Part C: Community Services Assessment

Chapter 4:

Needs Assessments, Key Informant Interviews & Focus Groups

COMMUNITY SERVICES ASSESSMENT

Data Collection Methods

The NARC Committee, the EPIC Committee, and the CPG completed an intensive review of inventory data. Additional data were 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' survey;
- Review of findings from contractual project reports; and
- 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. Iowa's Drug Control Strategy 2006	The plan is a product of a statewide strategic planning process and serves as a guide for five years of prevention services for alcohol, tobacco, and other drug abuse and related problems. Goals included those to be addressed by state agencies and by local substance abuse comprehensive contracts/projects. The plan also contains needs and issues of various communities and populations. Below are statistics from 2005 for substance abuse in Iowa. • Methamphetamine increased as the primary drug for persons entering substance abuse treatment from 12.3% in 2002 to 14.4% in 2005. • Marijuana slightly decreased as a primary drug from 22.7% in 2002 to 22.4% in 2005. • Alcohol use decreased as a primary drug from 58.5% in 2002 to 55.8% in 2005. http://www.state.ia.us/government/odcp
2. Ryan White Statewide Coordinated Statement of Need (SCSN), 2006	The SCSN is jointly prepared 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. (See Chapter 8.)
3. HIV/AIDS and STD in Iowa, 2005	IDPH report on the epidemiology of HIV/AIDS and sexually transmitted diseases in Iowa. (See Chapter 3.) http://www.idph.state.ia.us/adper/hiv_aids_programs.asp#surveillance
4. HIV/AIDS Prevention Program and Yearly Summary Reports, 2005.	Reports from contract recipients of HIV/AIDS prevention activities that describe interventions, challenges, positive accomplishments, and creative solutions.
5. Counseling, Testing and Referral (CTR) Sites, 2005	Compiled from University of Iowa Hygienic Laboratory and the IDPH. It contains epidemiological data on persons being counseled and tested at IDPH-funded CTR Sites. • 8,699 tests were performed. • 25% of the people tested were from a high-risk target population. • 48 persons testing positive were identified (0.55%). • 50% of testing was conducted in an outreach setting. • The overall return rate from all CTR sites was 63%.

	Of 6,777 males and 6,156 females (12,937 total) • 59% had been tested for HIV before; • 33% had an STD; • 2% had sex with a person who had HIV/AIDS; • 10% had used drugs with a needle; • 71% had sex while using alcohol; • 34% had sex while using drugs; • 5% had sex in return for drugs, money or favor; • 20% stated their partner had an STD; • 2% said their partner had sex with a person with HIV/AIDS; • 10% said their partner had used drugs with a needle; • 65% said their partner had sex while using alcohol; • 32% said their partner had sex while using drugs; • 4% said their partner had sex in return for drugs, money or favors; • 51% had 2-5 partners in the past year; • 7% had 6-9 partners in the past year; and • 5% had more than 10 partners in the past year.
6. Substance Abuse Treatment Data, 2005, IDPH	This report summarizes data from 42,025 people that were admitted into state treatment programs in 2005. Key findings regarding prevalence and patterns of substance use are presented for alcohol, tobacco, and other drugs. • 11.4% of people reported past IV drug use. • Alcohol was the most commonly used substance among adult Iowans, and the substance responsible for most treatment needs (61.7%). • Marijuana was the most commonly reported illegal drug used by adult Iowans (22.1%). • Stimulants (including methamphetamine) were the third most common category of drugs used by adult Iowans (12.3%). • The largest proportion of substance abusers was 25-34 years of age.
7. Iowa Youth Risk Behavior Survey (YRBS): Regular High School, 2005	A CDC-sponsored survey of students in grades 9-12 in regular public school. This is a 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 and sexual activity. The 2005 Iowa YRBS was coordinated by the Iowa Department of Education. Following are the findings: • 43.5% of students in grades 9-12 reported having had sexual intercourse at some time in their lives. In 1997, the figure was 42.8%. • 32.8% of students reported having had sexual intercourse within the last three months; in 1997, the percentage was 33% and 34% in 2001. • 22.9% of students who reported having sexual intercourse during the last three months said they had drunk alcohol or used drugs before their last sexual intercourse. This was a reduction of 2.1% from 2001. In 1997, the percentage was 24.4% • Among those who reported having had sexual intercourse

	during the past three months, 61.8% used a condom during their last sexual intercourse. In 1997, the percentage was 47.6%. • 4.3% of students indicated they had ever used methamphetamines, down from 7% in 2001. • 85.6% of students have ever been taught about HIV/AIDS infection in school. In 1997, the percentage was 92.4%.
8. Homelessness in Iowa: The 2005 Summary	This report aims to provide accurate and current information on the homeless population in Iowa and to estimate the number of people who were homeless at some point during 2005. This study was conducted on behalf of the Iowa Council on Homelessness to meet specific data needs of state agencies concerned with homelessness. Detailed information on the characteristics of people who are at risk of being homeless in Iowa during 2005 is provided as well. This study builds upon previous research completed in 1999 and 2003; it also provides a detailed demographic profile of the homeless and nearly homeless populations, reports the causes of homelessness, and reports service providers' perceptions of causes, barriers, and trends in numbers served. *Of the unduplicated raw counts of homeless Iowans in 2005*: • 38% are school/ Head Start children; • 12% are non-school children; • 51% are adults. *Of the annualized estimate*: • 11% are school / Head Start children; • 16% are non-school children; • 72% are adults. *Gender of homeless and nearly homeless adults* *Homeless*: • 56% females • 44% males *Nearly Homeless*: • 68% females • 32% males • The number one cause of homelessness is family break-ups. • Women account for more than half the adult homeless in Iowa, no doubt related to their presence as single parents in 94% of those households. • Half of all homeless households rely on income from employment. This suggests that higher paying jobs are out of reach or unavailable. • 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. http://www.ifahome.com/docs/ICH/2005HomelessStudy.pdf

9. STD/HIV Clinic Risk Assessments from CTR sites & substance abuse facilities. 2004	This summary reflects responses to 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 two not indicated). Of the 12,820 surveys: • 57% indicated they had been tested for HIV before. • 30% indicated they had an STD. • 2% indicated they had sex with a person who had HIV/AIDS. • 9% indicated they had used drugs with a needle. • 71% indicated they had sex while using alcohol. • 35% indicated they had sex when using drugs. • 5% indicated they had sex in return for drugs, money or favors. • 19% indicated their partner had an STD. • 2% indicated their partner had sex with a person who had HIV/AIDS. • 8% indicated their partner had used drugs with a needle. • 65% indicated their partner had sex when using alcohol. • 33% indicated their partner had sex when using drugs. • 4% indicated their partner had sex in return for drugs, money or favors. • 51% indicated they had sex with 2-5 partners in the past year. • 7% indicated they had sex with 6-9 partners in the past year. • 5% indicated they had sex with ten or more partners in the past year. • 14% indicated they used condoms every time. • 48% indicated they used condoms sometimes. This is a 23% drop since 1999. • 35% indicated they never used condoms. This is a 16% increase since 1999.
10. Prevalence of HIV-1 Antibody in Civilian Applicants for Military Service, Jan 2004-Jun 2005 MSMR Vol.11 No.4	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. 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. The prevalence of HIV-1 antibody in Iowa from Jan 2004 to June 2005 was 0.04% of the nearly 460,000 tests conducted. http://amsa.army.mil/AMSA/amsa_home.htm
11. Iowa HIV/AIDS Project School Health Education Profile (SHEP), 2004	The 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, alcohol and other drug use, improper nutrition, sedentary lifestyle, intentional and

	unintentional injuries, and violent activities. Health education was required for students in one or more of grades 6 through 12. Data show the following: • 92% of Iowa's middle schools, in 83% of the state's junior/senior high school and in 68% of its senior high schools agree to the health education requirement. • 40% of secondary school principals indicated that health education is taught in a combined health education and physical education course, 19% in a course about another subject. • 47% of teachers taught how to use a condom correctly as part of required health education. • 92% of teachers taught abstinence as the best way to avoid HIV infection..74% of teachers taught condom efficacy. • 60% of high school lead-health education teachers said they provided instruction in condom use. • 35% of staff received development courses in HIV prevention. Required health education is usually scheduled in grades 7 or 8 (middle school), 8 or 9 (junior/senior high school) and 9 or 10 (senior high school). During the senior year of high school, the reported incidence of sexual intercourse was highest and reported condom use was lowest, but only 26% of students received a health education course. http://www.iowa.gov/educate/content/view/399/669/1/1/
12. Iowa Behavioral Risk Factor Surveillance System (BRFSS), 2004	The Iowa Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing monthly telephone survey that is financially and technically supported by CDC. BRFSS is designed to collect information on health risk behaviors of Iowa residents age 18 and over and to monitor prevalence of these behaviors. In the 2004 BRFSS, 5,048 people participated. The risk behaviors surveyed are major contributors to illness, disability, and premature death. Findings include the following: • Only 29% had been tested for HIV. • 88.8% were aware that medical procedures can help a person with HIV live longer. • 33.6% did not know if HIV transmission from mother to child can be reduced. • The most commonly reported place of testing was a private doctor or HMO (35.1%), hospital (23.5%) and clinic (20.7%). • 9.7% of respondents reported they had talked to a health care provider about preventing sexually transmitted diseases other than HIV/AIDS through condom use. The figure can be compared to 8.2% in 2003. http://www.idph.state.ia.us/brfss/common/pdf/2004BRFSSannual.pdf

13. Viral Hepatitis Plan – A Collaboration Plan for Action 2004	In January 2004, the Iowa Department of Public Health (IDPH) received funding from the Council for State and Territorial Epidemiologists to form a task force to review issues related to viral hepatitis in Iowa and to produce a plan for approaching these issues in public health. The task force consisted of key stakeholders who provided services to persons potentially infected with viral hepatitis and individuals that are hepatitis C positive. The mission statement of the task force identifies the following focus: "To outline a comprehensive, culturally appropriate, and systematic approach that will prevent the spread of viral hepatitis infection in Iowa." The plan addresses viral hepatitis A, B, and C, with the primary focus on hepatitis C. Committees were formed in the areas of prevention, education, management, surveillance, and hepatitis A and B. Goals and objectives for each of the areas are identified in the plan. The task force identified eight major areas that were either Urgent, or very important. They are listed in ranking order of importance and included legislative, hepatitis A and B immunization, education, program development, management of infected individuals, data reporting and analysis, evaluation, and needle access and disposal. After reviewing current procedures for hepatitis A, B and C, the task force determined that a structure to implement hepatitis C services was of greatest need because hepatitis C is a major emerging public health issue with which most states are least prepared to deal. The plan can be accessed online at: http://www.idph.state.ia.us/adper/common/pdf/hepatitis/hepatitis_plan.pdf
14. Survey and Analysis of the Health Needs and Disparities of the Immigrant Population, 2003	This report is the culmination of a series of studies conducted by the Iowa/Nebraska Primary Care Association (IA/NEPCA) on behalf of the Bureau of Health Care Access at IDPH. It is the third annual installment of findings on immigrant health needs and disparities in Iowa. A total of 1,051 interviews were used in this study. The respondents were 18 years or older and the majority were Latino immigrants. • 47.9% of immigrants interviewed felt that ethnicity was a barrier to receiving health care. • 49.1% felt that transportation was a barrier. • 46.6% reported that cost was a significant barrier. • 17.4% of immigrants interviewed have never seen a primary care doctor. http://www.ianepca.com/news_publications_and_events/immigrant_survey.php

15. Methamphetamine Trends, 2001-2002	• Over the last two years (2002 & 2003), the Iowa Department of Human Services classified 821 Iowa children as victims of abuse due to parents manufacturing methamphetamine or possessing methamphetamine precursor chemicals. • Prevent Child Abuse Iowa reports 1,167 confirmed child abuse cases involving the presence of an illegal drug in a child's body in 2003, nearly triple the number from the previous year. • State narcotics agents confiscated 352 pounds of methamphetamine from communities throughout Iowa in 2003, twice the previous record quantity. • In 2003, over 99% of the meth lab precursor submissions for analysis by the Iowa Division of Criminal Investigation contained some form of pseudoephedrine (66% of the single active ingredient variety, and 33% containing multiple active ingredients or both types). • The proportion of Iowa's drug treatment adult clientele listing methamphetamine as their primary substance of abuse has risen to an all-time high of 15.8 percent (IDPH-FY 2004). • A federal report on drug treatment admissions says Iowa has the 4th highest rate of methamphetamine addiction in the nation.
16. Dynamics of Race, Culture and Key Indicators of Health in the Nation's 100 Largest Cities and Their Suburbs, 1998-2000	• Des Moines had a teen birth rate of 14% in 2000. • Des Moines was 11th in 1998-1999 for the least amount of people below the federal poverty level. • Des Moines was 44th in 1998-1999 in per capita income. http://www.downstate.edu/healthdata

Key Informant Interviews

The CPG 2004-2006 Comprehensive Plan Gap Analysis identified foreign-born populations as being the fastest growing group among target populations. The Gap Analysis also indicated the need to obtain more information on foreign-born populations through focus groups and key informant interviews to identify emerging, unmet needs among foreign-born populations.

The CPG was interested in better understanding the prevention education needs of foreign-born populations. The CPG conducted a comprehensive community needs assessment across the state of Iowa to gather information on the health status of targeted populations, to identify prevention resources and services, and to assess gaps in resources throughout the state. The CPG's goals were to identify best practices to share throughout the state and to identify areas of focus for improvement and redirection of existing resources. The CPG also sought information about HIV prevention messages given to clients and assessment of what providers are doing to increase client skills to change risk behavior.

CPG members conducted telephone interviews with seven key informant professionals who served foreign-born populations in Iowa during the months of April to July 2004. The seven key informants worked at seven different agencies providing services to foreign-born clients and other minority populations. These key informant agencies included one health care access partnership, one college/university program, one neighborhood free clinic, one refugee services cooperative, one community educational resource center, one community-based organization, and one non-profit agency serving farm workers, immigrants, and other diverse populations.

The key informant interviews consisted of 38 questions designed by the CPG to gather information about prevention needs in the participants' communities. Of the 38 questions, 18 were multiple-choice, 18 were open-ended, and two questions were part multiple-choice and part open-ended. Additional key informant comments were also recorded during a post-survey discussion about the issues the key informants thought were important regarding helping their foreign-born clientele reduce their risk of HIV transmission.

Interview Results

Agency Services

The most common services provided by the agencies serving foreign-born clients were health and medical related services, which were provided by five of the seven agencies. Specific services identified included specialized medical services, such as obstetrical care, sexually transmitted disease (STD) testing, and diabetes support. Four of the seven agencies provided employment-related services. Educational and training services were provided by three agencies. Other common services identified by two agencies included case management, outreach support, support groups, and services focused on Hispanic/Latino populations. Only one of the six foreign-born agencies provided HIV/AIDS-specific services, such as HIV/AIDS social services and support groups (Table 1).

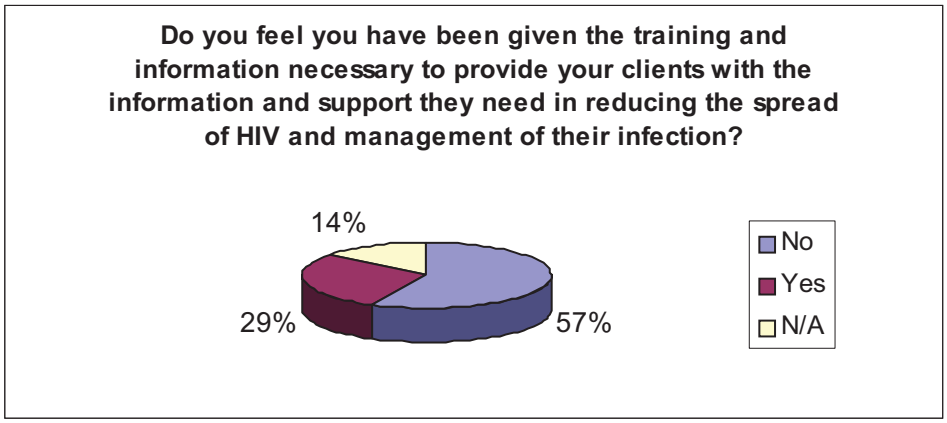
Table 1
Services Provided by Key Informants' Agencies

Services	Number of Agencies	Percentage
Health or Medical Care Services	5	71%
Employment Services	4	57%
Educational and Training Services	3	43%
Case Management	2	29%
Outreach Support	2	29%
Support Groups	2	29%
Services for Hispanic/ Latino Populations	2	29%
HIV/AIDS Social Services	1	14%
HIV/AIDS Support Group	1	14%

Key Informant Experience

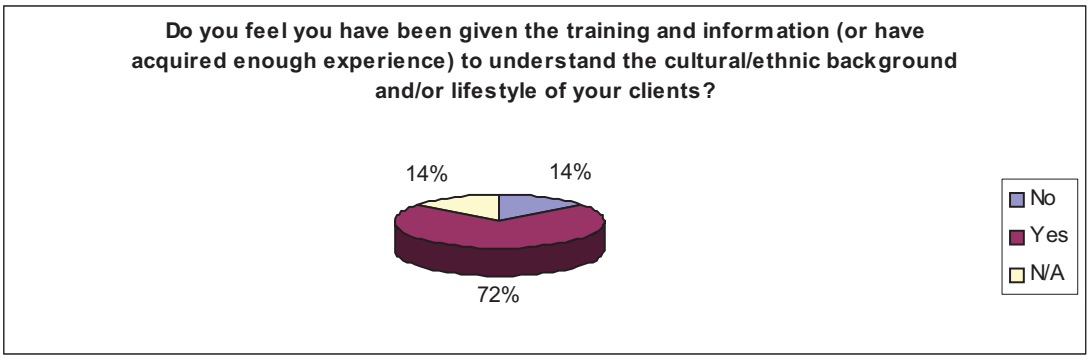
Four of the seven key informants had experience or worked with clients at-risk or living with HIV/AIDS that related to cross cultural communication and support. Three participants identified experience working with Latinos. The majority of key informants had some experiences related to HIV testing or risk assessment and reduction. Two key informants had experience with HIV/AIDS educational/training work and two had a friend or relative with HIV. The majority of responding participants felt they have not been given the training and information necessary to provide their clients with needed information and support to reduce the spread of HIV and manage their infection (Figure 1).

Figure 1



Despite the described lack of HIV-related training, five of the seven responding participants felt they do have the necessary training, information, and experience to understand the cultural/ethnic background and/or lifestyle of their clients (Figure 2). All seven felt it is important in their work to understand the cultural/ethnic background and/or lifestyle of their clients.

Figure 2



HIV-Related Services

In terms of HIV-related services provided by key informant agencies, five of the seven agencies provide some type of health care services or referrals. Four of the agencies provide HIV-related outreach and three provide client advocacy. In addition, two agencies provide HIV-related services such as individual counseling, group intervention, and case management.

All seven key informant agencies reach foreign-born populations with their HIV prevention services. The most common population identified was Latinos, listed by five of the seven informants. Three agencies reach women as a specific population. Two agencies reach refugees/immigrants, African-Americans, and people less than 21 years of age. Additional populations mentioned include HIV positive, injection drug users (IDU), Liberians, Native Americans, Asian/Pacific Islanders, Bosnians, Somalians, Sudanese, Mexicans, and Eastern Europeans.

Client Risk Reduction Behaviors

The key informants were asked three questions to rate the following: their clients' level of *knowledge* about HIV risk reduction behaviors that would prevent them from spreading HIV/AIDS, their clients' *skills* to follow through with HIV risk reduction behaviors, and clients' *motivation* to follow through with HIV risk reduction behaviors. These questions were asked using a scale of 1 = below average, 2 = average and 3 = above average. Six of the seven participants rated their clients as having a below-average *level of knowledge* about HIV risk reduction behaviors that could prevent them from spreading HIV/AIDS. Four of the seven participants felt their clients had an average level of *skills* to follow through with risk-reduction behaviors. Four felt their clients had a below-average level of *motivation* to follow through with risk reduction behaviors. The complete results are listed below (Table 2).

Table 2
Key Informants' Ratings of Clients' Knowledge, Skills, and Motivation

Question	Rating	Number	Percentage
Level of Knowledge about HIV risk-reduction behaviors	Below Average	6	86%
	Average	1	14%
Skills *to follow through with risk reduction behaviors*	Below Average	3	43%
	Average	4	57%
Motivation *to follow through with risk reduction behaviors*	Below Average	4	43%
	Average	3	57%

The key informants rated whether they thought setting risk reduction tasks for clients was effective in reducing behaviors considered risky in spreading HIV. Possible responses included not effective, somewhat effective, or very effective. All seven key informants thought that setting risk-reduction tasks for clients to accomplish is at least somewhat effective in reducing behaviors considered risky in spreading HIV. In fact, four of the seven thought that setting risk-reduction tasks for clients is very effective in reducing risky behaviors and the remaining three thought that it was somewhat effective (Table 3).

Table 3
Effectiveness Rating of Setting Risk-Reduction Tasks

Effectiveness	Number of Participants	Percentage
Not Effective	0	--
Somewhat Effective	3	43%
Very Effective	4	57%

Client Strengths and Barriers

Five of the seven key informants identified their client populations' strong sense of family and/or partner commitment and support as strengths supporting HIV risk reduction behaviors among these populations. Four participants identified the populations they serve as having a significant family orientation and commitment that served as a source of strength for dealing with issues such as HIV risk reduction. The participants also identified strengths related to clients' additional support systems, such as cultural community support and community and school outreach. Personal motivations and beliefs supporting their HIV risk reduction behaviors such as motivation to care for each other, improve health, self-sufficiency, and motivation to learn were also identified as strengths.

Five of the seven participants identified language barriers and cultural beliefs as traits preventing the populations they serve from practicing risk-reduction behaviors. Specific cultural barriers included not using condoms due to cultural and premarital sex beliefs and the fact that women do not have a voice in certain cultures. Four of the seven participants identified a lack of education and knowledge of HIV prevention as the major barrier preventing their client populations from practicing risk-reduction behaviors. The participants identified both a lack in general education as well as specific knowledge of HIV transmission, where to access resources, and false knowledge about risk reduction as being barriers to practicing risk reduction behaviors. Four of the seven key informants identified social stigma or taboo related to HIV or sex as preventing these populations from practicing risk reduction behaviors. Religious beliefs were also mentioned as a barrier, promoting a lack of condom use due to premarital sex beliefs and the inhibiting discussion of health and relationship issues.

Risk Assessment

The key informants were asked four questions relating to how often they were able to complete activities such as assessing their clients' level of risk of spreading HIV, assessing clients' readiness to change, setting risk-reduction tasks, and following up with clients. Possible responses indicated the amount of time the key informants participate in these activities and were based on the following scale, 1 = less than half the time, 2 = about half the time, and 3 = more than half the time.

The majority of the key informants indicated the ability to discuss their clients' level of risk of spreading HIV more than half of the time. Four of the participants identified being able to assess their clients' *readiness to change* behaviors that risk spreading HIV to others about half of the time or less. Five of the seven key informants identified being able to *set risk reduction tasks* to establish a sense of competence and success among their clients about half of the time or less. The majority indicated they were able to *follow up with* their clients to reinforce change efforts, discuss problems encountered, and further encourage risk reduction changes less than half of the time. The complete results are listed below in Table 4.

