IDU sexual partners, IDU who are in treatment, and in correctional facilities.</li> <li>• For Outreach with IDU not in treatment, all projects exceeded their projections.</li> <li>• Regular contact helped with trust and disclosure issues.</li> <li>• Strengthened relationships with community organizations.</li> <li>• Large numbers of high-risk inmates reached.</li> <li>• Needs assessment showed that 49% of Prevention Providers are serving IDU and 38% are serving IDU/MSM.</li> </ul>	<ul style="list-style-type: none"> <li>• Needs assessment showed that the perception of the adequacy of prevention services for IDU for all interventions was that of “Somewhat provided but not sufficient to meet demand.”</li> <li>• The IDU’s were one of the groups rated as most in need of outreach services and prevention case management. The survey also indicated that IDU were rated as significantly lacking in community –level interventions, health communication and public information programs, and HIV prevention capacity building.</li> <li>• Challenges include access to high-risk clients and sites, disclosure issues, staff turnover, integration of programs into facilities.</li> <li>• <b>Estimate: Unmet need</b></li> </ul>
High-risk Heterosexual	<p>The numbers are increasing somewhat, but much of this is due to the influence of diagnoses among foreign-born persons.</p> <p>AIDS Incidence – Avg. # of diagnoses/yr. (2000-2002) – 8                      Diagnosed HIV cases (3 yr. Average)</p>	<ul style="list-style-type: none"> <li>• 2 projects funded to do PCM, 1 with HIV+ Heterosexuals with high-risk unprotected sex, and 1 project funded to do Outreach with High-risk heterosexuals that trade sex for money, drugs or favors.</li> <li>• Offered testing to partners of</li> </ul>	<ul style="list-style-type: none"> <li>• On the Needs Assessment, the overall perception of prevention services for all interventions was that “Services were provided but not in sufficient quantity to meet demand.”</li> <li>• At-risk women were rated as most in need of outreach</li> </ul>

Potential Target Populations	Need	Met Need	Unmet Need
	<p>– 16 Diagnosed HIV cases per 100,000 pop (3 yr. Average) – 32/100,000 Diagnosed HIV Prevalence (including AIDS) – 170</p>	<p>HIV+ people.</p> <ul style="list-style-type: none"> <li>• Good partnerships and collaborations with other organizations.</li> <li>• Needs assessment showed that 54% of prevention providers work with High-risk Heterosexuals.</li> </ul>	<p>services, capacity building, and prevention case management.</p> <ul style="list-style-type: none"> <li>• Challenges included recruitment and difficulty in identifying population by self-disclosure.</li> </ul>
Corrections	<p>Per 100,000 population, there are a significant number of diagnoses made through the prison system.</p> <p>AIDS Incidence – Avg. # of diagnoses/yr. (2000-2002) – 2 Diagnosed HIV cases (3 yr. Average) – 5 Diagnosed HIV cases per 100,000 pop (3 yr. Average) – 62/100,000 Diagnosed HIV Prevalence (including AIDS) – 38</p>	<ul style="list-style-type: none"> <li>• 1 funded project to provide PCM to IDU in Corrections, 4 projects were funded to provide GLI to IDU in Corrections, and 9 funded projects to do GLI with youth in juvenile detention facilities.</li> <li>• Previously the focus was on the behavior or a further defined population within a correctional facility.</li> <li>• Inmates were given personalized risk assessments, risk reduction information and linkages to community resources.</li> <li>• Participants often recruited other inmates into the program.</li> <li>• Evaluations showed that the course was of benefit to the inmates, large increase in knowledge shown.</li> <li>• The Needs Assessment showed that 40 % of all Prevention Providers were serving Incarcerated persons.</li> </ul>	<ul style="list-style-type: none"> <li>• The level of service currently being provided to incarcerated individuals was measured through other high-risk definitions, i.e., IDU, or Youth. High-risk youth receiving ILI were the only prevention services to receive a rating of “adequately provided.”</li> <li>• Challenges include little control over who attended and how often.</li> <li>• Budgetary problems at the facilities</li> <li>• Staff changes</li> <li>• Funding cuts to treatment programs.</li> <li>• <b>Estimate: Somewhat unmet need</b></li> </ul>
High-Risk Youth	<p>Youth under age 21 was used in original analysis. Data was not provided because the numbers are low. Youth who engage in high-risk behaviors and who are in shelters, alternative schools, detention centers,</p>	<ul style="list-style-type: none"> <li>• Numerous interventions have been funded. 9 projects funded to do GLI with Youth in Shelters, 9 projects funded to do GLI and 1 to do Outreach with youth in Alternative School Settings. 5</li> </ul>	<ul style="list-style-type: none"> <li>• The Needs Assessment also indicated that the perception of how well services are provided to high-risk youth was “Somewhat provided but not in sufficient quantity to meet demand.”</li> </ul>