Table 4
Key Informants Experience with Risk Reduction

How often are you able to …	Amount of Time	Number	Percentage
Communicate/discuss the clients' level of risk of spreading HIV?	About half of the time or less	3	43%
	More than half of the time	4	57%
Assess your clients' *readiness to change* behaviors that risk spreading HIV to others?	About half of the time or less	4	57%
	More than half of the time	3	43%
Set *risk-reduction tasks* to establish a sense of competence and success among the clients?	About half of the time or less	5	71%
	More than half of the time	1	14%
	Not applicable	1	14%
Follow-up with clients to reinforce change efforts, discuss problems, and further encourage risk-reduction changes?	About half of the time or less	5	67%
	More than half of the time	2	33%

Specific HIV Interventions and Needs

Specific HIV prevention interventions varied depending upon the participant and their agency. The most common interventions were individual level intervention and condom distribution, each identified by four of the seven key informants. Group level intervention was the second most common intervention, identified by three key informants. Two key informants offered testing, two offered brochure dissemination, and one offered family-based intervention. Participants suggested that testing could be accessible, but that anonymity is needed for clients to be willing to utilize testing.

The key informants from the foreign-born agencies identified a variety of specific client HIV prevention- related needs that are not being met:

- Easy condom access (four participants);
- Long-term support in formats such as one-on-one contacts, counseling, and groups (four participants);
- Cross-cultural communication and linguistic support, including the need for materials in Spanish and other languages (three participants); and
- HIV/AIDS education and understanding, HIV testing, anonymity with testing, clean needle access, and clients' ability to trust (one participant each).

Two key informants included the following reasons why these needs are not getting met: funding issues, other priorities, other things on which their agency focuses, and having testing available by the local health department.

Challenges in Providing Prevention Services

The challenges faced in providing prevention services varied depending upon the participant and the populations with whom they worked, with the most common challenge being the need for more partnerships and/or leadership. Other challenges included:

- A lack of sufficient partnerships and/or leadership (three participants);
- A lack of sufficient funding for programs (two participants);
- A lack of knowledge and awareness of risks of HIV by clients (two participants);
- A feeling of shame among clients;
- Difficulty in discussing prevention in group settings;
- Difficulty in approaching subject among different cultures due to the sexual connection.
- The existence of language barriers;
- The use of alcohol by clients;
- A lack of client awareness that their spouses are not monogamous;
- The presence of condom stereotypes; and
- A lack of condom use due to religion.

Major Health Issues

The key informants were asked to identify major health-related issues and concerns in addition to HIV/AIDS among the populations they serve. Some individual responses were specific to cultural or ethnic groups; however, some common trends appeared among the responses in general. Five of the seven key informants identified access to mental health and dental care as a

concern. A lack of access to medical resources and services was identified by four participants. Three participants identified concerns of diabetes, substance abuse, and racism or cultural competence by professionals. Two participants identified each of the following concerns: blood pressure, heart disease, hepatitis, and homelessness or lack of housing.

Discussing Risk Behaviors

The key informants were asked six questions relating to how often they communicate about sexual and drug use risk behaviors with their clients. Participants were asked to respond based on the following scale; 1 = less than half of the time, 2 = about half of the time, 3 = more than half of the time.

Five of the seven key informants indicated they feel comfortable discussing risk-reducing strategies with their clients more than half of the time. Four participants talk with their clients about half of the time or less about safely using needles/ syringes and about the risk involved with using non-injection drugs. Four of the seven key informants talk with their clients about properly using a condom to prevent the spread of HIV/AIDS infection about half of the time or less.

The key informants were asked two questions relating to how often they talk with their clients who are on medication for HIV/AIDS about unprotected sex with individuals who are also *infected with HIV* and who are *uninfected*. For most of the responding participants, these two questions were not applicable to their professional practice. The complete results of these six ratings are below (Table 5).

Table 5
Discussing Risk Reduction Strategies with Clients

How often do you…	Amount of Time	Number	Percentage
Feel comfortable discussing risk-reducing strategies with your clients?	About half of the time or less	2	29%
	More than half of the time	5	71%
Talk with your clients about safely using needle/syringes?	About half of the time or less	4	57%
	More than half of the time	3	43%
Talk with your clients about the risk involved with using non-injection drugs?	About half of the time or less	4	57%
	More than half of the time	3	43%
Talk with your clients about how to properly use a condom to prevent the spread of HIV/AIDS infections?	About half of the time or less	4	57%
	More than half of the time	3	43%
Talk with your clients who are on medication for HIV/AIDS about unprotected sex with individuals who are *uninfected*?	About half of the time or less	1	14%
	More than half of the time	1	14%
	Not Applicable	5	71%
Talk with your clients who are on medication for HIV/AIDS about unprotected sex with individuals who are also *infected with HIV*?	About half of the time or less	1	14%
	More than half of the time	1	14%
	Not applicable	5	71%

Use of Risk Reduction Messages

Six of the seven key informants used brochures as a form of communication to deliver risk reduction messages. Five participants communicated verbally with clients to deliver risk reduction messages. Other forms of communication mentioned included groups, community forums, PowerPoint presentations, diagrams, interpretations, stories, demonstration models, props, and specific curriculum models. Participants felt that the use of face-to-face interactions and lots of talking was most effective for communicating risk reduction messages.

When asked to rate which of five factors would be most important to help their HIV-positive clients adhere to risk reduction behaviors to reduce the spread of HIV, three of the responding participants rated the alleviation of social factors, such as poverty, homelessness, or family/relationship pressures, as most important. For another three key informants, this question was not applicable to their professional practice. One participant indicated more time with each client would be most important to helping HIV positive clients adhere to risk reduction behaviors. See the table below for the complete responses to this question (Table 6).

Table 6
Factors to Help HIV Positive Clients Adhere to Risk-Reduction Behaviors

Most Important Factor	Number	Percentage
Alleviate social factors	3	43%
Increase time with each client	1	14%
Improve clients' ability to keep appointments	0	--
Increase training to learn skills to help clients	0	--
Other	0	--
Not Applicable	3	43%

Risk Reduction Referrals

The key informants were asked whether they have offered a referral for any HIV-positive clients to a sexual risk reduction program, such as counseling, workshops, or group education, during the past year. For three of the seven participants, this question was not applicable to their professional practice. Three key informants indicated they had offered such a referral and one did not know or did not remember whether they had offered a referral to a sexual risk reduction program. Of the participants who have offered a sexual risk reduction program referral, the only common type of referral offered was to the local AIDS organization. Additional referrals included the following: mental health agencies, parenting services, Visiting Nurses Association, support groups, and other local providers.

In addition, the key informants were asked whether in the past year they had offered a referral for any HIV-positive client to a program addressing risk associated with drug use, such as counseling, workshops, or group education. None of the key informants had personally done

this; three indicated no, three found this question not applicable to their practice, and one indicated they did not know or did not remember whether they had made such a referral.

The key informants were asked to name barriers they face in making referrals to HIV risk reduction programs. Of the six key informants responding, four identified a lack of language or culturally competent programs as being a barrier in making HIV risk reduction program referrals. Other barriers mentioned included: stigma, clients' willingness to identify themselves, money issues, lack of insurance, transportation issues, and the need to provide support for the client.

Accessing HIV/AIDS Information

The Internet and websites were the most common locations key informants identified where they would access HIV/AIDS information, listed by five of the seven key informants. Three key informants identified the local AIDS service organization as their information source. Additional common responses included the IDPH HIV/AIDS Program and Planned Parenthood, each identified by two key informants.

The key informants identified a variety of different locations when asked where they thought their clients would access HIV/AIDS information. Three participants felt clients would access information from their peers and three felt they would not access HIV/AIDS information anywhere. Two participants mentioned the local health department as a source. Additional responses included various local agencies and forms of media.

The Community Planning Group (CPG)

The key informants were asked whether they had heard about the IDPH HIV/AIDS Community Planning Group. Five of the seven indicated that they had and that they knew something about the group. Four of the seven participants indicated that they have seen the 2004-2006 Iowa Comprehensive HIV Plan.

Key Informant Comments and Recommendations

Following their interviews, the majority of the key informants offered their comments and recommendations for HIV prevention services. Those suggestions included:

- Providing access to additional prevention services for ethnic minority populations, including Hispanics and African-Americans;
- Advocating for a clean needle exchange program;
- Starting Spanish support groups;
- Increasing the variety of places projecting HIV prevention messages, including utilizing the media to send prevention messages; and
- Increasing HIV testing for patients/clients.

Summary

The key informants and agencies represented in the interviews served a variety of foreign-born populations with health, medical, employment, educational, and HIV-related services. These agencies and key informants worked with foreign cultures and languages, most commonly with Hispanic/Latino cultures, and the Spanish language.

The majority of the key informants indicated understanding their clients' cultural or ethnic background and lifestyle. However, most did not feel they have sufficient training and information needed to assist their clients to reduce the spread of HIV and manage their infection.

The participants viewed family and partner commitment as strengths encouraging client populations to practice risk-reduction behaviors. The participants viewed language barriers and cultural beliefs as barriers preventing client populations for practicing risk-reduction behaviors. Time factors and funding related issues were identified as challenges faced by key informants in providing HIV-related prevention services. The key informants' HIV prevention needs included increased condom access, increased long-term support for clients, and to have culturally competent providers. Mental health and dental care were viewed as top health concerns for client populations, in addition to access to medical resources and services in general.

Most of the participants did feel comfortable discussing risk-reduction strategies with their clients. Specific practices of delivering risk-reduction messages appeared to be limited. A significant portion of the key informants found questions related to HIV prevention and risk-reduction did not apply to their practice due to their agency's focus. A lack of cross cultural communication and linguistic support was identified as a barrier preventing other key informants from offering risk-reduction referrals to other providers. Several participants viewed alleviation of social factors as the most important factor to help HIV positive clients adhere to risk-reduction behaviors.

Conclusion

It appears more information is needed in order to determine how to reach these populations with HIV prevention efforts. For the most part it was determined that the foreign-born populations have many needs that are not being met and face cultural and language barriers when accessing services.

In order to gain more detailed information, focus groups will be held with these hard to reach populations to gain the client perspective on the issues of prevention and how to best implement plans for risk reduction behaviors.

Focus Groups

The purpose of conducting focus groups was to collect information about prevention and care needs from 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 CPG with a vast amount of important qualitative data that is then used to serve the people in Iowa better through effective HIV prevention and care planning. The strengths of qualitative methods are that they generate rich, detailed data that include the study participants' perspectives.

Focus groups involve gathering information and opinions that are "focused" on one subject from a small group of 8 to 10 people to provide insights that might not emerge in interviews or surveys. Focus groups can be used in all stages of programming from planning to determining effectiveness. Typically participants with similar characteristics are recruited for a focus group (e.g., men who have sex with men, people who inject drugs) because group discussions often thrive on common experience.

A series of focus groups were conducted from 1995 to 2003. Plans to conduct additional focus groups have been altered due to the changes in the epidemic. Planning and recruitment of participants for focus groups can take time to coordinate to ensure that groups are comfortable and not intimidated by the subject matter, the facilitator, or other assistants. A planned focus group with migrant farm workers was cancelled as new epidemiologic data indicated that the trends of infection were no longer moving in this direction. In reviewing focus groups conducted over many years with similar target group populations, it was found that similar comments and conclusions were drawn. This leads us to wonder if things have really changed for these populations in the past 5 to 6 years.

As advances in technology have affected all other areas of life in Iowa, use of the Internet in relation to sexual activity may need to be explored in the near future to determine what trends have emerged in the past few years. In addition, the increased use of methamphetamine injection drug use may be affecting risk behaviors in relation to HIV/AIDS. Plans are currently underway to conduct focus groups in each of these two areas within the very near future.

Summaries of each of the focus groups conducted beginning in 1995 can be found within the 2004-2006 Iowa Comprehensive Community Group Plan documents and will not be repeated here. The common concerns within all communities and groups, past and present, in Iowa are summarized below:

- HIV/AIDS is not as prioritized as it was in the 80s and 90s. Many people think it is no longer a threat;
- Denial is still very present;
- Participants expressed the importance of having "familiar faces" and people who have previous experience with the risk behavior conducting outreach and prevention activities (e.g., sex workers suggested using well known women in the industry as gatekeepers to others);
- Outreach efforts need to be expanded beyond the "stereotypical areas;"
- More community outreach is needed;

- Participants identified a need for more advertising and prevention messages in the media;
- Have more safer-sex workshops and risk reduction interventions; distributing information isn't enough;
- More physicians need to ask about sexual history;
- More information needs to be developed for non-English speaking/reading citizens;
- Confidentiality is very important;
- The lack of community, especially in rural areas, impacts prevention;
- There is more awareness of HIV/AIDS service agencies, especially in rural areas;
- New and innovative ways of approaching the topic of prevention are needed;
- The stigma associated with living with HIV/AIDS needs to be addressed;
- HIV+ participants were more comfortable talking about care-related issues than about prevention;
- Disclosure of HIV status is a barrier to prevention. HIV+ people reported fear associated with disclosure;
- Fear keeps people from getting tested;
- Drugs and alcohol impact risk;
- A strong tie between trading sex for money or drugs and injection drug use was noted by female sex workers and incarcerated women:
- IDUs are more concerned about contracting and dying of hepatitis C than HIV/AIDS;
- Injection drug users were aware that they were at high risk and had increased their risk by knowingly sharing unclean rigs;
- Access to clean needles and syringes was one of the biggest and most common problems for injection drug users;
- More HIV/AIDS education is needed;
- Many injection drug users learned more about HIV/AIDS within the department of corrections than anywhere else;
- Educators should be open, honest, and frank and share information in a culturally appropriate manner;
- More discussion about HIV/AIDS in churches and synagogues is needed;
- Youth wanted schools to show them how to use condoms;
- Easy access to condoms is important;
- Youth indicated that condom availability is good;
- Youth expressed that they don't talk with partners before having sex because it makes the act of having sex "weird;"
- Youth did not want to offend partners by asking them to wear condoms;
- The Internet was identified as a site where both youth and MSM meet partners as well as seek information; and
- Knowing someone who has HIV decreases risk behaviors.

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 years of age. 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.

To gain information about the participants, their partners, and their relationships, participants were asked 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 or heterosexuals, and that 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, and at the river or in 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 poz." 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; and
- 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); and
- 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 they didn't like using them but felt it was necessary to be safe. The processes 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 and didn't have one available, when their partner had a latex allergy, or when 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.

Safe sex messages 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; and
- 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 TV or newspaper;
- Having booths where HIV information is disseminated at community events;
- Using television shows to promote behaviors;
- Making information available where MSM meet for sex; and
- 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 Iowa, Young Adult Roundtables (YARTs) serve as the youth voice for assessing the needs and expressing the concerns of young adults for the CPG. YARTs are led by a facilitator and by a mentor. The mentor is an Iowa HIV/AIDS Community Planning Group (CPG) member.

At each YARTs location, meetings were held once every two months from December 2003 to August 2004. An additional meeting for the year will take place in October 2004. In 2004, 40 young people representing varied backgrounds, cultures, identities and personal experiences participated.

2004 Questionnaire

At the first meeting of the year, YARTs members completed an anonymous questionnaire. The majority of the youth identified themselves as being Caucasian, female, straight, and single. The average age was 18 years.

Questionnaire results are summarized in Tables 7 through 10.

Table 7: Demographics
N=40

City	Davenport	13	33%
	Des Moines	11	28%
	Sioux City	16	40%
Age	Average Age	18	Range 14-23
Gender	Females	27	68%
	Males	13	33%
Race	White/Caucasian	26	65%
	Black/African American	6	15%
	American Indian or Alaskan	2	5%
	Native	2	5%
	Asian	4	10%
	No Answer		
Ethnicity	Hispanic or Latino	10	25%
	Non-Hispanic or Latino	29	73%
	No Answer	1	3%
Sexual Orientation	Straight	36	90%
	Gay	2	5%
	Bisexual	1	3%
	No Answer	1	3%
Relationship Status	Single	32	80%
	Married	1	3%
	Living With Partner	4	10%
	Other	4	10%

Only 5 percent of the youth who participated in YARTs considered themselves to be at risk for HIV. Most of the youth lived with their parents or guardians, the majority attended school or college, and about half worked either full or part-time. YARTs were the most common sources of HIV/AIDS information for the youth. The complete results are listed in Table 8.

Table 8: HIV Knowledge and Risks of YARTs Participants
N=40

Consider self at risk for HIV:	Yes	2	5%
	No	38	95%
Knows someone living with HIV or AIDS:	Yes	15	38%
Knows someone who has died from AIDS:	Yes	7	18%
Self reported level of HIV knowledge:	Very Low	0	--
	Low	3	8%
	Average	20	50%
	High	12	30%
	Very High	5	13%
Ever tested for HIV:	Yes	11	28%
Smoke cigarettes:	Yes	4	10%
Ever sexually active:	Yes	22	55%
Are the parent of a child:	Yes	8	20%
Have ever used drugs:	Yes	18	45%
Living arrangements:	With Parents/Guardians	33	83%
	In Own Apartment	6	15%
	Other	1	3%
Work status:	Working Full Time	9	23%
	Working Part Time	12	30%
School status:	Attend School or College	25	63%
	In Home-School	1	3%
	Attend Alternative School	1	3%
	Dropped Out of High School	2	5%
Sources of HIV/AIDS information:	YARTs	30	75%
	Television	19	48%
	Newspapers	15	38%
	Friends	14	35%
	School	14	35%
	Magazines	10	25%
	Family	9	23%
	Radio	4	10%

Of the youth that were sexually active, half had been tested for HIV. The majority knew their partners' HIV status and used condoms to some extent, and 55 percent indicated they never had unsafe encounters (Table 9).

Table 9: YARTs Members Who Have Been Sexually Active
N=22

Number of sex partners within the past 12 months?	One Two Three Four Not Sure No Answer	12 5 1 2 1 1	55% 23% 5% 9% 5% 5%
Know partners' HIV status?	Yes	17	77%
Ever had any sexually transmitted diseases?	Yes	1	5%
Do you use condoms?	Yes	19	86%
How often do you have "unsafe" encounters?	Often Sometimes Never	4 6 12	18% 27% 55%
Have you ever been pregnant or have you gotten someone pregnant?	Yes No	9 13	41% 59%

Eighteen of the YARTs members indicated they had used drugs at some point, listing alcohol as the most common drug used (Table 10). Of those who used drugs, 72 percent used occasionally, and 67 percent stated they have never used substances while sexually active.

Table 10: YARTs Members Who Have Ever Used Drugs
N=18

Which drugs have you used?	Alcohol Marijuana Crack/Cocaine Methamphetamine	17 10 1 1	94% 56% 6% 6%
How often do you use them?	Only Once Once in a While	5 13	28% 72%
Ever used substances while sexually active?	Yes No	6 12	33% 67%

2004 Activities

A number of the participating youth were returning members, and their added experience contributed to the enduring process of the YARTs. Equally, the new members provided fresh perspectives on the purpose, goals, and processes of the groups. Throughout the year, the YARTs participated in various discussions, activities, and screening exercises. As part of their role in the HIV planning process, the YARTs evaluated HIV education and awareness materials throughout the year, including conference presentations and three videos. The youth made numerous recommendations for effective HIV educational approaches and materials directed towards a youth audience. These recommendations included:

- Make presentations interactive, such as using hands-on activities and role-playing;
- Speak directly to the youth by gearing materials and presentations specifically towards the youth and young adult age groups;
- Use presenters and characters for materials that are of the same age and background of the targeted audience, as the youth were more receptive to them;
- Utilize peers to help with educating youth;
- Ensure materials are diverse and are representative of the targeted young adults' background, culture and community;
- Avoid stereotypes;
- Make scenarios in materials realistic to help youth relate to them;
- Discuss the real issues, choices and consequences young adults face relating to HIV/AIDS;
- Present materials in an honest, non-judgmental way;
- Portray specific negative consequences, such as symptoms of HIV/AIDS, rather than only showing "healthy looking" persons with HIV/AIDS; and
- Use care when determining music to use for videos and presentations. The type of music used at times determined the impact the materials had on the youth and whether or not they liked the materials.

The YARTs participated in various activities to discuss and explore sexually transmitted disease (STD) and HIV risks as well as where and how they would access related resources. The YARTs identified goals and activities for developing a youth STD/HIV prevention program within their community and prioritized which activities they would implement if given a very limited amount of resources. These goals included: developing programs to provide HIV education, counseling, information, and referral to HIV resources. The YARTs identified initial activities such as coordinating with clinics and agencies to determine youth friendly services available and researching myths of HIV to collect information. The groups' activities would also focus on creating booklets to disseminate HIV prevention information, presenting facts learned at a local conference, and holding activities with games and skits focusing on HIV and STD-related information within communities. The groups identified using resources that would not cost money, such as volunteer time to complete activities, encouraging the community and local colleges and theatre groups to donate services, and utilizing the media.

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

Feelings/Beliefs	Strategies	Action Steps
▪ HIV/STD prevention is not taught before 8th grade in most schools. ▪ Faculty members in schools tend to be uncomfortable when talking about sex with students and usually don't have up-to-date information. ▪ Schools don't allow you to talk openly about everything (sex, condoms).	▪ Start teaching prevention methods at an earlier age. ▪ Cover HIV/ STD prevention in mandatory health classes and other classes that could integrate prevention into their curricula. ▪ Peer educators.	▪ Set up peer-education programs in the schools. ▪ Make it a point to educate teachers and give them up-to-date information on HIV/AIDS. ▪ Parent involvement is a must. ▪ Need a comprehensive health program.

PARENTS

Feelings/Beliefs	Strategies	Action Steps
▪ Feel that parents take the wrong approach when discussing sex with children. ▪ Many parents don't have information regarding HIV/ STD prevention. ▪ Many thought that dads were harder to talk to about sex. ▪ Parents don't talk about it; it is taboo.	▪ Open discussions between parents and children. ▪ Educate parents so they feel comfortable talking to their children. ▪ HIV/ STD programs. ▪ Parents must have discussions with their children about sex and character. ▪ Parents need to be more involved in youth's education; COMMUNICATION.	▪ Education is the key to getting full support from parents. ▪ Encourage parents to have open communication with their children. ▪ Have conferences so parents can learn about HIV/AIDS. ▪ 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.

ATTITUDES/BELIEFS

Feelings/Beliefs	Strategies	**Action Steps***
▪ From a religious viewpoint, there should be no sex before marriage. ▪ Looked down upon when talking about sex. ▪ HIV/AIDS not prevalent in north Iowa. ▪ If you are on the pill you don't have to worry about HIV.	▪ Have people living with HIV speak to youth. ▪ Knowledge that sex is a very small part of a relationship and that protecting yourself is very important.	

CULTURE

Feelings/Beliefs	Strategies	**Action Steps***
▪ Our culture sends a message to youth about what is acceptable and what is not. ▪ Hispanic cultures are usually from a Catholic faith. ▪ Cultural beliefs get in the way of using protection. ▪ Northern Iowa has a conservative culture.	▪ Talk to any adult who has an open mind and will listen to your questions about sex. ▪ Give information to elders in the community to show how important education is for the youth.	

LANGUAGE

Feelings/Beliefs	Strategies	**Action Steps**
▪ The use of slang words tends to drive adults away from conversations and may keep them from understanding what is being said. ▪ Teachers need to talk to you and not down to you. ▪ Reach people by talking their language.	▪ Make sure that information is in all languages.	▪ Make all documents in the top four languages in that community. ▪ Know when to use slang. ▪ Talk "to" youth and not down, above, or at them.

SOCIETY (In general and/or peers)

Feelings/Beliefs	Strategies	**Action Steps***
▪ Contributes to how youth feel and act towards sex. ▪ Videos, music, and movies all promote sexual behaviors. ▪ If society wants it to happen, it will. If it doesn't, then it won't. ▪ Scared of the stigma about HIV/AIDS. ▪ People are stigmatized if they are having sex. ▪ People don't want to believe premarital sex happens.	▪ Make it harder for youth to be permitted into "R" rated movies and to buy music containing messages about sex. ▪ People need to accept that times have changed; just because it used to be like that, doesn't mean that it is now.	