Potential Target Populations	Need	Met Need	Unmet Need
	treatment centers, or residential care are the targeted population.	<p>projects receiving funds to do GLI with youth in Substance Abuse Treatment Facilities and 9 funded projects for GLI in Juvenile Detention.</p> <ul style="list-style-type: none"> <li>• From the Needs Assessment, 79% of all Prevention Providers served young adults (13-24).</li> <li>• In addition, according to the Needs Assessment, ILI for high-risk youth was perceived as the only prevention service to be adequately provided. However, no ILI were funded in the cycle.</li> <li>• High-risk youth received the highest scores, regardless of intervention type. Youth scored below 1.0 only for HIV prevention capacity building and outreach.</li> </ul>	<ul style="list-style-type: none"> <li>• Although large numbers of youth are seen; many of the youth were too transient to complete sessions. Staff turnover and loss of shelters also contributed to programs not being completed.</li> <li>• Many youth were hard to reach and there were behavior problems</li> <li>• <b>Estimate: Somewhat unmet need</b></li> </ul>
Foreign Born	<p>The fastest growing group, but a diverse category. There has been a 250% increase in the last two years in the foreign-born population.</p> <p>AIDS Incidence – Avg. # diagnoses/yr. (2000-2002) – 12                      Diagnosed HIV cases (3 yr. Average) – 19                      Diagnosed HIV cases per 100,000 pop. (3 yr. average) – 21/100,000                      Diagnosed HIV Prevalence (including AIDS) – 97</p>	<ul style="list-style-type: none"> <li>• Populations and interventions were not broken down by race, ethnicity, or country of origin.</li> </ul>	<ul style="list-style-type: none"> <li>• Emerging population. Need more information needed regarding the foreign-born population and the definition of foreign-born in Iowa.</li> <li>• Information needed in the form of focus groups and Key Informate Interviews</li> <li>• Additional data will help in targeting programs correctly and evaluate prevention efforts currently being done</li> <li>• Foreign-born can fall under all the target populations</li> <li>• <b>Estimate: Unmet Need</b></li> </ul>

## **Gap Analysis – Conclusions and Recommendations for Proposed Target Populations**

Based on the Epidemiological Profile, Provider Services Survey, Focus Groups, and the resulting gap analysis the following are recommendations and conclusions to be consider for future planning:

### **1. HIV-Positive Persons**

- must overcome “burnout” and recruitment issues
- perceived need for Outreach, Community-Level Interventions, Public Information, and Capacity Building
- continue to involve HIV- partners who bring in HIV+ partners
- focus on targeted groups vs. support groups
- development of innovative programs – incentive programs, creative hours, and structured interventions proven to work
- continue to work with the University of Iowa HIV Program to recruit through the HIV clinic and HIV support group
- survey clients/consumers to determine what works and future needs

### **2. MSM**

- projects going to easy-to-reach locations vs. to areas where interventions are really needed
- perceived need for Community Level Interventions, Public Information, Outreach, and Capacity Building
- must overcome apathy to and disinterest in HIV prevention messages
- focus groups to reach MSM in Communities of Color
- more information needed to reach and provide service to rural MSM

### **3. IDU**

- overcoming disclosure issues; access to high-risk sites and clients
- perceived need for Community Level Interventions, Public Information, Prevention Case Management, Outreach, and Capacity Building
- need more public information about alcohol and other drugs as co-factors in HIV infection, and where to access prevention and treatment resources
- safe disposal sites for used injection equipment

### **4. High-Risk Heterosexuals**

- recruitment of clients
- perceived need for Community Level Interventions, Public Information, Prevention case Management, Outreach, and Capacity Building
- prevention and services with HIV+ and IDU can often lead to contact with partners

### **5. Corrections/Incarcerated**

- current programs have worked well; all projects met or exceeded goals
- must overcome scheduling issues, staff changes, budgetary problems, and disclosure concerns
- can reach a large number of high-risk individuals – make HIV information mandatory as part of their orientation period at the facility
- peer-ed programs – participants recruit other inmates into the programs

### **6. High-Risk Youth**

- no control over the number of youth that can be reached in institutionalized settings
- perceived need for Outreach and Capacity Building
- more HIV/STD education in school settings will reach all youth
- develop new relationships with administration of institutions so that curriculum is accepted
- must overcome behavior and compliance problems with High-Risk Youth

### **7. Foreign-Born**

- focus groups needed across the state to gain more information about this diverse population
- reluctance of some cultures to identify with certain behaviors
- risk Assessments show that no identified risk and heterosexual contact are the two most common risk factors for foreign-born
- need to determine if they will be identified as a sub-group or within the other targeted populations

## Prioritization of Target Populations

Setting priorities in HIV prevention planning leads to programs that are responsive to community-validated needs within defined populations. Iowa epidemiological data and research on at-risk populations, focus groups, key informant interviews, and reviews of the literature and contractual project reports, provided the data for defining the target populations for HIV prevention efforts in Iowa. The CPG considered the following population characteristics of the current epidemic in Iowa; age, race, ethnicity, gender, sexual orientation, and geographic distribution. To better understand the target population and refine priorities, the CPG developed tools to assist in further identifying the following:

- Issues/needs/barriers/gaps of target populations related to accessing HIV/AIDS prevention services;
- Resources available to target populations; and
- Recommended prevention strategies for target populations.

In setting target populations, the CPG used modified consensus. In those cases where the CPG could not reach consensus, a super majority vote (2/3 or 66%) was called. Priorities were ranked using a nominal group process.

### Identify Target Populations

To define populations, the CPG reviewed past priority target populations and groups, epidemiological profiles, needs assessments, and research literature. Target populations were described as specifically, and as mutually exclusively, as possible.

*“There aren’t enough dollars for HIV prevention, and there are likely to be fewer in the future. HIV prevention efforts have to be focused on people most at risk. The question that all groups need to answer is: How can we prevent the most infections in our community?”*

The CPG defined target populations by HIV risk behavior(s), age, HIV status, and incarceration status. Risk behavior categories are males who have high-risk unprotected sex with other males, injecting drug users who share contaminated injecting equipment, and high-risk unprotected heterosexual sex. Age categories are youth (under 25 years of age) and adults (25 years and over).

## Description of Target Populations

### HIV-POSITIVE PERSONS

*HIV-positive persons who continue to engage in high-risk sex and needle-sharing behaviors, partners of HIV-positive persons, and foreign-born persons from high incidence areas of the world*

Because of the use of newer and more effective treatments, persons with HIV in Iowa are living longer. Many people with HIV are experiencing improved quality of life, which can include regaining or improving their sex lives. With more HIV-positive people being sexually active, the possibility of HIV transmission increases. In response, programs are needed to address HIV-positive people as the audience for prevention messages (DeCarlo & Grinstead, 2000).

*Most HIV+ persons are concerned about not infecting others and have made efforts to prevent transmission. Yet there has not been much support for HIV+ persons to gain the necessary skills and tools to adopt new, safer behaviors.*

Prevention needs of persons with HIV can be looked at in two distinct areas: primary and secondary prevention. In primary prevention, the concern is those practices that allow transmission of HIV from an infected to an uninfected person. Secondary prevention entails a range of services to help bring people already infected with HIV into treatment and ensure that they receive available medical intervention to prevent the onset of opportunistic infections. In both cases, care must be taken to address the prevention needs of people with HIV from all risk factors and demographic groups represented in the Iowa HIV epidemic.

#### *Men Who Have Sex With Men*

Social stigma and fear of disclosure in a rural environment make access to gay and bisexual men that are living with HIV extremely difficult. Men who have sex with men account for the largest proportion of HIV and AIDS cases in Iowa. Sixty-one percent of adult and adolescent cumulative AIDS cases (903/1478) and 50% of HIV diagnoses among adults and adolescents in 2002 (52/104) were among men who have sex with men (Chapter 2).

#### *Injecting Drug Users*

A survey of 135 HIV-positive injection drug users found that among participants with a main sexual partner, 44% had HIV-negative partners and 8% had partners whose HIV status they did not know. Almost two-thirds of participants of unknown status reported engaging in some sexual risk behavior. This study highlights the need for interventions for HIV-positive injection drug users that focus as much on sexual behaviors as they do on drug-using behaviors (DeCarlo & Grinstead, 2000).

#### *Heterosexuals*

People living with HIV and their partners clearly fall into the category of a population with increased presence and risk of HIV. Social stigma and fear of disclosure in a rural environment make access to these populations extremely difficult. The availability of protease inhibitors as an effective treatment for many people with HIV makes attention to prevention in this population even more important and complicated.

### *Foreign Born*

Diagnoses of HIV among foreign-born persons in Iowa increased 250% from 1999 – 2002. In 2002, foreign-born persons accounted for 27% of HIV diagnoses and 22% of AIDS diagnoses among residents of Iowa. Of the foreign-born persons diagnosed with HIV in 2001 and 2002, half were Hispanic and 41% were African. As a group, foreign-born persons are more likely to have late diagnoses of HIV, and to convert to AIDS more quickly than U.S.-born persons. While the term foreign-born encompasses an extremely diverse group of people of many races, ethnicities, languages, and cultures, reaching immigrants from high-incidence areas of the world quickly is essential for preventing the spread of HIV to others and improving the health of these residents of the state.

### *Partners of HIV-positive Persons*

Most HIV prevention efforts focus on preventing infection among susceptible individuals in the general population or in groups considered to be at risk. Little attention has been given to preventing transmission from infected people to their uninfected contacts. Studies have shown that for sero-discordant couples in declared primary relationships, knowledge that one partner was infected led to reduced rates of unprotected sex and HIV transmission (Temoshok & Frerichs, 1998). Yet, knowledge alone does not always appear to result in positive behavior change. Results of a survey of U.S. military personnel indicated that 80% practiced risky sex with susceptible partners in all types of relationships (Temoshok & Patterson, 1996).

Many people at risk of acquiring HIV are unaware of their risk of infection. Once notified that they have recently been exposed to HIV and appropriately counseled, many demonstrate significant risk reduction behavior changes.

There are many interrelated factors that determine sexual risk behaviors in serodiscordant relationships, including age and ethnicity, length of the relationship, previously established behaviors, communication patterns, and substance use. Psychological factors include feelings of depression and hopelessness, personal preferences in sexual behavior, personal perceptions of risk, and motivations for change (Remien, Carballo-Diequez, & Wagner, 1995).