RURAL AREAS

Feelings/Beliefs	Strategies	**Action Steps**
▪ Seem to be isolated. ▪ Have less funding for HIV/ STD prevention. ▪ Fewer testing services. ▪ Schools are uncomfortable with condom distribution.	▪ Use of Internet prevention sites. ▪ Choose someone who would be willing to learn and keep up on new HIV/ STD prevention information. ▪ Increase services for testing.	▪ Use popular media when available. ▪ Internet peer education as a resource. ▪ Health fairs put on by local agencies. ▪ Media campaign focusing on rural residents.

PERSONAL RESPONSIBILITY

Feelings/Beliefs	Strategies	**Action Steps***
▪ Responsible for only your behaviors. ▪ Never assume anything. ▪ Handling pressure to drink and engage in sexual activities is a challenge. ▪ It's only the guy's responsibility to remember condoms.	▪ Educate youth on how to assess risks, recognize risks, and prevent transmissions. ▪ Let others know of your beliefs and values from the start. ▪ Take care of yourself. ▪ Set limits.	

AGE DIFFERENCE IN PARTNERS

Feelings/Beliefs	Strategies	**Action Steps***
▪ Girls mature faster than boys and tend to date older men. ▪ Older men and younger women are more acceptable than older women and younger men. ▪ The larger the difference in ages between the partners, the less likely the young person is to find out about the partner's history.	▪ Encourage youth to date in their own age range. ▪ Talk about the publication called a Mother's Voice and what Carol and David Ellingsworth have done for prevention. ▪ Talk to older men and find out why they would want to date younger women.	

RELIGION

Feelings/Beliefs	Strategies	**Action Steps**
▪ Premarital sex is a no-no, but no one is doing anything to stop it. ▪ Abortion – no one wants to talk about. ▪ No birth control/not protecting themselves.	▪ Improvements in communication.	▪ Be realistic and don't preach "just say no." ▪ Tell the entire story and let the youth decide. ▪ Continue the dialog even if you don't like what is being said.

PEOPLE WHO ARE MENTALLY CHALLENGED

Feelings/Beliefs	Strategies	**Action Steps**
▪ What you see in movies is not what occurs in real life. ▪ Are trusting and vulnerable; can have sex and not know what happened.	▪ Educate ▪ Explain in a simple and repetitive manner.	▪ Specific classes that are geared toward their learning ability. ▪ Posters that they can relate to. ▪ Use language that they understand. ▪ Hands-on activities would be helpful.

GOVERNMENT

Feelings/Beliefs	Strategies	**Action Steps**
▪ Not getting enough HIV information to people. ▪ Not enough access to free condoms. ▪ Lack of funding for education. ▪ Lack of trust in the government.	▪ Get word out that HIV infection can happen to anyone.	▪ Lobbying. ▪ Consider programs beyond abstinence-only. ▪ Increase funding for HIV prevention programs. ▪ Get Comprehensive Family Care Act passed.

REALISM

Feelings/Beliefs	Strategies	**Action Steps**
▪ Only evident when it affects someone close. ▪ The realization that HIV/AIDS is here.	▪ It could happen to anyone.	▪ Educate the community that HIV/AIDS is in Iowa. ▪ It can happen to anyone. ▪ Meeting people living with HIV/AIDS in their community.

*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.

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; and
- 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

The YARTs groups shared in a variety of discussions, participated in screenings of HIV materials, provided recommendations, and generated prevention planning ideas throughout the year. During the summer of 2004, 26 of the young adult members from Davenport, Des Moines, and Sioux City completed evaluations of the YARTs process. The outcomes of these evaluations reflected very positively on the YARTs group experiences. All of the responding youth felt comfortable participating in their group and with other group members—in fact, most felt a high level of comfort. The majority of the youth believed their contributing information is used in the statewide HIV prevention planning process.

Almost all of the youth were very comfortable with their group facilitator and with their CPG YARTs Mentor. The majority of the youth were very confident in the confidentiality of their group. Almost all of the participants were very comfortable with their groups' meeting space. They all felt their time attending meetings was well spent and almost all believed that their group representatives do a good job in representing YARTs.

The youth had many ideas for goals and changes they would like to see next year in YARTs, including: getting more people involved with YARTs and in the community, targeting young

people, doing activities and education in schools, staying focused on their group, and showing different or fewer movies. The members felt it would be helpful to have more in-depth HIV related information, as well as more information relating to teens, sex, and drugs. They also specified a desire to have more teen involvement in HIV prevention.

Part C: Community Services Assessment

Chapter 5:

Consumer Needs Assessment

Consumer Needs Assessment

EXECUTIVE SUMMARY

Background

In 2004 and 2005, the Iowa Department of Public Health (IDPH) and the HIV Community Planning Group (CPG) developed its first statewide consumer needs assessment. The IDPH, Ryan White Title II and III providers, and other interested community members provided input for the survey as it was developed.

The survey was designed and implemented to answer the following questions:

- What are the service needs, gaps, and barriers to care for people living with HIV/AIDS (PLWH/A) in Iowa?
- How do needs, gaps, and barriers vary by race/ethnicity, gender, and region?
- How much stigma do PLWH/A perceive and what form does this take?
- What are the reasons that PLWH/A who know their status don't get into care, or once in care, don't stay in care?

Methods

IDPH and CPG developed a survey that asked about background characteristics; health status; co-occurring problems; stigma; transportation; service needs, gaps, and barriers; health care access; and HIV medications, adherence, and side effects. It was piloted in October 2004 by a group of clients from each region of the state.

The list of potential respondents was compiled from all PLWH/A who were clients of Ryan White Title II and III providers, two private providers in Des Moines, or county and state correctional facilities.

Most surveys were distributed to clients through their case managers. Surveys were available in English and Spanish. Clients returned the surveys in confidential, self-addressed, stamped envelopes to the Department of Public Health or their case managers. For completing the survey, respondents received a $10 gift card to a local grocery store chain.

Survey distribution began the first of April 2005. Respondents were allowed approximately four weeks to complete and return the survey. A total of 713 surveys were distributed. Three hundred seventy-four responses were received by the due date, for a return rate of almost 53%.

Findings

1. Background Characteristics

Forty-two percent of respondents lived in central Iowa, 24% lived in southeast Iowa, 20% in northeast Iowa, and 14% in western Iowa. This is relatively reflective of the state's HIV population as a whole. The 2005 epidemiological profile reported that 40% of PLWH/A were from central Iowa, 28% were from southeast Iowa, 17% in northeast Iowa, and 15% in western Iowa.

Most survey respondents were male (77%). There were only two transgendered respondents, both male to female. For analysis, these two individuals were included with males.

Seventy-nine percent of respondents were white, non-Hispanic; 18% were black, non-Hispanic; and 5% were Hispanic/Latino(a). Again, this was very comparable to persons living with HIV/AIDS in the state.

Fifty-two percent of the respondents described themselves as men who only have sex with men; 21% as women who only have sex with men; 15% as men who only have sex with women; 9% as men who have sex with men and women; and 3% as women who have sex with women and men.

Over half of the respondents (55%) reported their primary risk factor for HIV as men who have sex with men (MSM), while just over one quarter of the respondents (26%) reported heterosexual sex, 5% reported injection drug use (IDU), 2% reported both MSM and IDU, 2% reported transfusions, 5% reported other, and 6% reported that they didn't know what their risk factor was.

2. Health Status

A majority (70%) of the survey's respondents had been living with HIV/AIDS for six or more years. Forty percent of the respondents had been living with HIV/AIDS for 10 or more years, 30% for 6 to 10 years, 28% for 1 to 5 years, and 2% had been living with HIV/AIDS for less than one year.

Sixty-three percent of the survey respondents reported being HIV-positive, but never having been diagnosed with AIDS. Thirty-seven of the respondents had been diagnosed by their doctor as having AIDS. Only 14% of the respondents had their most recent CD4+ count at 199 cells/microliter or less (below 200 cells/microliter is AIDS defining). Over half (53%) of the respondents had an undetectable viral load.

Eighty percent of the respondents knew their most recent CD4+ count and 83% knew their most recent viral load. Knowledge of viral load differed by race and ethnicity. While 90% of white, non-Hispanic respondents knew the value of their most recent viral load, only 64% of black, non-Hispanic respondents and 52% of Hispanic respondents knew theirs. Respondents' knowledge of their CD4+ and viral load counts also varied by stage of disease. Eighty-three percent of respondents with AIDS knew their most recent CD4+ count and 90% knew the value of their most recent viral load. Conversely, only 66% of respondents with HIV knew their most recent CD4+ count and only 80% of them knew the value of their most recent viral load.

3. Co-Occurring Problems

Forty-seven percent of respondents said that they struggled with depression, anxiety, or other mental health issues. Fatigue was another issue facing respondents, with 42% citing this as an issue. Other medical difficulties facing respondents were chronic illnesses (25%), other physical impairments (16%), hepatitis C (12%), problems with vision (11%), and problems with hearing (7%). Nine percent of respondents reported problems with alcohol use and 8% reported problems with use of other drugs.

Twenty-nine percent of respondents said they had been in prison at some time in their lives. This did not differ significantly by sex. Blacks were more likely than whites to have been incarcerated (43% vs. 25%), and IDUs and MSM/IDUs were very likely to have spent time in prison (74% and 80%, respectively).

4. Stigma

The Iowa HIV community was so concerned about how stigma affects people living with HIV in the state that it was decided to include a 40-question section on stigma in the 2005 Consumer Needs Assessment. *The HIV Stigma Scale,* developed by Barbara Berger, is a self-report questionnaire developed to assess stigma perceived and experienced by PLWH/A. It is considered to be the standard instrument for assessing HIV stigma in psychosocial studies of PLWH/A.

Women reported slightly higher total stigma scores than males. Minorities reported more stigma than whites. Specifically, persons reporting their race as American Indian/Alaskan Native, Asian, or "other" had much higher stigma scores than other races. Hispanics scored higher than blacks, who score only slightly higher than white, non-Hispanic persons. Rural respondents reported slightly more stigma than urban clients. Clients who had been homeless scored higher on stigma scales than clients who had never been homeless.

5. Transportation

Twenty-four percent of respondents had used some type of transportation assistance to get to appointments in the past 12 months.

Forty percent of respondents reported that they traveled more than 36 miles *one way* for HIV/AIDS medical care, with 23% of those respondents traveling in excess of 60 miles *one way.* Forty-nine percent relied on a friend or volunteer to take them to a care appointment and fifteen percent relied on an HIV/AIDS agency.

6. Housing

Fifty percent of respondents rented the place where they were living (apartment, house, mobile home, etc.); 26% owned a home, condo, or mobile home; and 12% lived with family or friends permanently. Thirty-four percent of respondents lived alone, 34% lived with a spouse or partner, 11% lived with their children, and 14% lived with another family member.

Thirty-six percent of respondents reported currently receiving assistance with housing. Of those, 58% were black, non-Hispanic, 31% were white, non-Hispanic, and 29% were Hispanic. More women (46%) than men (32%) received housing assistance. Thirty-two percent of respondents reported having been homeless at some point in their lives. Of those, 49% were black and non-Hispanic, 35% were Hispanic, and 28% were white and non-Hispanic.

7. Supportive Services

Respondents were asked to indicate what supportive services they had used in the past year and what services were unavailable but would be used if they were available. The top 5 services that would be used if they were available were alternative therapies (25%), help paying bills (17%), housing (16%), education assistance (16%), and insurance assistance (14%).

The problems that were most common when clients tried to receive HIV-related supportive services included the cost of the services/money issues, a lack of needed services, transportation issues, not qualifying for the service, lack of knowledge about resources or the system, paperwork, lack of funding, and personal issues, including stigma.

8. Medical Care and HIV Medications

Seventy-two percent of survey respondents had waited less than six months before getting HIV medical care after their diagnoses, 10% waited 6 months to a year, 13% waited between 1 and 5 years, and 5% waited more than 5 years to get treatment. During the course of their infections, 25% of respondents had chosen at some time to not receive medical care for a year or more.

For those who had waited more than a year to receive care, their reasons for waiting fell into four categories: Lack of symptoms, denial, cost/lack of insurance, and lack of knowledge. Most (70%) reported that they had no symptoms or that they were in denial (61%). Fifty percent reported lack of insurance as a reason why they did not seek care and 39% reported that they didn't seek care because they couldn't afford it. Other reasons included not knowing where to go (20%) and lack of transportation (12%).

Eighty-three percent of respondents were currently on medications to treat their HIV. Seventy-one percent of respondents who were taking HIV medications reported missing at least one dose at some point and 26% of those who had ever missed a dose had missed at least once in the week prior to the survey.

Side effects of the HIV medications had a strong effect on the lives of the respondents. Fifty-five percent of respondents noted that side effects limited what they did at least sometimes, and 20% said that side effects limited them everyday.

9. Prevention Services

Respondents were asked where they were diagnosed with HIV, what education they received at that time about reducing the risk of transmission, what access they had to materials to help them practice safer behaviors, and in what high-risk behaviors they had engaged during the past year.

Most respondents received their first positive test in a hospital (24%), health clinic (22%), or at a physician's office (19%). Seventy percent of respondents reported that they had received information from a doctor, counselor, or case manager about how to lower their chances of transmitting HIV to others after receiving the results of their test.

Forty-four percent of respondents had engaged in at least one high-risk activity within the last year. Two percent reported that they had shared a needle or syringe with someone for either medical or recreational purposes, 28% reported that they had not used a condom every time they had sex with another HIV+ person and 21% reported that they had not used a condom every time they had sex with someone who did not have HIV or who was unsure about his or her HIV status.

Next Steps

Future surveys should work to expand the potential respondents to include persons out of care at the time of the survey. Other foci should include looking at trends, increasing response rates, and ensuring better representation from minorities. These next steps, while challenging, will be crucial to ensure that PLWH/A in Iowa are able to access the services they need, are receiving high-quality care, and are able to lead healthy and satisfying lives.

The next consumer needs assessment will be conducted in March of 2008.

Part C: Community Services Assessment

Chapter 6:

STD/HIV/AIDS Provider Services Survey

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 2005 survey are described below. A copy of the survey is included in Appendix A.

The survey was sent to 193 individuals at agencies 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 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.

The survey was conducted via Internet by Luther Consulting, LLC, on behalf of the Iowa Department of Public Health (IDPH). The survey was made available between January 31, 2006, and April 4, 2006. Organizations were sent an initial e-mail from IDPH staff requesting that they complete the survey; IDPH staff also sent out two subsequent reminders to complete the survey. Most individuals responded via Internet; however three of them could not complete the survey via the Internet due to lack of access or security issues regarding Internet access at their agency. These individuals were mailed paper copies of the survey, which they subsequently returned. The data were entered into the Internet survey on their behalf by Luther Consulting, LLC staff.

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.

Who Responded?

Seventy-five agencies responded, for a response rate of 39%. A list of participants, by agency/organization and city, is included in Appendix C. In some cases, the survey was sent to more than one individual in an organization. Generally, only one individual responded on behalf of the organization. As a result, the return rate may be slightly higher than reported.

Organization/Agency Principal Function

Survey participants were asked to identify the principal function of their organization or agency from a list of 18 options, including "Other," which allowed the participants to specify the principal function in a text response.

Only nine of the 18 options were selected in survey participants' responses, with four of these accounting for more than 65% of the total number of responses. These were "Public Health Agency" (20%), "Corrections" (17%), "Family Planning Agency" (14%), and "Community-based Organization" (13%). Only two STD clinics responded. The complete breakdown of responses is included in Table 1.

Of the seven other responses (9% of the total), three specifically mentioned the agency's non-profit status, but otherwise there were no obvious groupings to note. A full list of responses is included in Appendix B.

Table 1. Principal Functions of Participants' Organizations/Agencies

Organization/Agency	Frequency	%
Public Health Agency	15	20
Corrections	13	17
Family Planning Agency	11	15
Community-based Organization	10	13
Community Health Center	7	9
Drug and Alcohol Prevention and/or Treatment Services	7	9
Other (Specify)	7	9
Hospital "Outpatient"	3	4
STD Clinics	2	3
Total	75	100

More than 65% of survey participants were from a Public Health Agency, Corrections, Family Planning Agency, or Community-based Organization.

Services Provided and Clients Served

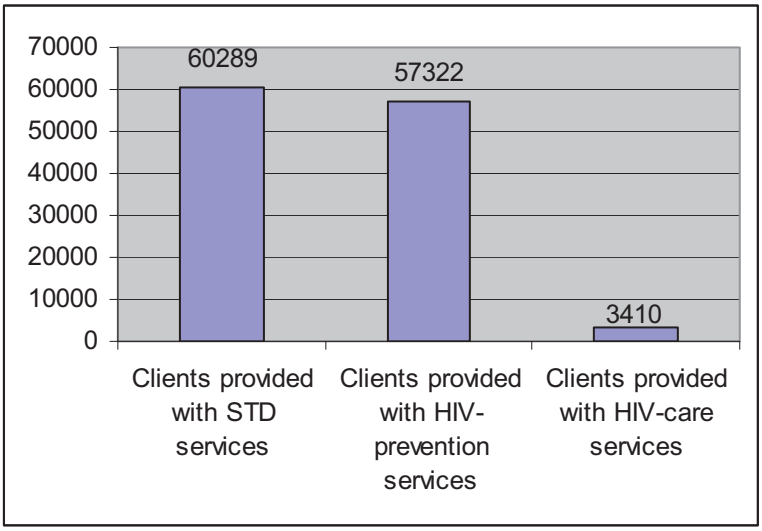
Respondents were asked to indicate whether their agency offered HIV prevention, STD prevention and treatment, and HIV care-related services. Details about each of these areas are found in subsequent sections of this report. Overall, respondents reported that their agencies served over 60,000 clients with STD services in 2005 and over 57,000 with HIV prevention services. Approximately 3,400 clients were provided with HIV care-related services in 2005. Because clients could be seen at more than one agency and the agencies reported only aggregate numbers, client counts are not unduplicated.

See Table 2 below for the numbers of clients served with STD services, HIV prevention services, and HIV care services. The total client numbers reported are also represented in Figure 1 below.

Table 2. Number of Clients Served

	Survey Participants/ Agencies Responding	Total Number of Clients Served	Fewest Clients Served (Other than 0)	Most Clients Served	Mean Number of Clients
Clients provided with STD services	26	60,289	10	19,455	1,436
Clients provided with HIV-prevention services	58	57,322	10	5,463	988
Clients provided with HIV-care services	25	3,410	2	900	136

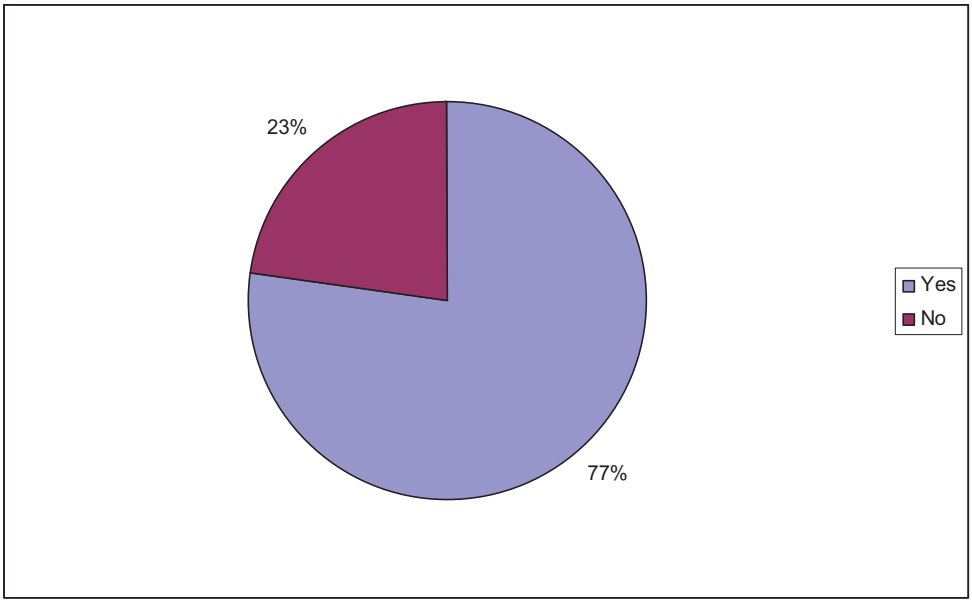
Figure 1. Total Clients Served by Survey Respondents



HIV/AIDS Prevention Services

Survey participants were asked whether their organizations provided HIV/AIDS prevention services. Fifty-eight of the respondents (77%) replied that their organization *did* provide HIV/AIDS prevention services (see Figure 2 below).

Figure 2. Does Your Organization/Agency Currently Provide HIV/AIDS Prevention Services?



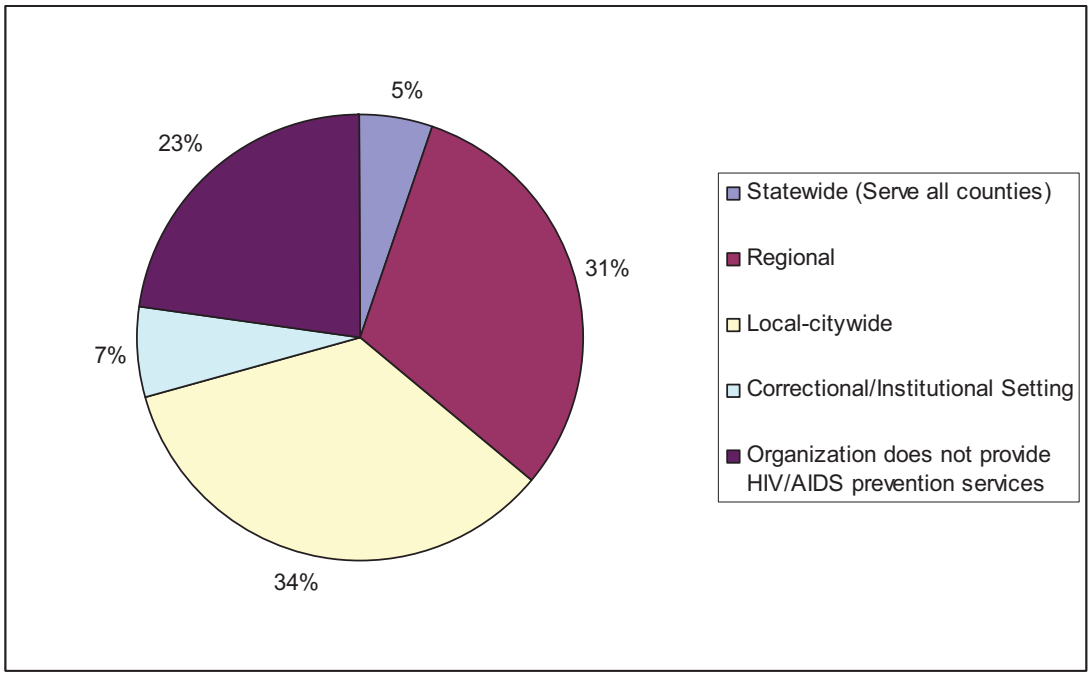
Geographic Area

Survey participants were asked to identify the geographic area that best described their service area. Almost 35% reported their service area as local or citywide, 31% as regional, 7% as correctional/institutional, and 5% as statewide (Table 3 and Figure 3).