Communication between men and women can be difficult, especially regarding condom use, disclosure of risk behaviors, or HIV status. Traditional social and cultural gender roles in the U.S. often portray women, and not men, as the "communicator" in relationships, which might serve to relieve men of responsibility for communication (Campbell, 1995). In 1995, over half of all female AIDS cases occurring via heterosexual contact were a result of sex with a male partner whose HIV risk was either unknown or unreported, showing that women are often unaware of their partner's HIV risk (CDC, 1995).

## **MEN WHO HAVE SEX WITH MEN**

*Men who have unprotected sex with men*

In Iowa, Men Who Have Sex With Men (MSM) remain the group predominately affected by the HIV epidemic. Since AIDS case reporting began in 1983, this exposure category has remained the most frequently reported, but the proportion of cases with this mode of exposure declined after peaking at 72% of all AIDS cases from 1988 - 1992. Diagnoses of HIV among MSM have increased each year since 1999, however, and in 2002, 50% of all HIV diagnoses among adults and adolescents were MSM (Chapter 2).

Recent reports of a "second wave" of HIV infection point to the need to rejuvenate prevention campaigns for MSM. Research shows that safer sex is effective at preventing HIV, but continuing safer sex behavior over a long time is difficult. Therefore, the challenge for prevention programs is not only to encourage gay and bisexual men to have safer sex, but to do so consistently and over an extended period of time.

Since the onset of the AIDS epidemic, gay and bisexual men, particularly in AIDS epicenters, have made substantial gains in reducing high-risk behaviors. However, in the past few years research has shown a decline in maintenance of safe sex behaviors exhibited by MSM (Ekstrand & Coates, 1990; Kelly et al., 1991; McKusick, Coates, Morin, Pollack, & Hoff, 1990). Additionally, there are large percentages of MSM who have not implemented risk reduction strategies and continue to engage in high-risk behaviors (Kelly et al., 1992; Rinck, 1995). Therefore, MSM continue to be a high-risk and high-priority population in need of prevention efforts.

Men who have sex with men but identify as straight are a hidden population that is difficult to reach (House, 1993). Men who have sex with other men and do not identify as gay or bisexual were found to have higher rates of unprotected sex than those that identified as being gay or bisexual.

### *Communities of Color*

HIV transmission in African-American communities is often viewed as a problem among heterosexual IDUs and their sexual partners but the proportion of HIV cases diagnosed among U.S.-born, Black, non-Hispanic persons in Iowa between July 1, 1998, and December 31, 2002, attributed to injection drug use was only 13%. Male-to-male sexual contact accounted for the largest proportion of HIV cases among all racial and ethnic groups. Thirty-seven percent of cases among U.S.-born, Black, non-Hispanic persons, 60% of U.S.-born Hispanics, and 47% of foreign-born Hispanics were MSM. Among Latino gay/bisexual men in the U.S., rates of HIV infection are increasing faster than among white gay/bisexual men - a 40% increase for Latinos from March 1993 to June 1994, compared to 29% for whites (Diaz, 1995).

In a survey of African-American gay and bisexual men in the San Francisco Bay Area, more than 50% reported unprotected anal intercourse, a considerably higher percentage than among White gay men. Those men were more likely to be poor; to have been paid for sex; to have used injection drugs; to engage in unprotected sex despite knowing the risk of HIV infection; and to

report less social support. Men with negative expectations and beliefs about condoms were less likely to use them (Peterson et al., 1992).

Cultural influences such as *machismo*, *familismo*, and homophobia may be internalized by Latino gay men and make safer sex practices difficult. *Machismo* dictates that intercourse is a way to prove masculinity. For gay Latinos, *familismo* can create conflict because families perceive homosexuality as sinful. Familial support is often achieved through silence about sexual preference, instilling low self-esteem and personal shame among Latino gay men (Diaz, 1995).

#### *Substance Use*

Causal links between drug use and sex are determined by multiple mechanisms. Researchers have proposed a variety of direct and indirect mechanisms to account for the associations between substance abuse and risky sex. These include psychosocial issues and contexts in which the behaviors take place. For example, a person's expectations of how he will react to a specific drug is a strong predictor of whether or not that drug will enhance or diminish sexual pleasure and willingness to engage in risky behaviors. Similarly, the learned use of a drug, such as alcohol, to reduce stress can play an important role in whether or not a specific drug is used as a sex drug in situations that raise anxiety (Ostrow, 1996).

The use of substances as a short-term coping mechanism to decrease anxiety surrounding sexuality or to facilitate sexual performance also has to be considered in terms of AIDS anxiety. Gay men, many of whom have fears about HIV related risk, discrimination, and grief and loss, may find themselves using drugs to dampen situational stress (Ostrow, 1996).

Longitudinal cohort studies show that MSM who use drugs and alcohol are more likely to engage in risky sex and to be HIV-infected (Ostrow et al., 1990; Stall, McKusick, Wiley, Coates, & Ostrow, 1986). Epidemiological data show that some drugs such as amphetamines, poppers, and cocaine and crack cocaine are enjoying renewed popularity among MSM (Ostrow, DiFranceisco, Chmiel, Wagstaff, & Wesch, 1995). There are close associations between methamphetamine use and both risky sex and new HIV infections among MSM (Gorman, 1996). Recent studies have identified the use of crack cocaine as a co-factor in HIV transmission among minority men (Ostrow, 1996).

#### *Young Men Who Have Sex With Men*

Young males who have sex with males on Iowa's Focus Group Panel (Chapter 3) had been or knew of others who had been forced to leave their homes once their parents found out about their sexual orientation. One adult agency representative reported that as many as 50% of homeless youth served by his agency identified themselves as gay, lesbian, or bisexual.

Desperation and lack of resources can override prevention concerns. Drug-addicted people may turn to prostitution to earn money to pay for illegal drugs. Many homeless youth have no training or means of support, and rely on prostitution for survival. Attention to the more immediate concerns of food, housing and addiction often takes priority over future concerns of HIV infection.

A study in 1989 by the U.S. Department of Health and Human Services estimated that at least 30% of successful suicides are committed by gay/lesbian/bisexual/transgender youth. Several studies estimate that 30% of gay youth have substance abuse problems. Other studies indicate that this figure may be much higher. Adolescence is often marked by an increased drive for sexual activity and experimentation with alcohol and other drug use. A study found that having sex under the influence of drugs was associated with HIV seropositivity in a general adolescent population. A study of gay adolescents reported that 20-32% reported they had blacked out after using alcohol or other drugs (Rotheram-Borus, Koopman, Haignere, & Davies, 1991).

Two studies (Hayes, 1990; Stall, Ekstrand, Pollack, McKusick, & Coates, 1990) found that young gay men report higher levels of risk behavior than gay men over 30. Forty-three percent of gay men between the ages of 18 and 25 surveyed in the Hays study reported having engaged in unprotected anal intercourse in the previous six months. These same respondents also perceived lower risk from unprotected anal intercourse than older men, suggesting that HIV-prevention messages had not effectively reached this group.

The illegality of prostitution in the U.S. drives the industry underground and engenders a strong distrust of both police and public health authorities among sex workers. This makes effective HIV prevention outreach difficult (Cohen, 1990).

The people most vulnerable to HIV infection are street workers, most of whom are poor or homeless. Many are young, have a history of childhood abuse and are likely to be drug or alcohol dependent. Street prostitutes are vulnerable to violence from clients, police, and lovers.

## **INJECTING DRUG USERS**

### *Injecting drug users who share contaminated injection equipment*

To date, more than a third of all reported AIDS cases in the United States occur among injecting drug users, their heterosexual sex partners, and children whose mothers were injecting drug users or sex partners of injecting drug users. Drug treatment services and risk reduction programs should offer and promote HIV counseling and voluntary testing of injecting drug users.

In the injection drug-using community, many researchers agree that the key means for preventing the widespread use of unsterilized works and needles by IDUs will depend on a shift in norms within the drug community. This shift must make it socially acceptable to not share needles within a group-shooting situation. IDUs who had been able to significantly reduce their potential for exposure were less likely to inject in settings where there would be strangers present, or were limiting their circle of acquaintances to no more than five people with whom they shared needles (Rhodes & Wolitski, 1989).

### *Not in Treatment*

In Iowa, IDU exposure alone accounts for 11% of cumulative AIDS cases among adults and adolescents. Another 7% are among MSM/IDU. In 2002, 4% of adult and adolescent HIV diagnoses among adults and adolescents were among IDU and another 6% among MSM/IDU. Substance abuse as an agent of HIV transmission encompasses a range of behaviors, including

both addictive and casual use of alcohol and other drugs. Injection drug use with unsterilized needles is the primary risk factor placing substance users at risk for HIV infection.

### *Communities of Color*

Injection drug use has played a major role in HIV infection among African-Americans. Although the majority of IDUs in the United States are White, HIV infection rates are higher for African-American IDUs than for White IDUs (SAMSHA, 1997). Unemployment and poverty are significant co-factors that may lead to high rates of addiction and risk behaviors such as sharing needles (Adimora et al., 2001).

In Iowa, differences between racial and ethnic groups in the importance of injection drug use as a mode of exposure are most evident among cumulative AIDS cases. Among Black, non-Hispanic persons, injection drug use was the second most common mode of exposure, with 26% of cases attributed to IDU. In contrast, IDU accounted for only 14% of cases among Hispanic persons and 9% among White, non-Hispanic persons.

Studies of HIV prevalence among patients in drug treatment centers and STD clinics find the rates of HIV among African Americans to be significantly higher than those among Whites. Sharing needles and trading sex for drugs are two ways that substance abuse can lead to HIV and other STD transmission, putting sex partners and children of drug users at risk as well (CDC, 1999). Recent studies show that female inmates, inmates age 25 or younger, and African American and Hispanic inmates are at greatest risk for HIV infection (Polonsky et al., 1994).