Table 3. Geographic Area Served by HIV/AIDS Prevention Services

	Frequency	%
Statewide (Serve all counties)	4	5
Regional	23	31
Local-citywide	26	35
Correctional/Institutional Setting	5	7
Organization does not provide HIV/AIDS prevention services	17	23
Total	75	100

Figure 3. Geographic Area Served by HIV/AIDS Prevention Services



Coverage by County

Survey participants who identified the geographic area covered by their HIV/AIDS prevention services as regional were then asked to identify this area by county, including as many as applied. Black Hawk, Buchanan, and Fayette Counties were each selected by five agencies. All the remaining counties in the state, save one (Pottawattamie), were selected at least once, and 21 counties were selected by at least four agencies. The complete distribution of responses is included in Table 4.

Table 4. Number of Regional Agencies Serving Each County with HIV/AIDS Prevention Services

County	Agencies		County	Agencies		County	Agencies
Adair	1		Floyd	4		Monona	4
Adams	1		Franklin	4		Monroe	3
Allamakee	4		Fremont	1		Montgomery	1
Appanoose	3		Greene	2		Muscatine	3
Audubon	2		Grundy	3		O'Brien	2
Benton	3		Guthrie	2		Osceola	2
Black Hawk	5		Hamilton	1		Page	1
Boone	3		Hancock	4		Palo Alto	2
Bremer	4		Hardin	2		Plymouth	3
Buchanan	5		Harrison	4		Pocahontas	3
Buena Vista	2		Henry	3		Polk	2
Butler	4		Howard	4		Pottawattamie	0
Calhoun	3		Humboldt	1		Poweshiek	4
Carroll	3		Ida	2		Ringgold	1
Cass	2		Iowa	3		Sac	3
Cedar	3		Jackson	3		Scott	4
Cerro Gordo	4		Jasper	2		Shelby	2
Cherokee	2		Jefferson	4		Sioux	3
Chickasaw	3		Johnson	3		Story	3
Clarke	1		Jones	1		Tama	3
Clay	2		Keokuk	3		Taylor	1
Clayton	3		Kossuth	3		Union	1
Clinton	4		Lee	2		Van Buren	4
Crawford	2		Linn	2		Wapello	4
Dallas	3		Louisa	3		Warren	2
Davis	4		Lucas	2		Washington	3
Decatur	1		Lyon	2		Wayne	2
Delaware	2		Madison	2		Webster	1
Des Moines	3		Mahaska	4		Winnebago	3
Dickinson	2		Marion	3		Winneshiek	4
Dubuque	2		Marshall	3		Woodbury	3
Emmet	2		Mills	1		Worth	4
Fayette	5		Mitchell	4		Wright	1

Clients Served by Race and Ethnicity

Survey participants were asked to estimate what percentage of their clients came from each of seven racial and ethnic categories.

Of the 58 that responded that their agency provided HIV prevention services, 36 estimated their percentage of white, non-Hispanic clients to be greater than 70. The only other racial category with percentages that high was Hispanic, with two participants estimating percentages at 90 or higher. Figure 4 illustrates the number of agencies providing HIV prevention services to persons of specific races and ethnicities. Table 5 presents average percentage of clients provided with HIV prevention services, by racial and ethnic background of those individuals.

Figure 4. Number of Agencies Serving Each Racial and Ethnic Group

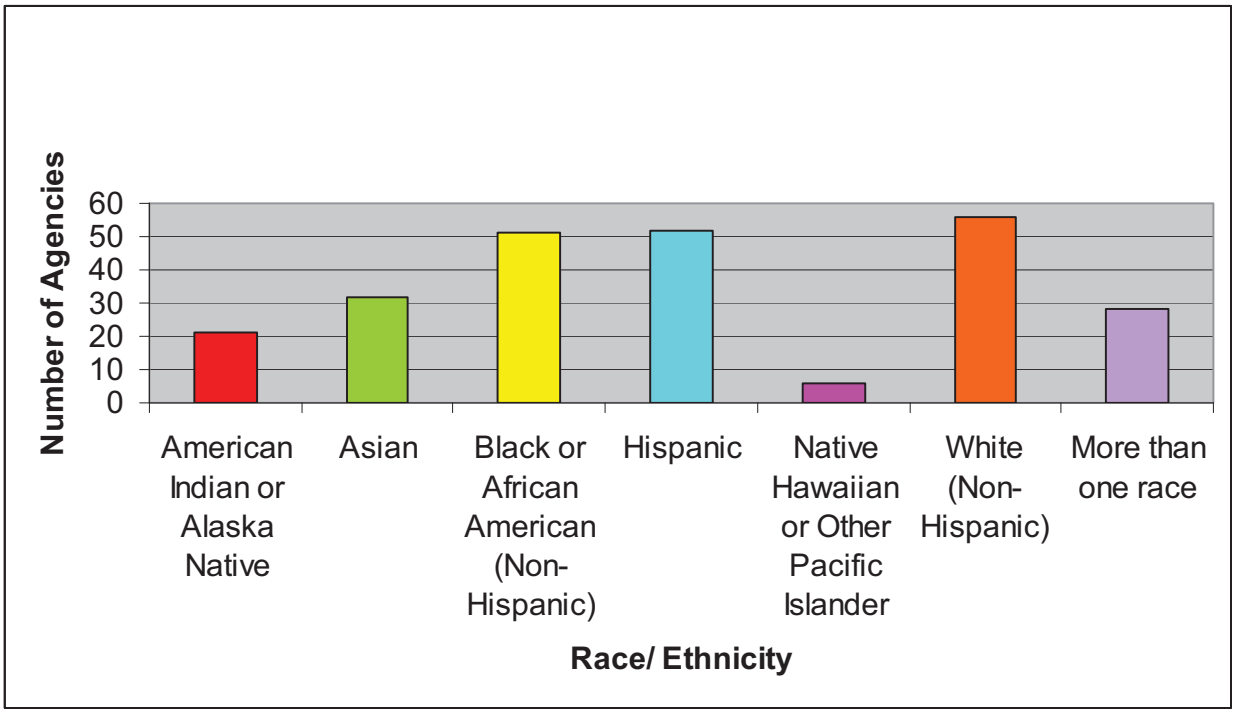


Table 5. Race and Ethnicity of Clients Receiving HIV/AIDS Prevention Services

	Average % of Clients	Std. Deviation	Range
White (non-Hispanic)	71	24	0-99%
Hispanic	13	19	0-99%
Black (non-Hispanic)	12	11	0-45%
More than one race	3	78	0-58%
Asian	1	2	0-10%
American Indian or Alaskan Native	1	1	0-5%
Native Hawaiian or Pacific Islander	0.1	0.7	0-5%

Funding Sources

Survey participants were asked to identify what percentage of their total funding for HIV/AIDS prevention services came from a list of 11 potential sources.

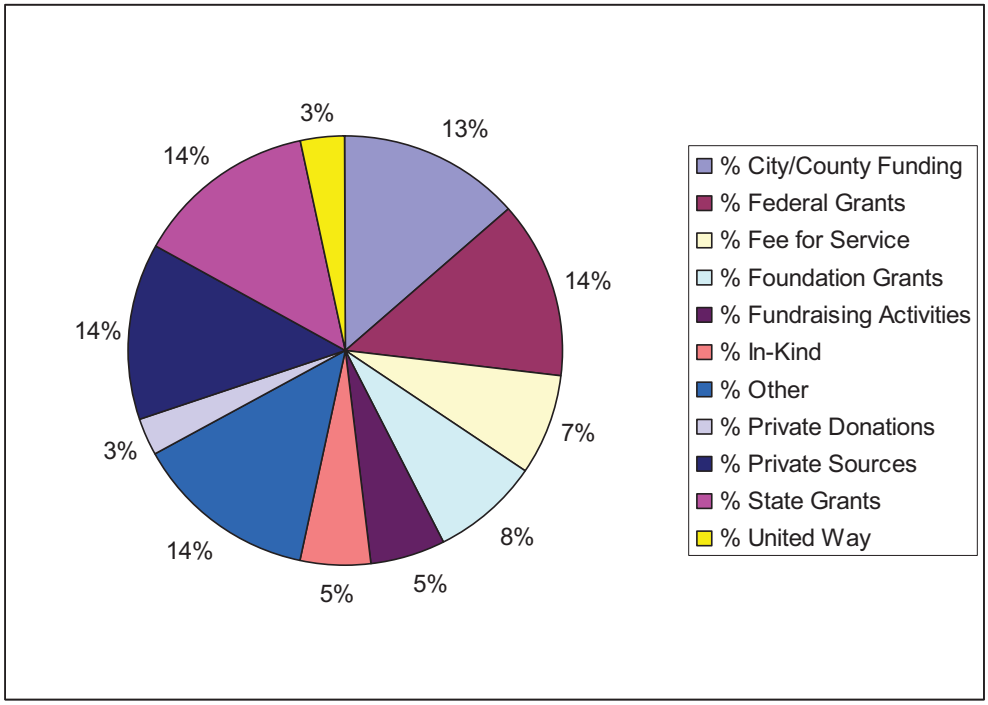
Of the 58 respondents who indicated that their agency provides HIV prevention services, 15 indicated that all of their funding came from a single source, either city/county funding (two respondents), federal grants (seven respondents), private sources (three respondents), or state grants (three respondents). Among those sources from which over 90% of survey participants indicated that they did not receive any funding were foundation grants, fundraising activities, in-kind contributions, private donations, private sources, and the United Way. Overall, the majority of funding comes from "other sources" and from federal and state grants. This is illustrated in Figure 5. Table 6 shows the summary of funding sources for all HIV prevention agencies. It should be noted that there is wide variation among the agencies.

Among the 21 other responses, the most frequently cited were state-associated funding (nine responses), including the Iowa Infertility Prevention Project (mentioned twice by name), and Medicaid (in five responses). The complete list of responses may be found in Appendix B.

Table 6. Sources of Funding for HIV/AIDS Prevention Services

	Average Percent of Funding	Std. Deviation	Range
% Federal Grants	23	36	0-100%
% Other	23	40	0-100%
% State Grants	22	34	0-100%
% City/County Funding	11	25	0-100%
% Fee for Service	6	14	0-55%
% Private Sources	6	22	0-100%
% In-Kind	3	8	0-40%
% Foundation Grants	3	10	0-60%
% Fundraising Activities	2	6	0-40%
% United Way	2	5	0-25%
% Private Donations	1	3	0-20%

Figure 5. Funding Sources for HIV Prevention



Client Numbers

Fifty-eight survey participants indicated that their agencies provide HIV prevention services. The total number of clients served was 57,322. The lowest number served (other than none) was 10; the largest number of clients served was 5,463; and the mean was 988. See Table 7 below.

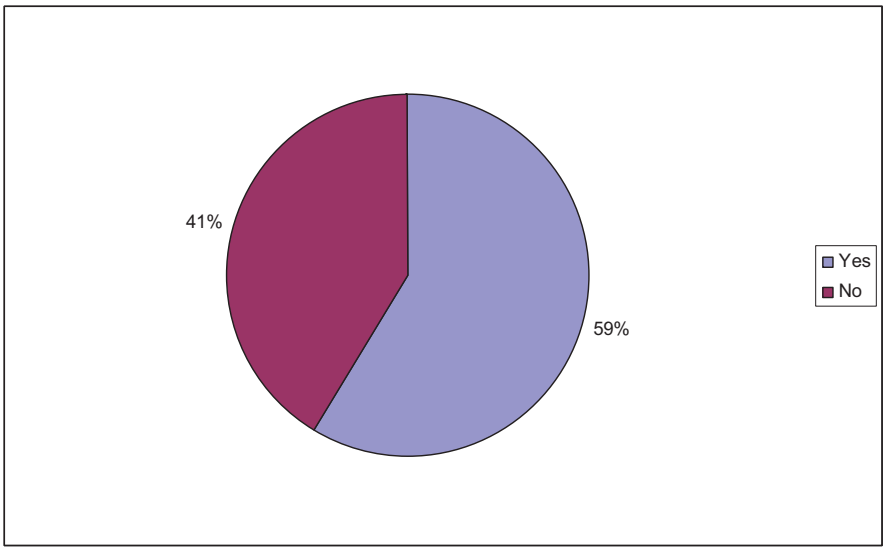
Table 7. Average Number of Unduplicated Clients Served (HIV Prevention)

	Average Number of Clients	Total Number of Clients	Fewest Clients per Agency	Most Clients per Agency	Survey Participants Responding
Clients provided with HIV prevention services	988	57,322	10	5,463	58

STD Prevention, Testing, and Treatment Services

Survey participants were asked whether their agencies provided STD prevention, testing, and treatment services. A total of 44 respondents indicated that their agencies provided these services. Whereas over three-fourths (77%) of the survey participants replied that their organization provided HIV/AIDS prevention services, considerably fewer, 59%, reported that their agency provided STD prevention, testing, and treatment services (see Figure 6). This may in part be due to the types of organizations that received and/or responded to the survey.

Figure 6. Does Your Agency Currently Provide STD Prevention, Testing, and Treatment Services?



Approximately 59% of respondents reported that their agencies provide STD prevention, testing, and treatment services.

Funding Sources

Respondents were asked to identify what percentage of their total funding for STD prevention, testing, and treatment services came from a list of 11 potential sources.

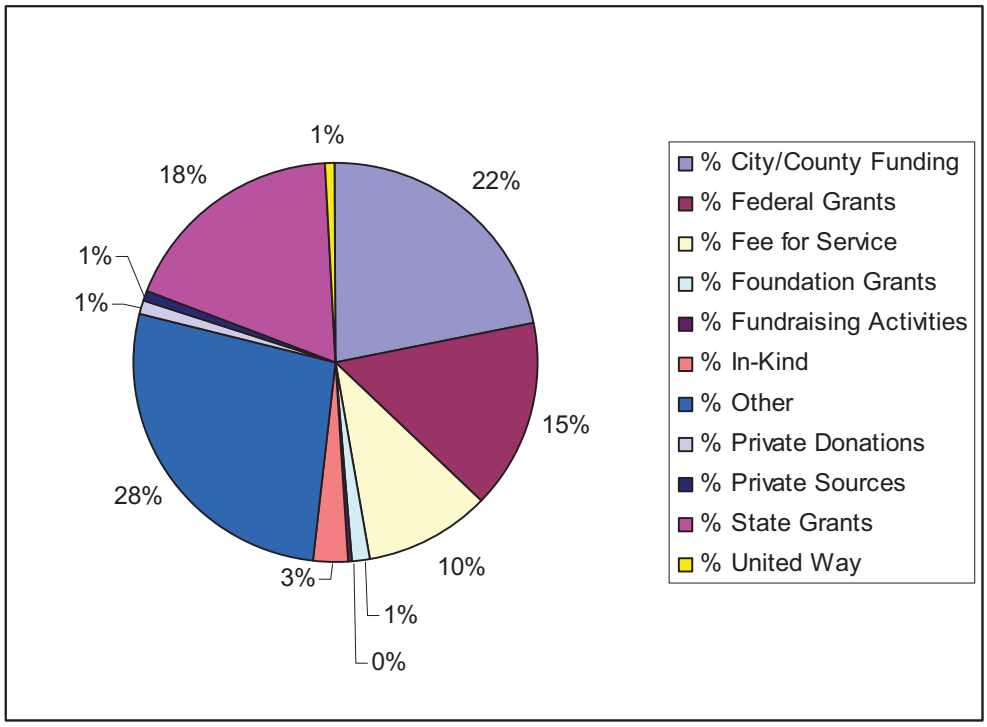
Of the 44 survey participants who indicated their agency received funding for STD prevention and treatment services, 24 indicated that all of their funding came from a single source, either city/county funding (seven respondents), federal grants (one respondent), fee for services (two respondents), state grants (five respondents), or another source (nine respondents). Overall, city/county funding, federal grants, fee for services, state grants, and "other" were the sources most frequently named. Sources of funding are shown in Table 8 and Figure 7. As with HIV prevention funding sources, there was wide variation between agencies.

Among the 16 responses of "other," the most frequently cited sources were some form of state-associated funding (in seven responses), including the Iowa Infertility Prevention Project (mentioned twice by name), and Medicaid (cited four times). The full list of responses may be found in Appendix B.

Table 8. Sources of Funding for STD Prevention, Testing, and Treatment

	Average Percent Funding	Standard Deviation	Range of Percentages
% City/County Funding	22%	39	0-100%
% Federal Grants	15%	29	0-100%
% Fee for Service	10%	25	0-100%
% Foundation Grants	2%	7.4	0-45%
% Fundraising Activities	0.2%	1.5	0-10%
% In-Kind	3%	9.5	0-40%
% Other	27%	42	0-100%
% Private Donations	1%	4.3	0-25%
% Private Sources	0.6%	2.8	0-16%
% State Grants	18%	35	0-100%
% United Way	1%	4.1	0-25%

Figure 8. Sources of Funding for STD Prevention, Testing, and Treatment



Client Numbers

Survey participants indicated how many unduplicated clients were provided with STD services at their agencies. The 26 agencies that responded served 60,289 clients (see Table 9). Of those agencies that served any clients, the lowest number served was 10 clients, the most served was 19,455 clients, and the mean was 1,436 clients.

Table 9. Unduplicated Client Numbers (STD Services)

	Survey Participants Responding	Total Number of Clients	Lowest Number of Clients (Other than 0)	Highest Number of Clients	Mean
Clients provided with STD services	26	60,289	10	19,455	1,436

STD/HIV/AIDS Prevention Activities and/or Services

Survey participants were asked to indicate what prevention services they offered from a list of 25 activities and services. They were able to choose as many options as applied.

Six activities and services were indicated by more than half of the providers. They included basic information about HIV prevention (87%); distribution of STD/HIV/AIDS educational materials (71%); individual risk reduction counseling and education (61%); condom distribution (59%); referrals to counseling, testing, or medical/support groups (55%); and STD screening and treatment (52%). One agency reported conducting needle exchange activities. A complete breakdown of the responses may be found in Table 10.

Table 10. STD/HIV/AIDS Prevention Activities and/or Services

Activities and/or Services	Frequency	%
Basic information about HIV prevention, e.g., AIDS 101	65	87
STD/HIV/AIDS educational materials (e.g. print, audiovisual) distribution	53	71
Individual risk reduction counseling and education	46	61
Condom distribution	44	59
HIV referrals, e.g. counseling, testing, medical/support groups	41	55
STD screening and treatment	39	52
On-site HIV counseling, testing, and referral	36	48
Telephone information and counseling	35	47
Skills training on the proper use of condoms through a demonstration	31	41
Skills training on how to negotiate condom use with a sex partner	28	37
Hepatitis B vaccine	27	36
School-based education	26	35
Hepatitis C counseling and testing	24	32
Sessions targeting those in alcohol/drug treatment	22	29
Hepatitis A vaccine	20	27
Offsite (bars, parks) HIV counseling, testing, referral	18	24
Peer education programs	14	19
Street outreach (defined as HIV prevention, education, counseling, and referrals)	11	15
HIV prevention case management	10	13
Mass media campaign (billboards, TV, PSA, newspaper)	10	13

HIV negative multi-session group interventions	9	12
Role model stories	8	11
HIV positive multi-session group interventions	2	3
Needle access	1	1
Needle exchange	1	1

Among the STD/HIV/AIDS prevention-related activities and/or services most often provided by survey participants' agencies were provision of basic information about HIV prevention; distribution of STD/HIV/AIDS educational materials; individual risk reduction counseling and education; condom distribution; referrals for counseling, testing, and medical/support groups; and STD screening and treatment.

Evidence-Based Interventions

Survey participants were asked to indicate the evidence-based interventions provided by their organizations. They were able to include as many options as applied. Of the 58 survey participants, 34 (57%) indicated their agency did not provide evidence-based interventions. Of the evidence-based interventions options provided, the most commonly selected category was "other," selected by 16% of respondents. "Making Proud Choices" was chosen by 10% and "Healthy Relationships" by 9%. A full breakdown of responses may be found in Table 11.

Table 10. Evidence-based Interventions

Evidence-based Interventions	Frequency	%
Other	9	16%
Making Proud Choices	6	10%
Healthy Relationships	5	9%
Real AIDS Prevention Project (RAPP)	3	5%
Power Moves	3	5%
Community PROMISE	3	5%
VOICES/VOCES	2	4%
Options	2	4%
Street Smart	1	2%
SISTA	1	2%
Safety Counts	1	2%
Popular Opinion Leader	1	2%
Partnership for Health	1	2%
Parents Matter	1	2%
MPowerment	1	2%
BART	0	0%
Willow	0	0%
Teens Linked to Care	0	0%
SiHLE	0	0%
Respect	0	0%
Many Men, Many Voices	0	0%
Holistic Health Recovery Program	0	0%
Focus on Kids	0	0%
None	34	59%

Out of 58 survey participants from agencies offering HIV prevention services, only 24 (41%) indicated that their agency provided evidence-based interventions.

Populations Served

Survey participants were asked to identify which populations their agencies reached with their HIV/STD/Hepatitis-related prevention activities and/or services. Participants could choose from 25 options or write in another population name under "other."

The most frequently selected populations across all three (HIV, STD, and hepatitis) prevention activities and/or services were persons of low socio-economic status, young adults 13 to 24 yrs of age, and substance abusers. The most frequently served group for both HIV and STD

prevention activities and/or services was young adults 13 to 24 years of age; for hepatitis prevention activities and/or services, it was persons of low socio-economic status.

Thirty survey participants (40%) indicated that their agency did *not* serve partners or family members of persons living with HIV. Among the other populations not served by 40% or more of the survey participants were men who have sex with men and inject drugs, persons living with HIV/AIDS, sex workers, and those who trade sex for drugs, money, or shelter.

The complete breakdown of responses is included below in Table 11 below. Among the 12 "other" responses, seven described a population that was included in the available options. For example, two respondents specified college/university students, but this group could have been included under the young adults category. One listed none of the above. The complete list of "other" responses may be found in Appendix B.

Table 11. Populations Served with HIV/STD/Hepatitis Prevention Activities and/or Services

	Service Provided			Not Served	Not Applicable
	HIV	STD	Hepatitis		
Population	Frequency			Frequency	
Developmentally disabled	46	48	20	31	17
General population	55	48	38	10	8
Heterosexual sex with someone at risk or infected with HIV	50	41	35	15	8
Homeless	37	32	28	22	15
Incarcerated	36	29	26	27	11
Injection drug users	42	33	33	25	8
Lesbians/Bisexual women	43	35	31	23	8
Low socio-economic status	58	52	43	11	3
Medical professionals	27	20	18	28	18
Mentally ill	44	37	33	22	8
Men who have sex with men	50	35	33	25	9
Men who have sex with men and inject drugs	40	29	28	32	10
Partners or family members of persons living with HIV	41	25	27	30	9
Persons living with hepatitis C	42	33	36	28	8
Persons living with HIV/AIDS	43	25	25	31	10
Persons infected with STDs (other than HIV)	51	49	37	16	6
Pregnant	48	42	33	17	9
Sex workers (Prostitutes)	34	28	26	31	16
Substance abusers	58	47	40	14	9
Trading sex for drugs/money/shelter	39	31	26	31	13

Transgendered persons	23	17	14	36	16
Visually or hearing impaired	30	22	22	35	14
Women who are at risk for or infected with HIV	56	43	32	16	9
Young adults (13-24 yrs)	59	54	35	11	6
Other	5	3	4	1	2

Specific Prevention Services

Individual-, Group-, and Community-Level Interventions

Survey participants were asked to assess the availability of individual-, group-, and community-level interventions (described in the survey as "health education and risk-reduction counseling") for six particular populations: HIV-positive persons, men who have sex with men, injecting drug users, high-risk heterosexuals, incarcerated persons, and high-risk youth (13 to 24 years of age).

Survey participants had five options for rating the availability of intervention services in their area: not provided, somewhat provided, adequately provided, unaware if provided, and not applicable. The "not applicable" response may have been selected by survey participants whose agencies did not offer health education and risk-reduction counseling for that level or population, or by those survey participants who did not perceive a need of such services in their area for any one of the given population groups.

Individual-Level Interventions

Individual-level interventions (ILIs) include helping clients make plans for behavior change and providing referrals for services in both clinic and community settings. Over 50% of the survey participants agreed that ILI services were adequately provided to HIV-positive persons. Nearly half of survey participants, 47% and 45%, identified ILI services to high-risk heterosexuals and high-risk youth, respectively, as adequately provided.

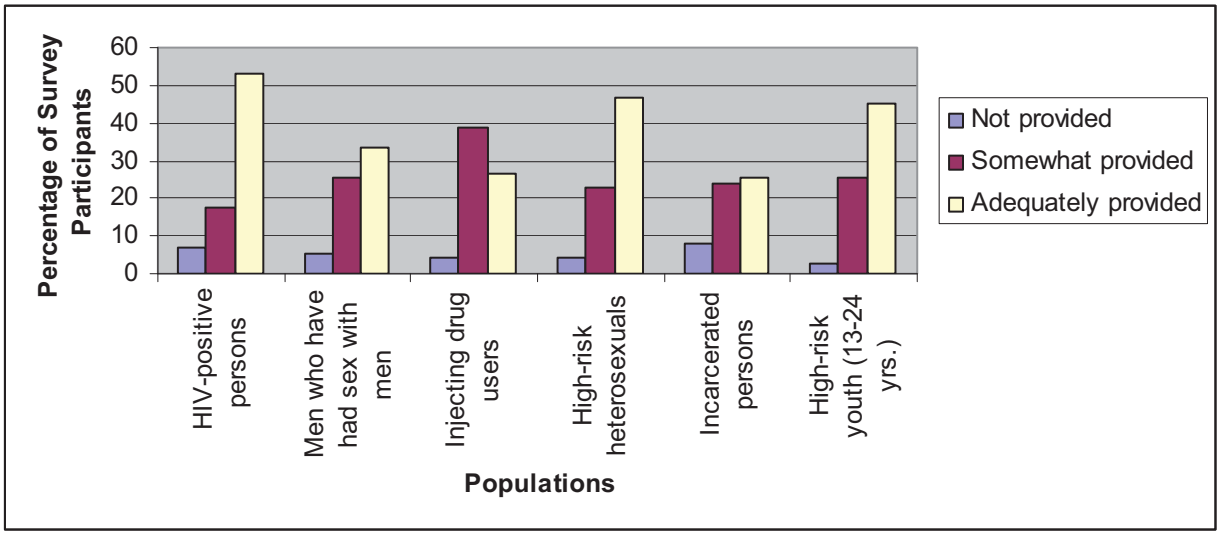
The percentages of survey participants who identified that ILI services were not provided for the six given population groups ranged between three and eight. The percentages of those who judged ILI services as not applicable in their area ranged between five and 15. Between 13% and 28% of participants were unaware if ILI services were provided.

The complete distribution of the frequency and percentages of survey participants' responses may be found in Table 12. Figure 9 illustrates the degree to which participants felt individual-level interventions were provided to each of the six priority population groups.

Table 12. Provision of Individual-Level Interventions for Priority Populations

	Not provided		Somewhat provided		Adequately provided		Unaware if provided		Not applicable	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
HIV-positive persons	5	7	13	17	40	53	10	13	7	9
Men who have had sex with men	4	5	19	25	25	33	20	27	7	9
Injecting drug users	3	4	29	39	20	27	18	24	5	7
High-risk heterosexuals	3	4	17	23	35	47	16	21	4	5
Incarcerated persons	6	8	18	24	19	25	21	28	11	15
High-risk youth (13-24 yrs.)	2	3	19	25	34	45	16	21	4	5

Figure 9. Provision of Individual Level Interventions for Priority Populations



Group-Level Interventions

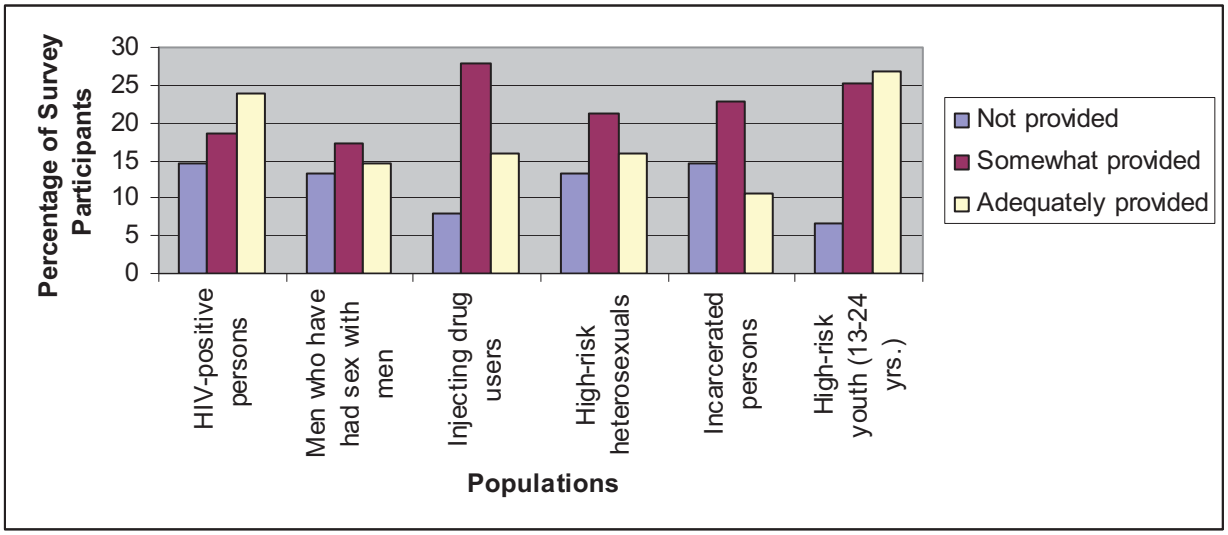
Group level interventions (GLIs) were defined in the survey as using "both peer and non-peer models" and including "information, skill-building education and support programs." In general, survey participants felt that GLI services were provided less frequently than individual-level interventions (as illustrated by a higher range in the percentage of survey participants who indicated that group-level interventions were not provided). There were two of the six given populations for which survey participants indicated that group-level interventions were at least somewhat adequate: Injecting drug users, for which 28% of the survey participants indicated that GLI services were somewhat provided, and high-risk youth, for which 27% indicated that GLI services were adequately provided.

The percentages of participants who indicated that group-level interventions were not applicable ranged between 9 and 15. Between 31% and 44% of participants were unaware if GLI services were provided in their areas. See Table 13 and Figure 10 for the full breakdown of responses.

Table 13. Provision of Group-Level Interventions for Priority Populations

	Not provided		Somewhat provided		Adequately provided		Unaware if provided		Not applicable	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
HIV-positive persons	11	15	14	19	18	24	25	33	7	9
Men who have had sex with men	10	13	13	17	11	15	33	44	8	11
Injecting drug users	6	8	21	28	12	16	29	39	7	9
High-risk heterosexuals	10	13	16	21	12	16	29	39	8	11
Incarcerated persons	11	15	17	23	8	11	28	37	11	15
High-risk youth (13-24 yrs.)	5	7	19	25	20	27	23	31	8	11

Figure 10. Provision of Group-Level Interventions for Priority Populations



Community-Level Interventions

For community-level interventions (CLIs), described as including "tailored prevention messages, social marketing, community mobilization/organization, community-wide events, and structural interventions," few respondents felt the services were provided well. Respondents described the services as somewhat provided for high-risk youth (29%) and HIV-positive persons (23%), and adequately provided for high-risk youth (23%).

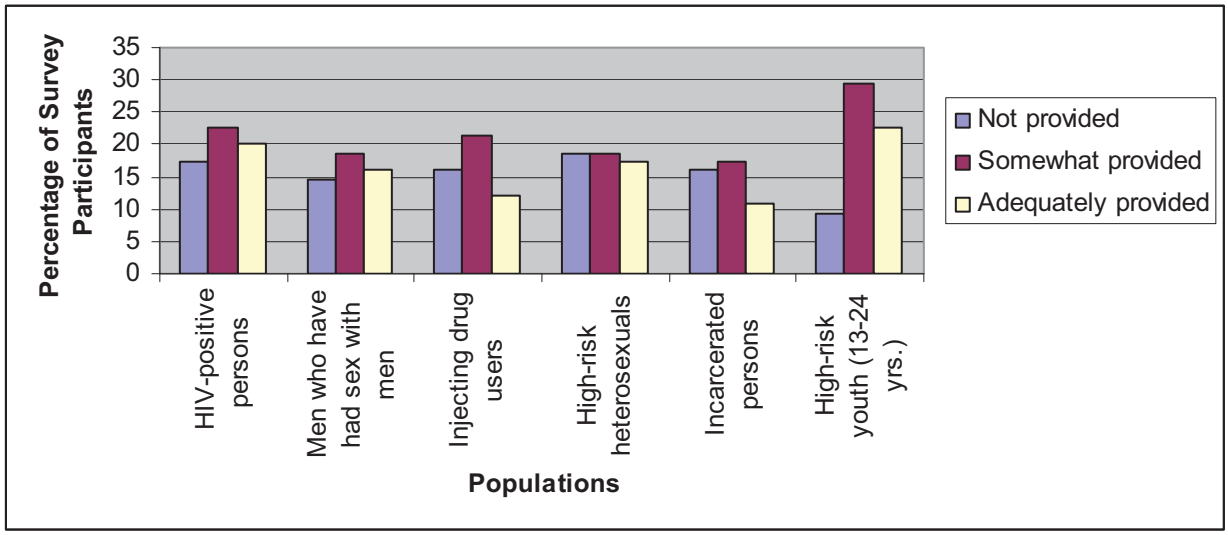
The percentages of survey participants who said that CLI services were not provided ranged between 9 and 19. The percentages of those who deemed that such services were not applicable ranged between 11 and 13. Many survey participants, between 27% and 43%, were unaware if community-level interventions were provided in their area.

The full distribution of responses is included in Table 14 below. Figure 11 illustrates the percentage of survey participants who responded that community-level intervention services were provided in some degree for each of the six priority population groups.

Table 14. Provision of Community Level Interventions for Priority Populations

	Not provided		Somewhat provided		Adequately provided		Unaware if provided		Not applicable	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
HIV-positive persons	13	17	17	23	15	20	22	29	8	11
Men who have had sex with men	11	15	14	19	12	16	30	40	8	11
Injecting drug users	12	16	16	21	9	12	30	40	8	11
High-risk heterosexuals	14	19	14	19	13	17	26	35	8	11
Incarcerated persons	12	16	13	17	8	11	32	43	10	13
High-risk youth (13-24 yrs.)	7	9	22	29	17	23	20	27	9	12

Figure 11. Provision of Community Level Interventions for Priority Populations



Individual, Group, and Community Level Interventions: Further Considerations

Based on the data reported by those who participated in this survey, the largest gaps in individual, group, and community level intervention services for risk populations exist for community-level interventions. Nineteen percent of survey participants indicated that CLIs were not provided for high-risk heterosexuals, 17% said that they were not provided for HIV-positive persons, and 16% responded that they were not provided for injecting drug users and incarcerated persons.

The percentages of survey participants who were unaware of interventions for specific risk populations were, on average, highest for group-level services. Forty-four percent of survey participants indicated that they were unaware if GLIs were provided for MSM. There were also high percentages of survey participants unaware of whether CLIs were provided for incarcerated persons (43%), MSM (40%), or injecting drug users (40%).

Other Interventions

Health Communication/Public Information

Survey participants were asked to assess the availability in their area of health communication and public information (HCPI) programs, HIV-prevention capacity building, prevention case management (PCM) services, and outreach services for the same six priority populations.

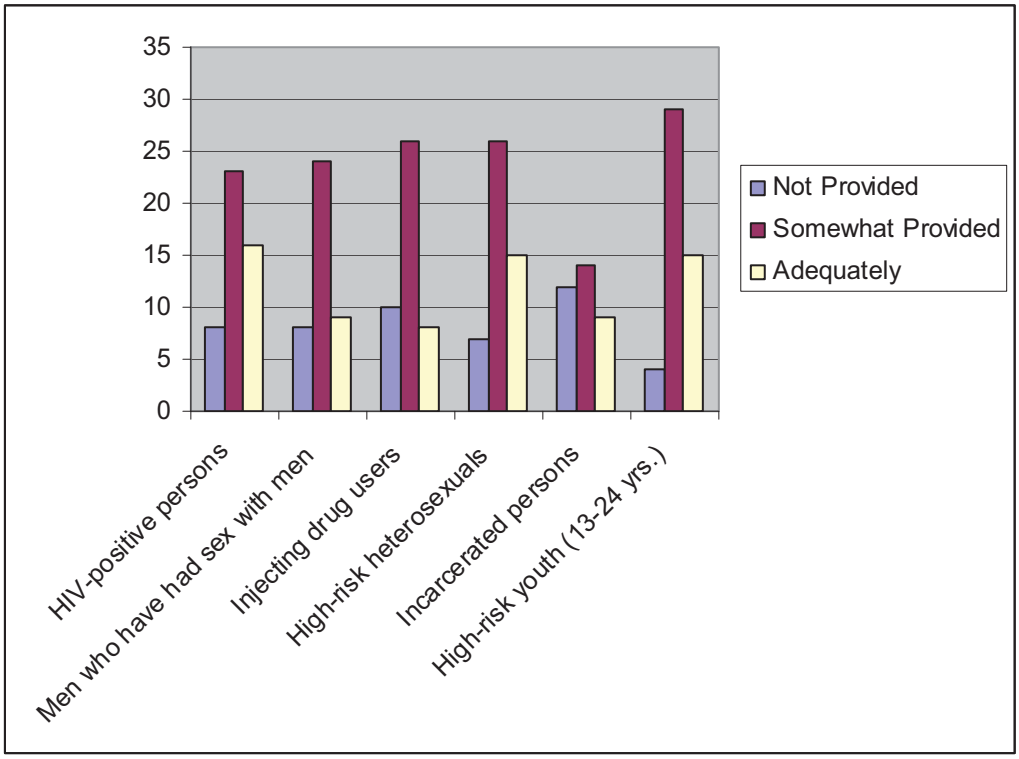
HCPI programs were defined by the survey as "planned HIV/AIDS prevention messages that target selected populations and aim to dispel myths about HIV transmission … [using] electronic and print media, hotlines, clearinghouses, and single-session presentations and lectures." Nearly 80% of participants felt that HCPI programs were inadequately provided for all populations. MSM, IDU, and incarcerated populations were the least likely to be adequately provided with HCPI programs. Approximately one-third of participants identified HCPI services as being somewhat provided for all populations except incarcerated persons. Only 19% of participants felt HCPI programs were somewhat provided for that population.

The percentages of survey participants who identified HCPI programs as not provided for the six given populations ranged between five and 16. High-risk youth were the least likely to be without any services, followed by high-risk heterosexuals. The complete distribution of the frequency and percentages of participants' responses may be found in Table 15.

Table 15. Provision of Health Communication/Public Information Programs for Priority Populations

	Not provided		Somewhat provided		Adequately provided		Unaware if provided		Not applicable	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
HIV-positive persons	8	11	23	31	16	21	22	29	6	8
Men who have had sex with men	8	11	24	32	9	12	28	37	6	8
Injecting drug users	10	13	26	35	8	11	25	33	6	8
High-risk heterosexuals	7	9	26	35	15	20	21	28	6	8
Incarcerated persons	12	16	14	19	9	12	31	41	9	12
High-risk youth (13-24 yrs.)	4	5	29	39	15	20	20	27	7	9

Figure 12. Provision of Health Communication/Public Information Programs for Priority Populations



HIV-Prevention Capacity Building

The survey defined HIV-prevention capacity building as "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."

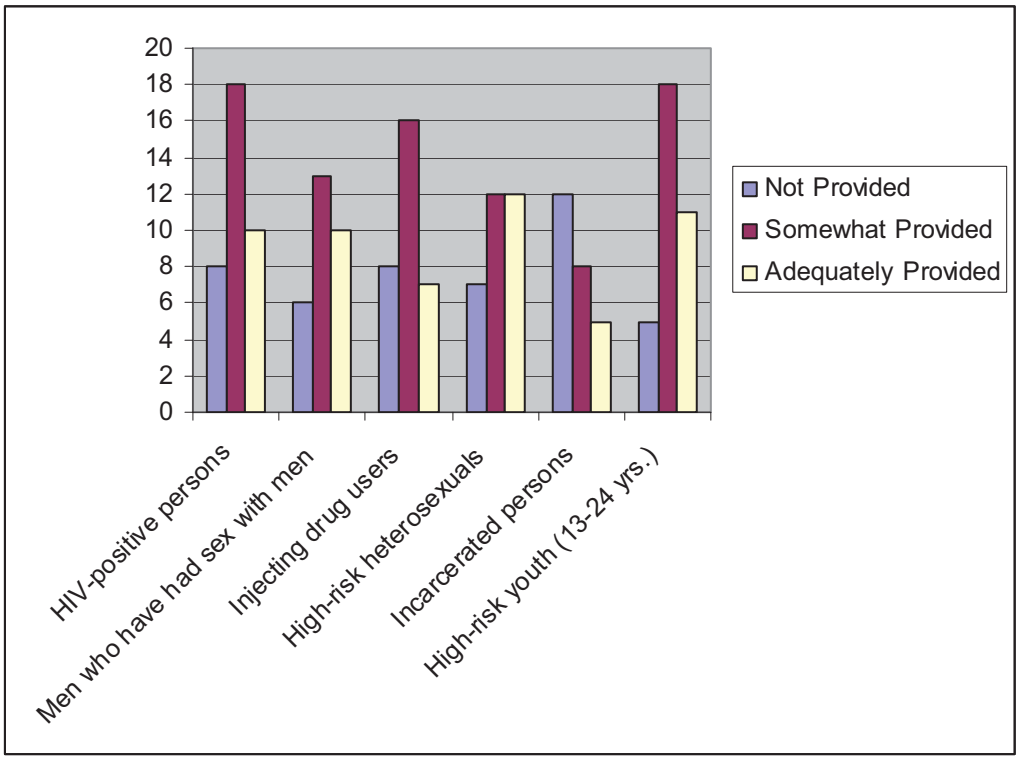
More participants were unaware of the availability of capacity building services than of HCPI programs. The percentages of survey participants who were unaware of HIV-prevention capacity building for the priority populations ranged from 41 to 56, compared to a range of 27 to 41 for HCPI programs.

Few survey participants felt HIV prevention capacity building services were adequately provided. Twenty-four percent of respondents said that capacity building services were somewhat available for high-risk youth and HIV-positive persons. Programs aimed at incarcerated persons were the least likely to have capacity building services. See Table 16 and Figure 13 for a description of the responses.

Table 16. Provision of HIV-Prevention Capacity Building Services for Priority Populations

	Not provided		Somewhat provided		Adequately provided		Unaware if provided		Not applicable	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
HIV-positive persons	8	11	18	24	10	13	31	41	7	9
Men who have had sex with men	6	8	13	17	10	13	40	53	6	8
Injecting drug users	8	11	16	21	7	9	39	52	5	7
High-risk heterosexuals	7	9	12	16	12	16	39	52	5	7
Incarcerated persons	12	16	8	11	5	7	42	56	8	11
High-risk youth (13-24 yrs.)	5	7	18	24	11	15	34	45	7	9

Figure 13. Provision of HIV Capacity Building for Priority Populations



Prevention Case Management/Comprehensive Risk Counseling and Services

The survey defined Prevention Case Management (PCM), also now known as Comprehensive Risk Counseling and Services (CRCS), as services designed to promote "the adoption of HIV risk-reduction behaviors by clients who display multiple, complex problems and risk reduction needs." Traditionally, this intervention has been delivered to HIV-positive persons only but could be useful for other populations as well.

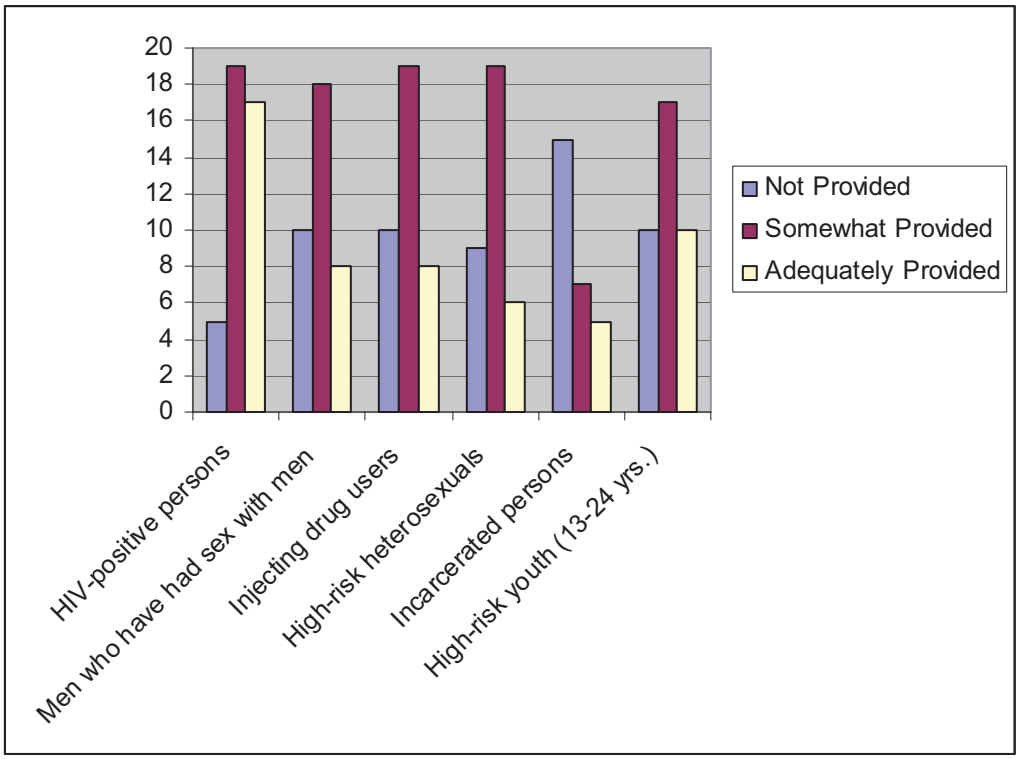
Nearly one-fourth of the respondents felt that PCM was adequately being provided to HIV-positive persons in Iowa. No other population had more then 13% of respondents rating the service as adequately provided. Incarcerated persons were the least likely to have PCM services provided.

The full distribution of responses is included in Table 17. Figure 14 illustrates the degree to which respondents felt that PCM/CRCS services are provided to the priority populations.

Table 17. Provision of Prevention Case Management (PCM)/ Comprehensive Risk Counseling and Services (CRCS)

	Not provided		Somewhat provided		Adequately provided		Unaware if provided		Not applicable	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
HIV-positive persons	5	7	19	25	17	23	26	35	8	11
Men who have had sex with men	10	13	18	24	8	11	31	43	8	11
Injecting drug users	10	13	19	25	8	11	32	43	6	8
High-risk heterosexuals	9	12	19	25	6	8	34	45	7	9
Incarcerated persons	15	20	7	9	5	7	38	51	10	13
High-risk youth (13-24 yrs.)	10	13	17	23	10	13	31	41	7	9

Figure 14. Provision of HIV Capacity Building: Not Provided, Somewhat Provided, or Adequately Provided



Outreach

Outreach was identified in the survey as "HIV prevention, education, counseling, and referrals for persons who engage in high-risk activities, delivered at informal … community congregation sites."