Although the numbers of minority AIDS cases are small in Iowa, HIV and AIDS disproportionately affect minority groups (Chapter 2). The number of cases of HIV infection diagnosed in 2002 among Black, non-Hispanic persons was 46.1 cases per 100,000 population, compared to a rate of 2.1 cases per 100,000 White, non-Hispanic persons. Black, non-Hispanic persons were reported with HIV infection at a rate more than 20 times that of White, non-Hispanic persons. Even if only U.S.-born residents are considered, Black, non-Hispanic persons were diagnosed over 13 times more frequently than White, non-Hispanic persons. Hispanic persons were diagnosed with HIV at a rate of more than 13 times the rate for White, non-Hispanic persons. Nearly all Hispanic persons were foreign-born.

### *In Treatment*

The National Household Survey on Drug Abuse (NHSDA) reports that only 30 percent of females and 35 percent of males 12 years of age and older get the drug treatment they need. A study conducted by the Office of Applied Studies at the Substance Abuse and Mental Health Services Administration (SAMHSA) concluded that approximately 3.5 million persons who had drug abuse problems in 1996 did not receive treatment. This number has increased by 33 percent in the total population since 1994. In 1996, 55 percent of those in need of substance abuse treatment were between 12 and 25 years old. Injecting drug users are a high-priority subpopulation of those in need of substance abuse treatment because of the additional consequences associated with HIV/AIDS.

### *Sexual Partners*

Sexual contact with an IDU continues to be a factor in expanding the number of heterosexual cases in Iowa. Sexual transmission of HIV from IDUs to their sex partners may present a greater risk for women than for men. Although both male and female IDUs are likely to have IDU partners, this possibility is particularly high among women (Mandell, Vlahov, Latkin, Oziemkowska, & Cohn, 1994). One study showed that 75 to 90 percent of female IDUs have a male injection-drug-using partner, compared with 20 to 50 percent of male users who have female drug-using partners (Donoghoe, 1992).

### **HETEROSEXUAL SEX**

*High-risk heterosexuals who have sex with an infected person, a bisexual male, an injecting drug user, or someone who exchanges sex for money, drugs, or favors*

Among adult and adolescent females diagnosed with HIV, heterosexual contact was the most common mode of exposure from 1996 – 2001, and the number of diagnoses was fairly steady at between 10 and 15 cases during that interval. The decrease in diagnoses in 2002 among heterosexuals could be real but could also be partially explained by the increase in the number of diagnoses among those without an identified risk. Diagnoses among injection drug users decreased steadily between 1997 and 2002.

From 2000 - 2002, 21 foreign-born females were diagnosed with HIV in Iowa. Nearly half had no risk identified, 29% had heterosexual contact, and 24% had a transfusion or transplant as the mode of exposure.

The relative proportions of cases among women, minorities, and heterosexual persons continue to increase over that previously seen among AIDS cases. This mostly reflects the fact that there are fewer White, homosexual men being diagnosed with HIV infection. Still, among persons living with HIV/AIDS in Iowa, heterosexual contact is the second most common exposure, with 15% of persons living with HIV/AIDS reporting this risk (Chapter 2).

The over-representation of minorities among cases of sexually transmitted diseases more traditionally associated with heterosexual transmission is substantial; particularly for Black, non-Hispanic persons in Iowa. Incidence rates of chlamydia are 15 times higher and incidence rates of gonorrhea are 54 times higher for Black, non-Hispanic persons than for White, non-Hispanic persons (Chapter 2). Black, non-Hispanic males have an incidence rate of gonorrhea that is over 100 times that of White, non-Hispanic males.

### *For Money, Drugs, Favors*

Although latex condoms can substantially reduce the risk of transmission of human immunodeficiency virus (HIV) and other sexually transmitted diseases, men frequently fail to use condoms during intercourse and thus place their female partners, as well as themselves, at risk for infection. Although most HIV prevention programs focus on women's responsibility to ensure that condoms are used, gender inequity often prevents women from protecting themselves in sexual encounters. It has been hypothesized that sex workers are more likely to be in control of sexual decision making than other women in terms of deciding what type of sex they are

willing to have and whether condoms will be used. However, only in Nevada's legal brothels is sex workers' insistence on condom use is upheld by law (Albert, Warner, & Hatcher, 1998).

Nevada's mandatory condom law and brothel workers' firm insistence on condom use are undoubtedly important factors in ensuring the use of condoms by clients. However, even more critical is the ability of sex workers to transform the condom into an acceptable part of sexual activity. Yet sex workers in Nevada who consistently used condoms with clients, failed to use condoms with their primary sex partner (Albert et al., 1998).

### **INCARCERATED INDIVIDUALS**

*Individuals who are in state- and community-based corrections, and who have used substances, injected drugs, or had high-risk unprotected sex*

A report published by the U.S. Department of Justice, National Institute of Justice, and the Centers for Disease Control and Prevention indicates that persons incarcerated in prisons and jails suffer disproportionately from infectious diseases, substance abuse, and socioeconomic problems. There are more cases of HIV infection, sexually transmitted diseases, and tuberculosis in inmate populations than in the general population (USDJ, 1998).

From July 1999 – June 2000, the Iowa Medical Classification Center/Mid-Eastern Council of Chemical Abuse interviewed 3067 inmates, who stated they were arrested 1992 times (65%) for substance usage. The incidence of AIDS in the prison population has been estimated at twenty times the rate in the population at large (Hammett, 1996). A study by the Centers for Disease Control in 1990 reported that 5.8 percent of the inmates tested were HIV positive ("Publicly funded HIV counseling and testing--United States, 1990," 1991).

Incarceration provides an environment in which early interventions and risk reduction behaviors can be taught and reinforced over time. It also provides an opportunity to provide the support and continuity of care when the individual is released and returns to his or her home community. Early access to care reduces both immediate and long-term health care costs for correctional institutions and the community. Although not standardized, Federal and State prison systems provide access to treatment and care to those individuals identified as infected with HIV.

### **YOUTH (13-24) WHO ENGAGE IN HIGH RISK ACTIVITIES**

*Youth who engage in high-risk behaviors and who are in shelters and residential care, in alternative schools, in substance abuse facilities, and in juvenile detention facilities*

Within the U.S., AIDS is the seventh leading cause of death among 15 to 24 year-olds. The number of AIDS cases is now doubling roughly every 18 months. Forty-two percent of people with AIDS were under the age of 35 when they were first diagnosed with an AIDS-defining condition, and 80% were diagnosed under the age of 44 years. Because it has historically taken an average of 10 years for HIV infection to progress to AIDS, it is clear that most people are infected from their late teens to middle twenties (Kalichman, 1998).

At least two aspects of developmental age account for the increases in HIV risk among youth. Sexual mixing and sexual networking patterns in younger populations promote the spread of

HIV because of rapid partner transitions. Second, young people often do not perceive their risks and are resistant to practicing risk-reducing behavior.

Adolescence is a time of exploration of self and risk-taking, and sexual behavior is a natural part of this exploratory pattern. This makes it difficult to estimate, for example, how many adolescents and young adults are gay or bisexual or how great a risk the adolescent population faces. Research shows that high teenage pregnancy and STD transmission rates point to high levels of risky behavior. In Iowa in 2001, females ages 15 – 24 had 36% of all live births. In 2002, 73.6 percent of the total cases of gonorrhea, early syphilis, and chlamydia occurred in people ages 15-24 years; 2001 YRBS data indicate that 43% of high school youth and 88% of youth in alternative high schools have had sexual intercourse. Over one-fourth of adolescents in alternative high schools have been pregnant or gotten someone pregnant at least once.

Studies have demonstrated that young people do not carry out AIDS-preventive behaviors based on knowledge levels alone. In general, adolescents and young people have not changed their sexual practices, their methods of contraception as a result of the AIDS epidemic (DiClemente, 1990). Fear and anxiety of HIV, attitudes about other STDs, and other safe behavioral intentions are not significantly related to consistent condom use among youth or adolescents.

#### *Shelters and Residential Care*

Adolescents represent a group at increased risk for HIV infection because of their experimentation with sexual activity and drugs. Research during the past decade indicates that adolescents are: engaging in sexual intercourse more often than ever; initiating sexual activity at a younger age; having sexual intercourse without using condoms; becoming infected with sexually transmitted diseases at a higher rate than other age groups; and using alcohol and other drugs that interfere with judgment and are associated with high-risk activities such as early and unprotected sexual intercourse.

Youth in out-of-home placement facilities are a particularly risky population for HIV infection due to high rates of vaginal, anal, and oral intercourse; inconsistent condom use; high rates of alcohol use prior to sexual intercourse; and high prevalence of forced sex.

#### *Alternative School Settings*

Data from the 2001 Iowa Youth Risk Behavior Study – Alternative School Settings, indicates that 88% of the students have had sexual intercourse and 18% had sex before age 13. Over half of the students interviewed had four or more partners in the last three months. Among those students who indicated they had sexual intercourse during the past three months, 46% used a condom during their last sexual intercourse.

#### *Substance Abuse Treatment Facilities*

So far the AIDS epidemic has not hit the teenage population to nearly the extent that it has older age groups. But since AIDS symptoms usually take a number of years to show up in the infected, it is possible that AIDS has spread into the teenage population without being apparent. There is definite risk among teenagers. Many teenagers are more wary of multiple sexual contacts, or of having sex at all, but the effect of AIDS on their sexual behavior overall is unclear. What is certain is the continued need for AIDS education for teenagers.

Effective dosages of HIV-related classroom instruction vary. Experts argue that effective interventions need to last for 14 or more sessions to cover important educational activities, but may be effective in fewer sessions if conducted in a small group setting with a leader for each group. This would suggest that in classroom settings, higher numbers of class sessions are needed for effective behavioral change. Since 46 percent of health education teachers spend only one or two class sessions on HIV, increasing the number of class sessions is likely to increase the effectiveness of instruction and increase the commitment with which efficacious interventions are delivered.