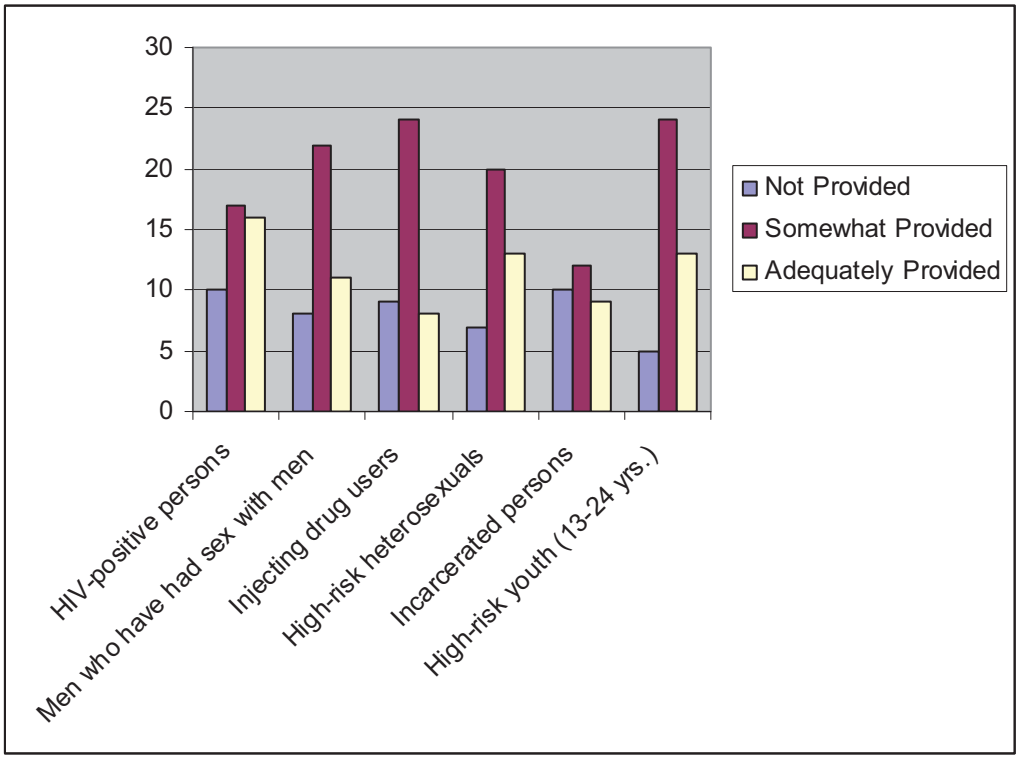
Just over 20% of respondents rated outreach services as adequately provided for HIV-positive persons. Fewer respondents felt that outreach was adequately provided for the other populations. Only 11% felt injection drug users had adequate outreach services, but 32% felt that the services were at least somewhat available. Nearly one-half of respondents were unaware if outreach services were provided for incarcerated persons. For each of the populations, at least one-third of respondents were unaware of whether outreach services were provided.

See Table 18 and Figure 15 for further detail of the responses.

Table 18. Provision of Outreach for Priority Populations

	Not provided		Somewhat provided		Adequately provided		Unaware if provided		Not applicable	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
HIV-positive persons	10	13	17	23	16	21	25	33	7	9
Men who have had sex with men	8	11	22	29	11	15	28	37	6	8
Injecting drug users	9	12	24	32	8	11	28	37	6	8
High-risk heterosexuals	7	9	20	27	13	17	29	39	6	8
Incarcerated persons	10	13	12	16	9	12	36	48	8	11
High-risk youth (13-24 yrs.)	5	7	24	32	13	17	27	36	6	8

Figure 15. Provision of Outreach to Priority Populations



HIV/AIDS Care-Related Services

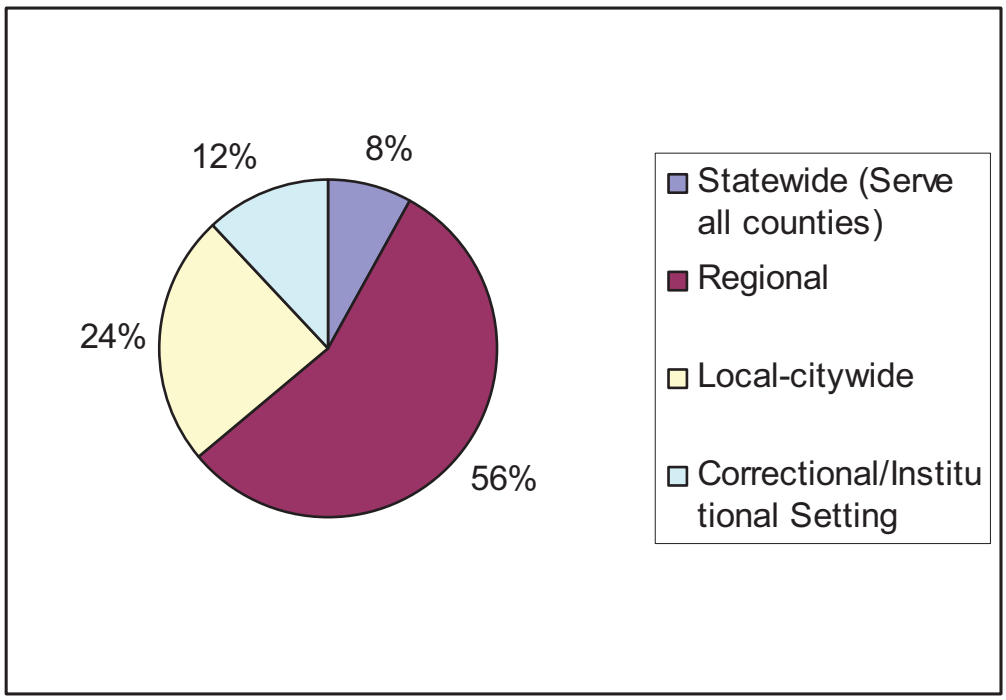
Geographic Area

Survey participants were asked whether or not their organization provided HIV/AIDS care-related services and, if so, what their service area was. Twenty-five of the respondents replied that their organization *did* provide HIV/AIDS care-related services. Of these agencies, only two describe their service areas as statewide. Over half had regional service areas Six agencies had citywide service areas and three served correctional or institutional settings (see Table 19 and Figure 16).

Table 19. Geographic Area Served by HIV/AIDS Care-Related Services

	Frequency	%
Statewide (Serve all counties)	2	8
Regional	14	56
Local-citywide	6	24
Correctional/Institutional Setting	3	12
Total	25	100

Figure 16. Geographic Area Served by HIV/AIDS Care-Related Services



Care Client Numbers

Survey participants were asked how many unduplicated clients their organization provided with HIV care services. A total of 3,410 clients were served by the 25 agencies, although there is duplication of clients between the agencies. The number of clients ranged from 2 to 900, with a mean of 136 (Table 20).

Table 20. HIV Care Client Numbers

	Survey Participants Responding	Total Number of Clients	Fewest Clients	Most Clients	Mean
Clients provided with HIV-care services	25	3,410	2	900	136

Hepatitis C Coinfection

The survey requested participants to estimate the percentage of their care clients who were co-infected with HIV/Hepatitis C. Only 12 participants responded. On average, 18% of clients were co-infected, with a range from 8% to 28%.

Coverage by County

Survey participants who identified the geographic area covered by their HIV/AIDS care-related services as regional were then asked to identify the counties served by their agencies. Cedar, Clinton, Hancock, Jackson, Johnson, Mahaska, Muscatine, Scott, and Washington Counties were each selected in by four agencies. Cherokee, Crawford, and Delaware Counties were not indicated as areas served by any of the participants who responded to this question; however, these counties may be covered by services offered through service providers identified by survey participants as statewide, local/citywide, or correctional/institutional. The complete distribution of responses is included in Table 21.

Table 21. Number of HIV Care Agencies with Regional Service Areas Serving Each County

County	# Agencies	County	# Agencies	County	# Agencies
Adair	1	Floyd	2	Monona	1
Adams	1	Franklin	3	Monroe	3
Allamakee	1	Fremont	1	Montgomery	1
Appanoose	3	Greene	3	Muscatine	4
Audubon	1	Grundy	2	O'Brien	1
Benton	1	Guthrie	1	Osceola	1
Black Hawk	2	Hamilton	1	Page	1
Boone	2	Hancock	4	Palo Alto	3
Bremer	1	Hardin	1	Plymouth	1
Buchanan	2	Harrison	1	Pocahontas	3
Buena Vista	1	Henry	3	Polk	2
Butler	1	Howard	1	Pottawattamie	1
Calhoun	3	Humboldt	2	Poweshiek	2
Carroll	2	Ida	1	Ringgold	1
Cass	1	Iowa	3	Sac	1
Cedar	4	Jackson	4	Scott	4
Cerro Gordo	3	Jasper	2	Shelby	1
Cherokee	0	Jefferson	3	Sioux	1
Chickasaw	1	Johnson	4	Story	1
Clarke	1	Jones	1	Tama	0
Clay	1	Keokuk	3	Taylor	1
Clayton	1	Kossuth	2	Union	1
Clinton	4	Lee	2	Van Buren	3
Crawford	0	Linn	1	Wapello	3
Dallas	2	Louisa	3	Warren	2
Davis	3	Lucas	2	Washington	4
Decatur	2	Lyon	1	Wayne	2
Delaware	0	Madison	2	Webster	3
Des Moines	3	Mahaska	4	Winnebago	2
Dickinson	1	Marion	3	Winneshiek	1
Dubuque	3	Marshall	2	Woodbury	1
Emmet	3	Mills	1	Worth	3
Fayette	1	Mitchell	3	Wright	2

Care Clients Served by Race and Ethnicity

Survey participants were asked for information on the race and ethnicity of their care clients.

Overall, 65% of clients were white, 19% were Black or African American, 10% were Hispanic, 4% were more than one race, and other groups accounted for 1% or fewer of clients (Table 22 and Figure 18). The ranges indicate that there is a wide variation among the agencies in the race and ethnicity of their clients. While 99% of the clients served by one agency are white, 94% of clients served by one agency are more than one race. Large standard deviations indicate large variability between the agencies.

No agency said that more than 50% of their clients were black or Hispanic. This indicates that no agency serves these populations exclusively or even predominantly.

Table 22. Race and Ethnicity of HIV Care Clients

	Mean %	Std. Deviation	Range
American Indian or Alaska Native	0.6	1.3	0-5%
Asian	1	2.1	0-10%
Black or African American	19	13	1-50%
Native Hawaiian or Other Pacific Islander	0.3	1.0	0-5%
Hispanic	10	13	0-49%
More than one race	4	18	0-94%
White	65	21	5-99%

Figure 17 shows the number of agencies that serve clients of each of the racial and ethnic groups. Native American clients were served by five agencies and pacific islanders by four. Black, non-Hispanic persons account for the largest minority group of persons with HIV/AIDS. They were served by all 25 agencies. Twenty agencies served HIV-positive Hispanic persons, the second largest minority group of persons with HIV/AIDS.

Figure 17. Number of Agencies Serving Racial and Ethnic Groups

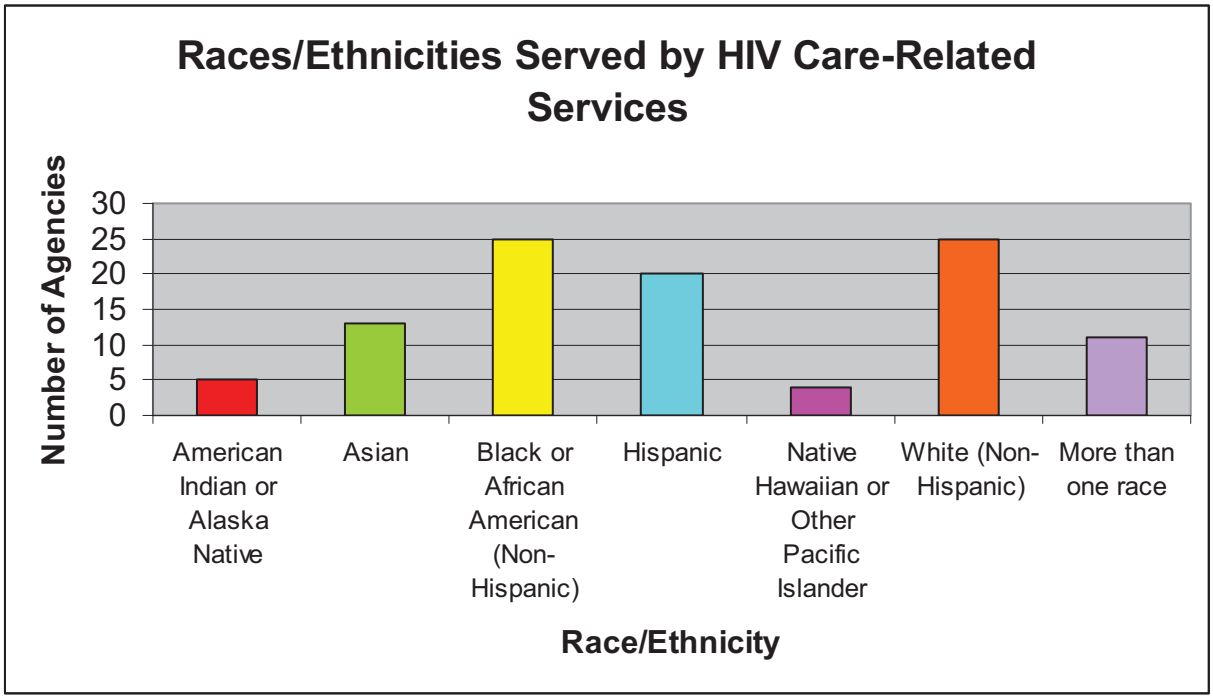
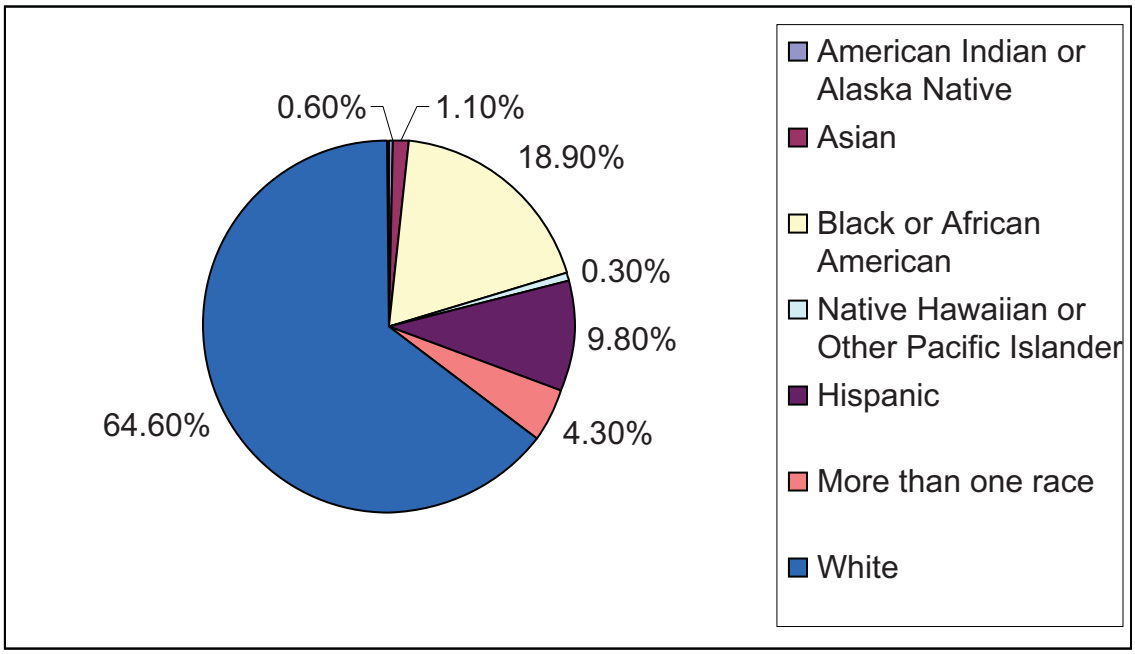


Figure 18. Race and Ethnicity of People Served with HIV/AIDS Care-Related Services



Funding Sources

Participants were asked to indicate what percentage of their total funding for HIV/AIDS care-related services came from a list of 12 options.

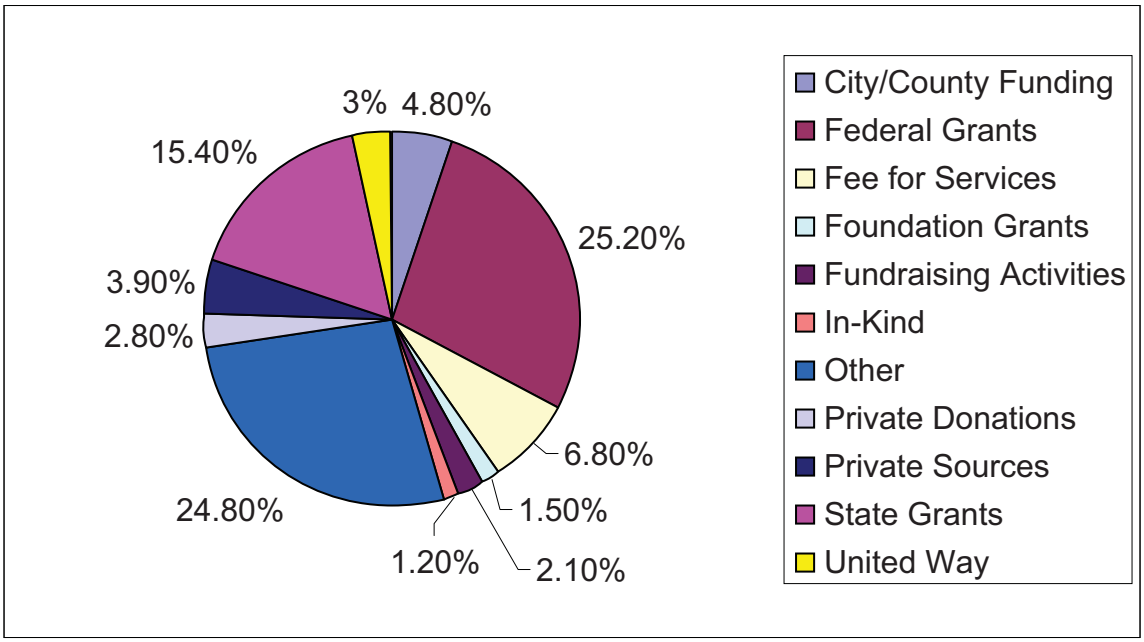
Nine survey participants indicated that 100% of their funding came from a single source, either federal grants (three respondents), state grants (two respondents), or other (four respondents). Overall, federal grants and "other" were the most frequent sources named. The complete breakdown of percentages per source is included in Table 23.

There were 10 sources that respondents wrote in under the category "other." Among these, the most frequently cited sources were some form of state-associated funding (in five responses) or private insurance/Medicaid (in two responses). The full list of other responses may be found in Appendix B.

Table 23. Sources of Funding for HIV/AIDS Care-Related Services

	Average Percent Funding	Std. Deviation (%)	Range
City/County Funding	5	18	0-90%
Federal Grants	25	34	0-100%
Fee for Services	7	18	0-79%
Foundation Grants	2	4	0-20%
Fundraising Activities	2	7	0-30%
In-Kind	1	4	0-20%
Other	25	38	0-100%
Private Donations	3	8	0-35%
Private Sources	4	9	0-35%
State Grants	15	33	0-100%
United Way	3	7	0-25%

Figure 19. Funding Sources for HIV Care Related Services



Health-related and Support Services

Survey participants indicated the health-related and support offered by their agencies or by another agency in their community. They were then asked which services, if funding were cut, they would most want to keep.

Among the services most often provided by the survey participants' own organizations/agencies were education (35%), case management (25%), and rides, transportation tokens, or vouchers (25%). Among the services that survey participants felt were not provided were child care (25%), scholarships or education assistance (21%), and buddy/volunteer support (13%). However, none of these services was included in the top five services that would be most important to continue if agency funding were cut.

The five services that survey participants judged most important to continue if agency funding were cut included case management (21%); prescription drugs (17%); medical care (16%); help paying for insurance premiums, co-payments, deductions (15%); and rides, transportation tokens or vouchers (13%).

A full account of the response frequencies and percentages may be found in Table 24.

Table 24. Health-related and Support Services in the Community

	Provided/ paid by own agency		Provided/ paid by another		Not provided		Would you want to keep this service?	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Alcohol and drug treatment: help with alcohol/drug addiction	7	9	19	28	0	0	4	5
Alternative/Complementary therapies: acupuncture, massage, chiropractics, etc.	4	5	17	23	8	11	0	0
Buddy/Volunteer support: help with daily living; practical and emotional support provided by trained volunteers	7	9	10	13	10	13	0	0
Case management: help figure out what services are needed and how to get them	19	25	11	15	3	4	16	21
Child care: help provide child care for people living with HIV	1	1	7	9	19	25	0	0
Client advocacy: provide support, education, and help in using services	18	24	9	12	3	4	8	11
Dental services: fillings, dental surgery, check-ups	15	20	15	20	2	3	4	5
Education: information on HIV disease, treatment, following doctor's advice, etc., including conferences, Internet, brochures, etc.	26	35	8	11	0	0	7	9
Employment assistance: help finding a job, developing a resume, job training, etc.	4	5	20	27	3	4	0	0
Food bank/Home-delivered meals: provide food and/or deliver meals to the client	8	11	19	25	3	4	0	0
Help paying bills: for heat, electricity, phone, etc. in case of an emergency (not case assistance)	12	16	21	28	3	4	6	8
Help paying for insurance premiums, co-payments, deductibles	12	16	12	16	7	9	11	15

Home health care: provide a nurse or helper in the home for medical help or personal care	8	11	18	24	3	4	3	4
Hospice care: provide medical and emotional care in the home or somewhere else for people near death or dying	3	4	23	31	2	3	1	1
Housing: financial assistance for rent and housing-related issues	13	17	14	19	3	4	5	7
Medical care: regular doctor or clinic visits, not including emergency room visits	18	24	14	19	1	1	12	16
Mental health/Support group/Counseling: to deal with feelings and problems about living with HIV	18	24	16	21	1	1	6	8
Prescription drugs: provide HIV/AIDS drugs for a small cost or free	14	19	15	20	2	3	13	17
Prevention services: talking with a case manager about HIV prevention, prevention support groups, etc.	15	20	10	13	6	8	5	7
Rides, transportation tokens or vouchers: to help travel to doctor's appointments or to get food	19	25	12	16	3	4	10	13
Scholarships or other education assistance: financial assistance to help clients return to school to compete a GED or higher education degree	5	7	7	9	16	21	0	0
Social support: events and activities designed to reduce isolation such as retreats or social groups	6	8	12	16	6	8	2	3

The five services that survey participants indicated would be most important for their agency to continue if funding were cut included case management; prescription drugs; medical care; help paying for insurance premiums, co-payments, deductions; and rides, transportation tokens, or vouchers.

Barriers and Plans for Prevention, Care, and Education Services

Barriers to STD/HIV/AIDS Prevention and Care-Related Services

When asked to identify significant barriers to or difficulties in the provision of STD/HIV/AIDS prevention and STD/HIV/AIDS care-related services, survey participants most often selected insufficient funding and insufficient staffing. These barriers were more often cited for prevention services than for care services.