#### *Juvenile and Detention Facilities*

Youth who are not in school have higher frequencies of behaviors that put them at risk for HIV/STDs, and are less accessible to prevention efforts. Out-of-school youth were significantly more likely than in-school youth to have had sexual intercourse, had four or more sex partners, and had used alcohol, marijuana and cocaine (*AIDS Community Demonstration Projects: What We have Learned, 1985-1990.*, 1992). More intensive STD/HIV and substance abuse prevention programs should be aimed at out-of-school youth or youth at risk for dropping out of school.

### Determining the Selecting Factors

The CPG agreed to use the following selecting factors to target populations greatest risk for HIV in Iowa.

Selecting Factor	Definition
Average AIDS Incidence	The number of AIDS cases diagnosed in a defined population in a specified period of time. (2000 – 2002)
Average Diagnosed HIV Incidence	The number of HIV cases diagnose in a defined population in a specified period of time. (2000 – 2002)
Average HIV Incidence per 100,000 population	The average number of persons diagnosed per 100,000 population. (2000 – 2002)
Diagnosed HIV Prevalence (including AIDS)	The number of people living with diagnosed HIV (including persons with AIDS) in a defined population, at a specified point in time.
Key Indicators/Frequency of Risk Behaviors.	Data sets that document that HIV risk behaviors are occurring within the target populations.
Riskiness of Population Behaviors	The nature and relative risk of behaviors that occur in the target populations.
Difficulty of Meeting Population Needs	The complexity of need and whether the population has been reached by current programs, whether service providers have capacity, etc.

### Weighting Factors

The CPG used weighting factors to indicate the relative importance of each selecting factor. Numeric weights were based on a scale of ascending importance. The most important factors were weighted more heavily than other factors. A numerical weighting system (1 = low, 2 = medium, 3 = high) was developed for each selecting factor.

Selecting Factor	CPG Weight Results
Average AIDS Incidence	2
Average Diagnosed HIV Incidence	4
Average HIV Incidence per 100,00 population	5
Diagnosed HIV Prevalence (including AIDS)	4
Key Indicators/Frequency of Risk Behaviors	2
Riskiness of Population Behaviors	3
Difficulty of Meeting Population Needs	2

### Rating Target Populations Using Weighted Factors

After the CPG members had assigned a weight to each selecting factor, the next step was to rate each of the potential target populations using the weighted factors. The rating scale evaluates the extent to which each factor applies or is met. The following table was used.

Factor	Rating Information	Rating Scale # Rate per 100,000
Average AIDS Incidence	On average, how many persons in the target population were diagnosed with AIDS from 2000 to 2002?	1: 0-10 2: 11-20 3: 21-30 4: 31-40 5: >40
Average Diagnosed HIV Incidence	On average, how many persons in the target population were diagnosed with HIV from 2000 to 2002?	1: 0-10 2: 11-20 3: 21-30 4: 31-40 5: >40
Average Diagnosed HIV Incidence per 100,000 Population	What is the estimated number of infected people per 100,000 population from 2000-2002?	1. 0-100 2. 11-25 3. 26-50 4. 51-199 5. >200
Diagnosed HIV Prevalence (including AIDS)	What is the estimated total number of persons living with HIV/AIDS on December 31, 2002 in the target population?	1: 0-100 2: 101-200 3: 201-300 4: 301-400 5: >400
Key Indicators/ Frequency of Risk Behaviors	How often does the population engage in risk behaviors?	1: infrequently 3: intermediate 5: frequently
Riskiness of Population Behaviors	What is the primary HIV risk behavior known to occur among the target population.	1: Being born in a high-risk country. 2: Oral sex w/infected partner 3: Vaginal sex w/infected partner 4: Anal sex w/infected partner 5: Sharing contaminated injection equipment 6: Multiple behaviors
Difficulty of Meeting Population Needs	Are there significant barriers to reaching the target population with HIV prevention interventions?	1: There are few or virtually no barriers 3: There are moderate barriers 5: There are substantial barriers

### Scoring the Target Population

Each CPG member determined a score for each factor for each target population. This was done by multiplying the factor's rating by its weight (**Rating x Weight**). In this way, factors that were determined by the CPG to be more important had a larger impact on the final decision.

### Ranking Populations

The rank for each target population was obtained by adding the individual scores of all CPG members, then averaging them thereby producing an overall score for that target population. The overall score reflected the combined impact of all the factors used to rate that target population.

<i>Rank</i>		<i>Score</i>
<b>1</b>	<b>HIV Positive Persons</b>	
<b>2</b>	<b>Men Who Have Sex With Men</b>	<b>105</b>
<b>3</b>	<b>Injecting Drug Users</b>	<b>73</b>
<b>4</b>	<b>High-Risk Heterosexuals</b>	<b>58</b>
<b>5</b>	<b>Incarcerated Individuals</b>	<b>57</b>
<b>6</b>	<b>High Risk Youth</b>	<b>37</b>

The CPG reviewed the results and agreed upon the final list of target populations. Discussion ensued regarding over representation of African American and Hispanic persons. The CPG concurred that intervention funding targeting African American and Hispanic persons must be proportional to the epidemic.