Out of 75 participants, 49 identified insufficient funding as a significant barrier to or difficulty in the provision of prevention services; 39 for care-related services. Out of 75 participants, 42 chose insufficient staffing as a significant barrier to or difficulty in the provision of prevention services; 29 chose this for care-related services.

The option that was deemed least significant as a barriers or difficulty for delivery of prevention services was insufficient coordination and collaboration (41 respondents). Care providers responded that staff safety concerns and difficulty prioritizing diverse client needs (33 respondents each) were the least important barriers or difficulties. The complete breakdown of barriers to prevention services is included in Table 24; barriers to care-related services may be found in Table 25.

Table 24. Significant Barriers or Difficulties to the Provision of STD/HIV/AIDS Prevention Services
(Ordered by Most Frequent Response)

	Yes		No		Not Applicable	
	Freq.	%	Freq.	%	Freq.	%
Insufficient funding	49	65	6	8	20	27
Insufficient staffing	42	56	13	17	20	27
Increasing caseloads	34	45	20	27	21	28
Target population not aware of services	28	37	23	31	24	32
Training for staff	27	36	28	37	20	27
Lack of bilingual staff	26	35	27	36	22	29
Small size of target population	24	32	28	37	23	31
Lack of bilingual materials	22	29	30	40	23	31
Staff training in fundamentals of mental health	21	28	29	39	25	33
Difficulty in prioritizing diverse client needs	20	27	29	39	26	35
Difficulty in responding to programmatic requirements	20	27	29	39	26	35
Lack of culturally and ethnically appropriate staff	19	25	31	41	25	33
Recruiting qualified staff	18	24	33	44	24	32
Insufficient coordination, collaboration between providers	13	17	41	55	21	28
Staff retention	11	15	37	49	27	36
Restrictive laws surrounding drug use/sex work, etc.	9	12	33	44	33	44
Staff safety concerns	7	9	37	49	31	41

Table 25. Significant Barriers or Difficulties to the Provision of HIV/AIDS Care-Related Services
(Ordered by Most Frequent Response)

	Yes		No		Not Applicable	
	Freq.	%	Freq.	%	Freq.	%
Insufficient funding	38	51	6	8	31	41
Insufficient staffing	28	37	16	21	31	41
Increasing caseloads	25	33	19	25	31	41
Target population not aware of services	19	25	25	33	31	41
Training for staff	18	24	27	36	30	40
Lack of bilingual staff	16	21	27	36	32	43
Small size of target population	14	19	32	43	29	39
Staff training in fundamentals of mental health	14	19	29	39	32	43
Insufficient coordination, collaboration between providers	14	19	30	40	31	41
Lack of culturally and ethnically appropriate staff	13	17	29	39	33	44
Recruiting qualified staff	13	17	29	39	33	44
Difficulty in responding to programmatic requirements	12	16	29	39	34	45
Lack of bilingual materials	12	16	31	41	32	43
Difficulty in prioritizing diverse client needs	10	13	33	44	32	43
Staff retention	10	13	31	41	34	45
Staff safety concerns	8	11	33	44	34	45
Restrictive laws surrounding drug use/sex work, etc.	7	9	32	43	36	48

Accessibility

In assessing their respective agencies for clients' accessibility to services, 67% of participants noted that their agencies do not offer services to clients on a walk-in basis (without an appointment), only 24% offered transportation assistance, and only 15% offered weekend or evening appointments. Child care was not offered by 75% of respondents. Interpreters were offered by 36% of agencies and 45% had bilingual phone menus. See Table 26 for an account of survey participants' responses.

One possibly helpful addition to a future version of this survey would be a follow-up question to assess the relative importance of each of these issues and the reasons that the services are not offered (i.e., funding, capacity, staffing, etc).

Table 26. Accessibility Issues at Participants' Agencies

	True		Partially True		False		Don't Know		Does Not Apply	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Parking is available	64	85	6	8	0	0	0	0	5	7
Agency is near public transportation	52	69	4	5	9	12	0	0	10	13
Transportation is provided for clients	11	15	15	20	37	49	1	1	11	15
Transportation assistance (tokens, cab vouches, cash) is provided for clients	18	24	14	19	32	43	0	0	11	15
Agency building meets ADA handicap accessibility requirements	64	85	4	5	2	3	1	1	4	5
Agency is located near populations/ predominant community served	64	85	4	5	2	3	1	1	4	5
Agency is located near other agencies to which your agency refers clients	33	44	31	41	7	9	1	1	3	4
Agency is located near hospitals/clinics that your clients use	38	51	22	29	11	15	0	0	4	5
Child care is available	1	1	7	9	56	75	0	0	11	15
Interpreters/translators are available	27	36	31	41	12	16	0	0	5	7
Bilingual phone menus are available	34	45	17	23	13	17	0	0	11	15
Sign language interpreters are available	26	35	26	35	15	20	1	1	7	9
Staff is representative of the population(s) served	25	33	31	41	11	15	3	4	5	7
Hours or appointments are available evenings and/or weekends	11	15	18	24	37	49	2	3	7	9
Agency has a policy that allows walk-in clients to receive services without scheduling an appointment	8	11	8	11	50	67	4	5	5	7

Stigma Associated with HIV/AIDS

Survey participants were asked to assess whether stigma associated with HIV/AIDS had affected their agency in 1) its ability to access funding; 2) collaboration with other entities, such as schools, churches, etc.; and/or 3) clients' willingness to access the agency's services. The majority of survey participants responded that stigma associated with HIV/AIDS had not affected activity in these areas. Seventy-seven percent said stigma had not restricted funding opportunities, 85% said stigma had not affected their abilities to collaborate with other agencies, and 89% said stigma did not affect the willingness of their clients to access their services.

Agency Training/Capacity Building Needs

Survey participants were asked to assess the need of their agency or organization for training and/or technical assistance within the next three years.

Client-Related Training Needs

The top client-related training needs dealt with special needs of populations. Training on dealing with clients who were interacting with the criminal justice system, were active substance abusers, had mental health issues, or were methamphetamine users were selected by 40% of participants. The next most-frequently chosen topics were basic information about HIV, STDs, and hepatitis. A full breakdown of responses, in rank order, is presented in Table 27.

Table 27. Useful Client-Related Training Topics

	Frequency	%
Clients with special needs (i.e., criminal justice system, active substance abusers, mental health)	30	40
HIV and Meth use	30	40
HIV/AIDS 101 (basic information)	25	33
STD update	23	31
Hepatitis	18	24
Domestic violence/Intimate-partner violence	13	17
HIV/AIDS confidentiality law	13	17
Immigrant and migrant communities	13	17
HIV/AIDS treatment update	12	16
Human Papilloma Virus	12	16
Hepatitis/HIV co-infection	11	15
HIV/AIDS-related stigma	11	15
Prevention with persons living with HIV	11	15
Partner-delivered STD therapy	9	12
HIV disclosure	7	9
Human sexuality	7	9
Living with HIV/AIDS	7	9
STD/HIV co-infection	7	9
TB	7	9
Adherence to HIV treatment	5	7
Chlamydia	5	7
Herpes	5	7
Gonorrhea	2	3
Syphilis	1	1

Intervention Design and Evaluation Training Topics

The intervention design and evaluation topics that participants judged most useful for their agencies dealt with selecting interventions that matched the needs of their communities. Participants were able to select four options from a list of nine topics on intervention design and evaluation. See Table 28 for the complete information on participant responses to this question, in order of most frequently selected.

Table 28. Useful Intervention Design and Evaluation Training Topics

	Frequency	%
Matching community needs to interventions	36	48
Selecting and tailoring scientifically-proven/ evidence-based interventions	28	37
Conducting needs assessments	27	36
Writing realistic program goals and objectives	26	35
Program monitoring/evaluation	25	33
Behavior change theory and application	22	29
Evaluating client-level outcomes	21	28
Data analysis for program improvement	16	21
Using statistics for program planning	11	15

Intervention Areas/Skills Training Topics

Participants were asked to select four intervention areas and skills trainings that would be most useful for their agencies. Risk reduction and behavior change was the only topic selected by at least one-fourth of respondents. Counseling skills, outreach, and presentation skills were the next most popular choices. The complete tally of responses, in order of rank, is included in Table 29.

Table 29. Intervention Areas/Skills Training Topics

	Frequency	%
Risk reduction/Behavior change	25	33
Counseling skills	18	24
Outreach – beyond materials distribution	17	23
Presentation skills	17	23
Faithfully implementing scientifically-proven/evidence-based interventions	15	20
Managing challenging client situations	15	20
Prevention Counseling	14	19
Developing training curriculum	10	13
Outreach as a marketing tool	9	12
Social marketing	9	12
Harm reduction	8	11
Partner notification	8	11
Prevention case management	8	11
Sexual history taking	8	11
Conducting skills-building workshops	6	8
Group facilitation	6	8
HIV/AIDS-Related stigma	6	8
Developing care plans/documentation	5	7
Vaccine administration, scheduling, and storage (Hepatitis A & B)	5	7
Care case management	4	5
Family-centered case management	4	5
Providing and tracking appropriate referrals	4	5
Implementing multi-session interventions	3	4
Working with sero-discordant couples	3	4

Organizational Infrastructure Training Needs

Participants were asked to choose up to four training topics on organizational infrastructural. Nearly half of the respondents answered that they needed training on engaging target populations. The next most popular response was training on grant writing. Few respondents needed help with the logistics of running an agency. Budgeting, staff hiring and recruitment, and board development were selected by few respondents. The complete tally of responses is included in Table 30.

Table 30. Organizational Infrastructure Training Topics

	Frequency	%
Engaging the target populations	37	49
Grant writing	30	40
Cultural competence	21	28
Developing interventions	20	27
Collaboration with other agencies	19	25
Strengthening referral services	18	24
Marketing/Public relations	16	21
Fundraising	12	16
Staff supervision/coaching	12	16
Volunteer recruitment and training	7	9
Budgeting and budget management	5	7
Staff recruitment and hiring	3	4
Board development	2	3

Other Training Topics

Participants had the opportunity to list in free-form text response any other issues that they would like to see covered in training. Eight out of 75 participants entered a response, but only five of these responses addressed the request, and there were no obvious or recurring themes:

> "Any and all available training that would give staff professional knowledge."
>
> "Dealing with offenders (persons in corrections) in this area. Ongoing training, not band-aide type training."
>
> "Continued updates on HIV/AIDS stats in Iowa, specifically in Polk County."
>
> "Updates on prevention and counseling."
>
> "Our biggest challenge is achieving local funding, due to a reluctance of citizens to recognize that youth are sexually active and need skills and resources in order to make good decisions. We also face the same challenge in convincing the local citizens that youth are doing drugs, including alcohol. Overcoming community denial is an ongoing issue. The services we provide are excellent for the targeted populations we are funded

for---kids in the system---and we do see an increase in a desire to be safer among a lot of these youth. We need to find a way to get access to and funding for providing education to all sexually active individuals--the chlamydia epidemic shows us how great the risk is for other infections."

Summary and Recommendations

The purpose of this survey was to assess which STD/HIV/AIDS prevention and care services are provided by agencies/organizations throughout the state. The following summary and recommendations highlight 1) information regarding those services, populations, and geographic areas for which survey participants' responses indicate perceived gaps; and 2) what additional resources were requested to fill these gaps.

- Fewer responding agencies provided STD prevention, testing, and treatment services (26 out of 75, or 35%) than HIV/AIDS prevention services (58 out of 75, or 77%). The disparity may be an artifact of the type of agencies to which the survey was sent. However, future versions of this survey could be amended with questions to ascertain the level of need for additional STD services from the perspective of the participating service provider representatives.

- One potential gap in STD/HIV/AIDS prevention services relates to injecting drug users. Injecting drug users were one of the populations for whom participants indicated that a variety of interventions (community level interventions, health communication/public information programs, etc.) were less adequately provided than for other populations. This was echoed in the services reported for this population. For example, needle access and exchange services were offered by only one agency/organization.

- Less than half of the survey participants who reported that their agency provided HIV prevention services indicated that their agencies made use of evidence-based interventions. This seems low given the requirements for use of evidence-based practices. IDPH may want to consider providing additional technical support and/or more closely linking funding to the provision of evidence-based practices.

- The responses related to the race and ethnicity of clients served with prevention and care services would seem to suggest that further analysis should be done to determine whether the reported percentages align with demographics in the specific areas represented by the agencies participated in the survey. In 2004, persons of Hispanic or Latino origin accounted for 3.5% of the overall population in Iowa, 2.3% were Black, and 1.4% were Asian (see http://quickfacts/census.gov/qfd/states/19000.html), but percentages may be higher in specific communities served by agencies/organizations represented by survey participants. Comparison with census data may help with planning for services.

- There is a potential gap in services related to group- and community-level interventions when compared to individual-level interventions. The percentages of participants who indicated that individual-level interventions were not provided ranged between three and eight; for group-level and community-level interventions, the percentages ranged from eight to 19. Specifically, multi-session group interventions for HIV-negative and HIV–positive individuals were provided much less often than individual risk reduction, counseling, and education, and were the least often provided services overall. Many evidence-based practices involve group interaction; moreover, groups are more cost-effective. IDPH may want to explore barriers to the provision of group- and community-level interventions, especially as such interventions relate to evidence-based practices.

- Several gaps in county coverage for prevention and care services were noted among agencies that had regional service areas. For prevention services, Pottawattamie County was not selected; and Cherokee, Crawford, and Delaware were not selected by care service providers. However, these counties may still be covered by statewide, local-citywide, or correctional/institutional agencies or organizations. Given that 118 agencies did not respond to the survey, there may be agencies not represented in the survey that serve Pottawattamie, Cherokee, Crawford, and Delaware counties. Such a possibility would seem to merit further investigation into the situation before conclusions are drawn from the survey response data.

- Survey participants named insufficient funding and staffing as significant barriers to the delivery of prevention and care services. Of particular concern is the number of survey participants who reported single-sources of funding for their agency or organization. For HIV/AIDS prevention service providers, 15 participants indicated that 100% of their funding came from a single source. Of the HIV/AIDS care service providers, 10 participants had a single source of funding; and 24 STD service providers had one source of funding. IDPH may want to consider how to help agencies/organizations identify other sources of support – whether through finding other funders or through diversifying into related services which may bring additional revenue streams. While some agencies may be unable to seek additional funding sources, others may benefit from encouragement to seek out different sources of revenue in light of federal budget reductions. Additionally, a number of agencies reported a high percentage of funding from "Other" sources. Further exploration of these responses may help determine if these responses stemmed from a misunderstanding of funding sources for the specific area (e.g., HIV prevention), or whether agencies have truly located alternative funding sources.

- In assessing their own respective agencies in terms of clients' accessibility to services, more than half the survey participants noted that their agency does not offer services to clients on a walk-in basis (i.e., clients seen without an appointment). Just less than half noted that transportation is not provided for clients and that evening and/or weekend appointments are not available. Future versions of this survey would benefit from a follow-up question to assess the relative importance of each of these issues for specific populations.

- A number of survey participants identified training on grant writing as potentially helpful to them. This may reflect the concerns that participants voiced in relation to the funding received by their agencies/organizations, and the single-source nature of this funding for so many of them. Survey participants also indicated a desire for further training in engaging the target populations, risk reduction/behavior change, counseling skills, and matching interventions to their community needs. Such responses, in combination with the apparent emphasis on traditional, individual-oriented services, may suggest a need for more systemic considerations, conceptualizations, and approaches to the STD and HIV prevention and care services.

▪ *Appendix A – Iowa Department of Public Health Survey*

The purpose of this survey is to assess what STD/HIV/AIDS prevention and care services are provided by organizations throughout Iowa. The questions in this booklet ask about the services provided by **your organization/agency**, your perception of services provided to different populations, and your opinion about STD/HIV/AIDS needs in the state. If your agency has multiple sites, answer for your location.

Thank you for your assistance.

1 Name: _____

2 Agency/Organization: _____

3 Address: _____

4 City:_____ 5 State: _____

6 Zip: _____ - _____

7 Phone Number: _____/_____

PART I: AGENCY DESCRIPTION

1. Which best describes the principal function of your agency? **(Check one)**

- ☐ 1 Corrections
- ☐ 2 Community Based Organization (CBO)
- ☐ 3 Community Health Center
- ☐ 4 Community Mental Health Center
- ☐ 5 Drug and Alcohol Prevention and/or Treatment Services
- ☐ 6 Family Planning Agency
- ☐ 7 Gay/Lesbian/Bisexual Service
- ☐ 8 Government Social Service Agency
- ☐ 9 Hospital "Inpatient"
- ☐ 10 Hospital "Outpatient"
- ☐ 11 Maternal/Child Health Clinic
- ☐ 12 Migrant Worker Service Provider
- ☐ 13 Primary Care
- ☐ 14 Private, For-Profit Agency
- ☐ 15 Public Health Agency
- ☐ 16 STD Clinics
- ☐ 17 Tribal Clinic
- ☐ 18 Other (Specify): _____

PART II: PREVENTION SERVICES PROVIDED BY YOUR AGENCY

2. We define **STD/HIV/AIDS prevention services** as activities that help prevent transmission of HIV and other STDs. The services include a range of activities that focus on individuals, groups, or communities. The activities may include outreach, education, counseling, testing, and other activities in which the primary objective is to prevent the transmission of STDs and HIV.

   Does your organization currently provide HIV/AIDS prevention services?

   ☐ 1 Yes, go to question 3
   ☐ 2 No, go to question 7

3. Which best describes the geographic area your organization/agency serves for prevention services? **(Check one)**

   ☐ 1 Statewide (Serve all counties)
   ☐ 2 Regional
   ☐ 3 Local-citywide
   ☐ 4 Correctional/Institutional Setting

If regional, check the counties:

☐ 1. Adair	☐ 21. Clay	☐ 41. Hancock	☐ 61. Madison	☐ 81. Sac
☐ 2. Adams	☐ 22. Clayton	☐ 42. Hardin	☐ 62. Mahaska	☐ 82. Scott
☐ 3. Allamakee	☐ 23. Clinton	☐ 43. Harrison	☐ 63. Marion	☐ 83. Shelby
☐ 4. Appanoose	☐ 24. Crawford	☐ 44. Henry	☐ 64. Marshall	☐ 84. Sioux
☐ 5. Audubon	☐ 25. Dallas	☐ 45. Howard	☐ 65. Mills	☐ 85. Story
☐ 6. Benton	☐ 26. Davis	☐ 46. Humboldt	☐ 66. Mitchell	☐ 86. Tama
☐ 7. Black Hawk	☐ 27. Decatur	☐ 47. Ida	☐ 67. Monona	☐ 87. Taylor
☐ 8. Boone	☐ 28. Delaware	☐ 48. Iowa	☐ 68. Monroe	☐ 88. Union
☐ 9. Bremer	☐ 29. Des Moines	☐ 49. Jackson	☐ 69. Montgomery	☐ 89. Van Buren
☐ 10. Buchanan	☐ 30. Dickinson	☐ 50. Jasper	☐ 70. Muscatine	☐ 90. Wapello
☐ 11. Buena Vista	☐ 31. Dubuque	☐ 51. Jefferson	☐ 71. O'Brien	☐ 91. Warren
☐ 12. Butler	☐ 32. Emmet	☐ 52. Johnson	☐ 72. Osceola	☐ 92. Washington
☐ 13. Calhoun	☐ 33. Fayette	☐ 53. Jones	☐ 73. Page	☐ 93. Wayne
☐ 14. Carroll	☐ 34. Floyd	☐ 54. Keokuk	☐ 74. Palo Alto	☐ 94. Webster
☐ 15. Cass	☐ 35. Franklin	☐ 55. Kossuth	☐ 75. Plymouth	☐ 95. Winnebago
☐ 16. Cedar	☐ 36. Fremont	☐ 56. Lee	☐ 76. Pocahontas	☐ 96. Winneshiek
☐ 17. Cerro Gordo	☐ 37. Greene	☐ 57. Linn	☐ 77. Polk	☐ 97. Woodbury
☐ 18. Cherokee	☐ 38. Grundy	☐ 58. Louisa	☐ 78. Pottawattamie	☐ 98. Worth
☐ 19. Chickasaw	☐ 39. Guthrie	☐ 59. Lucas	☐ 79. Poweshiek	☐ 99. Wright
☐ 20. Clarke	☐ 40. Hamilton	☐ 60. Lyon	☐ 80. Ringgold	

4. Estimate the percentage of the people you serve that are:

   ___% American Indian or Alaska Native
   ___% Asian
   ___% Black or African American (Non-Hispanic)
   ___% Hispanic
   ___% Native Hawaiian or Other Pacific Islander
   ___% White (Non-Hispanic)

___% More than one race

___
100%

5. In the last fiscal/calendar year, what percent of your total funding for HIV/AIDS Prevention came from the following sources? **(Check all that apply)**

☐ 1 City/County Funding _____%
☐ 2 Federal Grant(s) _____%
☐ 3 Fee for Services _____%
☐ 4 Foundation Grants _____%
☐ 5 Fund-raising Activities _____%
☐ 6 In-Kind _____%
☐ 7 Private Donations _____%
☐ 8 Private Source(s) _____%
☐ 9 State Grant(s) _____%
☐ 10 United Way _____%
☐ 11 Other (specify):_____

6. Last year, approximately how many "**unduplicated"** clients were provided HIV prevention services? _____

7. Does your organization currently provide **STD prevention, testing, and treatment services?**

☐ 1 Yes, go to question 8
☐ 2 No, go to question 10

8. In the last fiscal/calendar year, what percent of your total STD funding came from the following sources? (**Check all that apply**)

☐ 1 City/County Funding _____%
☐ 2 Federal Grant(s) _____%
☐ 3 Fee for Services _____%
☐ 4 Foundation Grants _____%
☐ 5 Fund-raising Activities _____%
☐ 6 In-Kind _____%
☐ 7 Private Donations _____%
☐ 8 Private Source(s) _____%
☐ 9 State Grant(s) _____%
☐ 10 United Way _____%
☐ 11 Other (specify):_____

9. Last year, approximately how many **unduplicated** clients were provided STD services?
_____

10. Which of the following STD/HIV/AIDS prevention-related activities and/or services **does your agency offer? (Check all that apply)**

- ☐ 1 Basic information about HIV prevention, e.g.,AIDS 101
- ☐ 2 Condom distribution
- ☐ 3 Hepatitis A vaccine
- ☐ 4 Hepatitis B vaccine
- ☐ 5 Hepatitis C counseling and testing
- ☐ 6 HIV negative multi-session group interventions
- ☐ 7 HIV positive multi-session group interventions
- ☐ 8 HIV prevention case management
- ☐ 9 HIV referrals (e.g., counseling, testing, medical and support groups)
- ☐ 10 Individual risk reduction counseling and education
- ☐ 11 Mass media campaign (billboards, newspaper/magazine advertisements , television public service announcements)
- ☐ 12 Needle access
- ☐ 13 Needle exchange
- ☐ 14 On-site HIV counseling, testing, and referral
- ☐ 15 Offsite (i.e., bars, parks, etc.) HIV counseling, testing, and referral
- ☐ 16 Peer education programs
- ☐ 17 Role model stories
- ☐ 18 School-based education
- ☐ 19 Sessions targeting those in alcohol and/or drug treatment
- ☐ 20 Skills training on how to negotiate condom use with a sex partner
- ☐ 21 Skills training on the proper use of condoms through a demonstration
- ☐ 22 Street outreach (defined as HIV prevention, education, counseling, and referrals for persons who engage in high-risk activities, delivered at informal sites, such as bars, parks, shooting galleries, bathhouses, beauty parlors, or other community congregation sites)
- ☐ 23 STD/HIV/AIDS educational materials (e.g., print, audiovisual) distribution
- ☐ 24 STD screening and treatment
- ☐ 25 Telephone information and counseling

11. Does your agency provide any of the following interventions/programs?
Yes _____ No _____
If yes, check all that apply:

- ☐ 1 BART
- ☐ 2 Community PROMISE
- ☐ 3 Focus on Kids
- ☐ 4 Healthy Relationships
- ☐ 5 Holistic Health Recovery Program
- ☐ 6 MPowerment
- ☐ 7 Making Proud Choices
- ☐ 8 Many Men, Many Voices
- ☐ 9 Options

☐ 10 Parents Matter
☐ 11 Partnership for Health
☐ 12 Popular Opinion Leader
☐ 13 Power Moves
☐ 14 Real AIDS Prevention Project (RAPP)
☐ 15 Respect
☐ 16 Safety Counts
☐ 17 SiHLE
☐ 18 SISTA
☐ 19 Street Smart
☐ 20 Teens Linked to Care
☐ 21 VOICES/VOCES
☐ 22 Willow
☐ 23 Other

12. In the past year, what populations did you reach in your HIV/STD/Hepatitis prevention-related activities and/or services? **(Check all that apply)**

	HIV	STD	Hepatitis	None Served	N/A
Developmentally disabled					
General population					
Heterosexual sex with someone at risk for or infected with HIV					
Homeless					
Incarcerated					
Injection drug users					
Lesbians/Bisexual Women					
Transgenders					
Low social-economic status					
Medical professionals					
Mentally ill					
Men who have sex with men					
Men who have sex with men and inject drugs					
Partners or family members of persons living with HIV					
Persons infected with STDs (other than HIV)					
Persons living with Hepatitis C					
Persons living with HIV/AIDS					
Pregnant					
Sex workers (prostitutes)					
Substance abusers					
Trading sex for drugs/money/shelter					
Visually or hearing impaired					
Women who are at risk for or infected w/HIV					

Young adults (13 – 24)					
Other (specify)_____					

13. **HIV Prevention Services** for Selected Populations in Your Service Area

This question asks about prevention services for selected populations in your area. Please assess the services provided in your area, but not necessarily by your agency. Use the following grid and assessment scale.

1 = Not provided at all; potential service gap
2 = Somewhat provided but not in sufficient quantity to meet demand
3 = Adequately provided
4 = I am unaware of the status of this service
5 = Not applicable

Write the number from the scale which best represents the services described for each of the corresponding populations.

Example: *If I thought that in my agency's service area HIV prevention services were "adequately provided" on an individual basis for men who have sex with men, I would write "3" in the box below.*

	Prevention Services Provided in Your Service Area:	**HIV Positive Persons**	**Men Who Have Sex With Men**	**Injecting Drug Users**	**High -Risk Heterosexuals**	**Incarcerated**	**High- Risk Youth (13-24)**
a.	**Individual Level Intervention:** Health education and risk reduction counseling for individuals. This includes helping clients make plans for behavior change and providing referrals for services in both clinic and community settings.						
b.	**Group Level Intervention:** Health education and risk reduction education for groups of individuals. Uses both peer and non-peer models and includes informational, skill-building education and support programs.						
c.	**Community Level Interventions:** Programs that target the selected community, involve community members in the design and delivery, and attempt to change community norms, attitudes, values, and behaviors. These include tailored prevention messages, social marketing, community mobilization/organization, community-wide events, and structural interventions.						
d.	**Health Communication/Public Information Programs:** The delivery of planned HIV/AIDS prevention messages that target selected populations and aim to dispel myths about HIV transmission. The messages support volunteerism for HIV prevention programs, reduce discrimination toward individuals with HIV/AIDS, and promote support for strategies and interventions that contribute to HIV prevention in the community. Includes electronic and print media, hotlines, clearinghouses, and single-session presentations and lectures.						
e.	**HIV Prevention Capacity Building:** 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.						
f. **Prevention Case Management (PCM):** 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. Concentrates on primary prevention, (preventing HIV transmission), and secondary interventions (advocating for early medical interventions to prevent or delay the onset of symptoms in HIV infected clients.						
g. **Outreach:** 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).						

PART III: CARE AND SUPPORT FOR PERSONS WHO ARE HIV INFECTED

14. Does your agency provide **HIV/AIDS care-related services?**

☐1 Yes, go to question 15
☐2 No, go to Part IV

15. Which best describes the geographic area your agency serves for care services? **(Check one)**

☐1 Statewide (Serve all counties)
☐2 Regional
☐3 Local-citywide
☐4 Correctional/Institutional Setting

If regional, check the counties:

☐ 1. Adair	☐ 21. Clay	☐ 41. Hancock	☐ 61. Madison	☐ 81. Sac
☐ 2. Adams	☐ 22. Clayton	☐ 42. Hardin	☐ 62. Mahaska	☐ 82. Scott
☐ 3. Allamakee	☐ 23. Clinton	☐ 43. Harrison	☐ 63. Marion	☐ 83. Shelby
☐ 4. Appanoose	☐ 24. Crawford	☐ 44. Henry	☐ 64. Marshall	☐ 84. Sioux
☐ 5. Audubon	☐ 25. Dallas	☐ 45. Howard	☐ 65. Mills	☐ 85. Story
☐ 6. Benton	☐ 26. Davis	☐ 46. Humboldt	☐ 66. Mitchell	☐ 86. Tama
☐ 7. Black Hawk	☐ 27. Decatur	☐ 47. Ida	☐ 67. Monona	☐ 87. Taylor
☐ 8. Boone	☐ 28. Delaware	☐ 48. Iowa	☐ 68. Monroe	☐ 88. Union
☐ 9. Bremer	☐ 29. Des Moines	☐ 49. Jackson	☐ 69. Montgomery	☐ 89. Van Buren
☐ 10. Buchanan	☐ 30. Dickinson	☐ 50. Jasper	☐ 70. Muscatine	☐ 90. Wapello
☐ 11. Buena Vista	☐ 31. Dubuque	☐ 51. Jefferson	☐ 71. O'Brien	☐ 91. Warren
☐ 12. Butler	☐ 32. Emmet	☐ 52. Johnson	☐ 72. Osceola	☐ 92. Washington
☐ 13. Calhoun	☐ 33. Fayette	☐ 53. Jones	☐ 73. Page	☐ 93. Wayne
☐ 14. Carroll	☐ 34. Floyd	☐ 54. Keokuk	☐ 74. Palo Alto	☐ 94. Webster
☐ 15. Cass	☐ 35. Franklin	☐ 55. Kossuth	☐ 75. Plymouth	☐ 95. Winnebago
☐ 16. Cedar	☐ 36. Fremont	☐ 56. Lee	☐ 76. Pocahontas	☐ 96. Winneshiek
☐ 17. Cerro Gordo	☐ 37. Greene	☐ 57. Linn	☐ 77. Polk	☐ 97. Woodbury
☐ 18. Cherokee	☐ 38. Grundy	☐ 58. Louisa	☐ 78. Pottawattamie	☐ 98. Worth
☐ 19. Chickasaw	☐ 39. Guthrie	☐ 59. Lucas	☐ 79. Poweshiek	☐ 99. Wright
☐ 20. Clarke	☐ 40. Hamilton	☐ 60. Lyon	☐ 80. Ringgold	

16. Estimate the percentage of the people you serve that are:

___% American Indian or Alaska Native
___% Asian
___% Black or African American (Non-Hispanic)
___% Hispanic
___% Native Hawaiian or Other Pacific Islander
___% White (Non-Hispanic)
___% Other
100%

17. In the last fiscal/calendar year, what were the sources of your HIV/AIDS care funding? **(Check all that apply)**

☐ 1 City/County Funding _____%
☐ 2 Federal Grant(s) _____%
☐ 3 Fee for Services _____%
☐ 4 Foundation Grants _____%
☐ 5 Fund-raising Activities _____%
☐ 6 In-Kind _____%
☐ 7 Private Donations _____%
☐ 8 Private Source(s) _____%
☐ 9 State Grant(s) _____%
☐ 10 United Way _____%
☐ 11 Other (specify):_____

18. Last year, approximately how many **"unduplicated"** clients were provided HIV care services? _____

19. Estimate the percentage of the people you serve that are co-infected with HIV/Hepatitis C. _____% Don't Know _____

20. In the following columns please indicate if the following services are provided or paid for by your agency or another agency in your community	…please check those services provided or paid by your agency.	…please check services that are provided or paid by another agency in your community.	…please check those services not provided at all in your community	If finding were cut check **up to five** of the most important services you would keep. If not applicable, leave blank.
a) **Alcohol and Drug Treatment:** help with alcohol/drug addiction				
b) **Alternative/Complementary Therapies**: acupuncture, massage, chiropractics, etc.				
c) **Buddy/Volunteer Support**: help with daily living practical and emotional support provided by trained volunteers				

d) **Case Management**: help figure out what services are needed and how to get them				
e) **Child Care**: help provide child care for people living with HIV				
f) **Client Advocacy:** provide support, education, and help in using services				
g) **Dental Services:** fillings, dental surgery, check ups				
h) **Education:** information on HIV disease, treatment, following doctor's advice, etc. including conferences, internet, brochures, etc.				
i) **Employment Assistance:** help finding a job, developing a resume, job training, etc.				
j) **Food Bank/Home Delivered Meals:** provide food and/or deliver meals to the client				
k) **Help Paying Bills:** for heat, electricity, phone, etc. in case of an emergency. This is not cash assistance.				
l) **Help Pay for Insurance Premiums, Co-Pays, Deductibles:**				
m) **Home Health Care:** provide a nurse or helper in the home for medical help or personal care				
n) **Hospice Care:** provide medical and emotional care in the home or somewhere else for people near death or dying				
o) **Housing**: financial assistance for rent and housing-related issues				
p) **Medical Care**: regular doctor or clinic visits, not including emergency room visits				
q) **Mental Health/Support Group/Counseling:** to deal with feelings and problems about living with HIV				
r) **Prescription Drugs**: provide HIV/AIDS drugs for a small cost or free				
s) **Prevention Services:** talking with a case manager about HIV prevention, prevention support groups, etc.				
t) **Rides, Transportation Tokens or Vouchers**: to help travel to doctor's appointments or to get food				
u) **Scholarships or other Educational Assistance:** financial assistance to help clients return to school to complete a GED or higher education degree				
v) **Social Support:** events and activities designed to reduce isolation such as retreats, or social groups				

PART IV: BARRIERS AND PLANS FOR PREVENTION, CARE, AND EDUCATION SERVICES

There are times when an organization offers STD/HIV prevention and care services, but has difficulty in delivering those services in an adequate or effective way. The questions that follow ask about the experience of your organization as a provider of STD/HIV prevention and/or care services and the barriers or difficulties your organization has faced.

21. Which of the following are **significant** barriers or difficulties to the provision of STD/HIV/AIDS prevention and care services for your agency?

	Prevention			**Care**		
Barriers/Difficulties	**Yes**	**No**	**Not Applicable**	Yes	No	**Not Applicable**
a. Insufficient funding						
b. Insufficient staffing						
c. Staff retention						
d. Lack of culturally and ethnically appropriate staff						
e. Training for staff						
f. Recruiting qualified staff						
g. Staff safety concerns						
h. Increasing caseloads						
i. Small size of target population						
j. Target population not aware of services						
k. Difficulty in prioritizing diverse client needs						
l. Insufficient coordination, collaboration between providers						
m. Lack of bilingual staff						
n. Lack of bilingual materials						
o. Restrictive laws surrounding drug use/sex work, etc.						
p. Difficulty in responding to programmatic requirements						
q. Staff training in fundamentals of mental health						

22. Please rate each statement as True, Partially True or False for your agency.

Answer True if the statement is true of your agency, without limitations or restrictions; Answer partially true if this service is available at your agency with limitations or restrictions or only in particular circumstances, answer false if the statement is not true of your agency under any circumstances.

Some examples of partially true/limitations/limited availability statements would be:

Item 'E': (Handicap Accessibility) Your agency does have a wheelchair ramp, but does not meet all ADA accessibility requirements.

Item 'I': (Child Care) Your agency can provide child care in specific circumstances, but it must be arranged in advance and is not offered on a routine basis.

	TRUE	Partially True/Limitations/Limited Availability	FALSE	Don't Know	Doesn't apply to my agency
a. Parking is available					
b. Agency is accessible by public transportation					
c. Transportation (rides) is provided for clients					
d. Transportation assistance (tokens, cab voucher, cash) is provided for clients					
e. Agency building meets ADA handicap accessibility requirements					
f. Agency is located near population/predominant community served					
g. Agency is located near other agencies to which your agency refers clients					
h. Agency is located near hospitals/clinics that your clients use					
i. Child care is available					
j. Interpreters/translators are available					
k. Bilingual phone menu is available					
l. Sign language interpreters are available					
m. Staff is representative of the population(s) served					
n. Hours or appointments are available on evenings and/or weekends					
o. Agency has a policy that allows walk-in clients to receive services without scheduling an appointment					

23. In the past 12 months has stigma associated with HIV/AIDS affected your agency's: (check all that apply)

____ ability to access funding

____ collaboration with other entities (schools, churches, other service agency)

____ clients willingness to access your services

PART V: TRAINING/CAPACITY BUILDING NEEDS

The following questions are designed to assess your need for training and/or technical assistance within the next three years. Please check (√) or fill in the response that best represents your agency's needs..

1. Which of the following *client-related topics* would be useful for your agency? Please √ **up to 4 topics** that would be useful for your agency.

- ☐ HIV/AIDS 101 (Basic Information)
- ☐ HIV/AIDS Confidentiality Law
- ☐ HIV/AIDS Treatment Update
- ☐ HIV/AIDS Related Stigma
- ☐ Hepatitis
- ☐ Hepatitis/HIV Co-infection
- ☐ TB
- ☐ Chlamydia
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Human Papilloma Virus
- ☐ Herpes
- ☐ STD/HIV Co-infection
- ☐ Partner Delivered STD Therapy
- ☐ STD Update
- ☐ HIV and Meth Use
- ☐ Living with HIV/AIDS
- ☐ Human Sexuality
- ☐ Adherence to HIV Treatment
- ☐ HIV Disclosure
- ☐ Domestic Violence/Intimate Partner Violence
- ☐ Clients with special needs, i.e., Criminal Justice System, Active Substance Abusers, Mental Health
- ☐ Immigrant and Migrant Communities
- ☐ Prevention with Persons Living with HIV

2. Which of the following topics would be <u>useful to your agency</u> in the area of *Intervention Design and Evaluation*? Please √ **up to 4 topics** that would be most useful for your agency.

- ☐ Conducting Needs Assessments
- ☐ Behavior Change Theory and Application
- ☐ Writing Realistic Program Goals and Objectives
- ☐ Matching Community Needs to Interventions
- ☐ Data Analysis for Program Improvement
- ☐ Program Monitoring/Evaluation
- ☐ Using Statistics for Program Planning
- ☐ Evaluating Client Level Outcomes
- ☐ Selecting and Tailoring Scientifically Proven/Evidence Based Interventions

3. In which of the following *Intervention areas/Skills* does your agency need training? Please √ **up to 4 topics** that would be most useful for your agency.

- ☐ Conducting Skills Building Workshops
- ☐ Outreach as a Marketing Tool
- ☐ Outreach – Beyond Materials Distribution
- ☐ Developing Training Curriculum
- ☐ Presentation Skills
- ☐ Faithfully Implementing Scientifically Proven/Evidence-Based Interventions
- ☐ Implementing Multi-Session Interventions
- ☐ Counseling Skills
- ☐ Prevention Counseling
- ☐ Risk Reduction/Behavior Change
- ☐ Harm Reduction
- ☐ Vaccine Administration, Scheduling, and Storage (Hepatitis A & B)
- ☐ Group Facilitation
- ☐ Social Marketing
- ☐ Care Case Management
- ☐ Prevention Case Management
- ☐ Family Centered Case Management
- ☐ Developing Care Plans/Documentation
- ☐ Managing Challenging Client Situations
- ☐ Providing and Tracking Appropriate Referrals
- ☐ Sexual History Taking
- ☐ Partner Notification
- ☐ Working with Sero-discordant Couples
- ☐ HIV/AIDS Related Stigma

4. Which of the following topics would be useful to your agency in the area of *Organization Infrastructure*? Please √ **up to 4 topics** that would be most useful for your agency.

- ☐ Board Development
- ☐ Developing Interventions
- ☐ Budgeting and Budget Management
- ☐ Volunteer Recruitment and Training
- ☐ Collaboration with Other Agencies
- ☐ Staff Supervision/Coaching
- ☐ Marketing/Public Relations
- ☐ Grant Writing
- ☐ Fund Raising
- ☐ Staff Recruitment and Hiring
- ☐ Strengthening Referral Services
- ☐ Cultural Competence
- ☐ Engaging the Target Population

5. In the space below, please list other issues that you would like to see covered in a training.
6.

_____

_____

_____

Thank you for completing this survey.

Appendix B – Iowa Department of Public Health Survey: Text Responses

Note: In all cases in this report in which survey respondents' text comments appear, they are presented with the respondents' own use of spelling, capitalization, punctuation, abbreviations, grammar, etc. preserved.

Which best describes the principle function of your organization?

Other (Specify)

- CAPP non-profit
- Community Action Agency
- Private Non Profit Community Action Org.
- Private, Non-Profit Agency
- Sex Offenders Rehab Program
- student health clinic at a university
- Vocational Training Facility

In the last fiscal/calendar year, what percent of your total funding for HIV/AIDS Prevention came from the following sources?

Other (Specify)

- .002% from Iowa Infertility Project
- Agency Discretionary Funds
- donated test from state
- funding is managed by lead agency
- Illinois State Prevention Grant
- In Kind and YSS general fund info will be sent
- Iowa Infertility Prevention Project
- legislative appropriations
- local and state taxes
- Local funding not specific for any laboratory program
- Medicaid
- Medicaid
- Medicaid (Title XIX); Title XX
- Medical revenue from insurance & Medicaid
- no funding
- no funds received
- none, program would not accept a 0
- Private Insurance
- state
- State funds-UHIC
- TXIX, Ins, Misc. Income

In the last fiscal/calendar year, what percent of your total funding for HIV/AIDS care-related services came from the following sources?

Other (Specify)

- All Iowa AIDS Fund
- chapter contributions
- Dubuque Regional AIDS Coalition
- included in our state budget
- no cases last year
- our own state budget
- Private Insurance
- Private insurance, Medicare, Medicaid
- state
- test donated

In the last fiscal/calendar year, what percent of your total STD funding came from the following sources?

Other (Specify)

- above denotes patient/client payment from all sources
- Central Iowa AIDS Project
- Iowa Infertility Prevention Project
- Iowa Infertility Prevention Project
- Iowa university
- legislation budget/funding.
- managed by lead agency
- Medicaid (Title XIX); Title XX (Social Services Block Grant)
- Medical revenue from insurance & Medicaid
- Medicare, Medicaid, private insurance
- our budget-state
- Private Insurance
- state
- TXIX, Ins, Misc.
- We did not receive any funding
- YSS general fund

In the past year, what populations did you reach in your HIV/STD/Hepatitis related prevention activities and/or services?

Other (Specify)

- All Ages
- General public, ISU students
- give out much info to college health pop here
- None
- persons in substance abuse facility
- Pregnant women
- Young Adults 10-18YRS

In the space below, please list other issues that you would like to see covered in a training.

- Any and all available training that would give staff professional knowledge
- when dealing with offenders in this area. Ongoing training, not band-aide type training.
- Continued updates on HIV/Aides stats in Iowa, specifically in Polk County.
- Updates on prevention and counseling
- none
- Our biggest challenge is achieving local funding, due to a reluctance of citizens to recognize that youth are sexually active and need skills and resources in order to make good decisions. We also face the same challenge in convincing the local citizens that youth are doing drugs, including alcohol. Overcoming community denial is an ongoing issue. The services we provide are excellent for the targeted populations we are funded for---kids in the system---and we do see an increase in a desire to be safer among a lot of these youth. We need to find a way to get access to and funding for providing education to all sexually active individuals--the chlamydia epidemic shows us how great the risk is for other infections.
- We do not intend to expand our services in this area - we refer male patients with, or suspected of having, STIs to the PCHD; and we treat female patients.
- This was a bit challenging as I really wanted to provide you accurate information – and our agency as a CHC provides a full array of services though I a most familiar a the HIV/AIDS services.

Appendix C – Iowa Department of Public Health Survey: Survey Participants

Note: In all cases in this report in which text supplied by survey respondents appears, it is presented with the respondents' own use of spelling, capitalization, punctuation, abbreviations, grammar, etc. preserved.

Agency	City	Participant
4th Judicial Dist Dept of Correctional Services	Council Bluffs	Robert W. Schroder
5th Judicial District OWI Programs	Des Moines	Marlana Lalli
6th Judicial District, Hope House	Coralville	Mick Meeks
7th Judicial District, Dept. of Correctional Service	Davenport	Mark J. Matkovich
AIDS Project of Central Iowa	Des Moines	Peggy Stecklein
AIDS Project Quad Cities	Davenport	Pauline Meagher
Allen Women's Health	Waterloo	Sandra Kahler
American Red Cross - Rapids AIDS Project	Cedar Rapids	Shaun Tullis
Black Hawk County Health Department	Waterloo	Ann Rogers
Cedar AIDS Support System	Waterloo	Cedar AIDS Support System
Center for Alcohol & Drug Services, Inc.	Davenport	Carolyn Ross
Center for Behavioral Health	Des Moines	Desiree Reed, Clinical Director
Central Iowa Family Planning, Inc.	Marshalltown	Dinny L. Nielsen, RN, Executive Director
Cerro Gordo Co. Dept. Public Health	Mason City	Karen Crimmings
City of Council Bluffs Health Department	Council Bluffs	Kelly Schierbrock
Civil Commitment Unit for Sexual Offenders	Cherokee	Mary S Benson
Community Health Care Regional Virology Center	Davenport	Sandee Millage ACRN
Community Health Centers of Southern Iowa	Leon	Patricia Magle, MD
Community Opportunities	Carroll	Vickie Steffes
Crawford County Home Health, Hospice and Public Health	Denison	Margie Gorden
Denison Job Corps Center	Denison	Janet Brus
Department of Correctional Services	Cedar Rapids	Bobbie Peters
Department of Correctional Services	Davenport	Waylyn McCulloh
Department of Corrections/ Sheldon Residential Treatment	Sheldon	Maureen Hansen
Dept of Correctional Services - Marshalltown Resid	Marshalltown	John McPherson
Des Moines County Health Department	Burlington	Cathy Jarrett RN
DHS	Eldora	State Training School
Drake University Student Health	Des Moines	Lynn Bennink
Dubuque Visiting Nurse Association	Dubuque	Cathy Tieskoetter
Emma Goldman Clinic	Iowa City	Brandice Armstrong

Employee & Family Resources, Inc.	Des Moines	Paul Hedquist
Family Planning Broadlawns Medical Center	Des Moines	Maria Kennedy
Fort Dodge Residential Correctional Facility	Fort Dodge	Don Sorensen
Harrison County Family Planning	Logan	Amy Heffernan
HCCMS Family Planning	Harlan	Rachel Birks
Hillcrest Family Services	Dubuque	Christy Ficke
IA Dept of Corrections	Sioux City	Residential Treatment Facility
Iowa Center for AIDS Resources and Education (ICARE)	Iowa City	Becky Clayton
Iowa Correctional Institution for Women	Mitchellville	Cheryl Overlin
Iowa Dept. of Corrections	Oakdale	Chris Gesie
Jackson Recovery Centers Inc.	Sioux City	Linnea Fletcher
Johnson County Public Health	Iowa City	Karen Robinson
La Clinica de la Esperanza	Des Moines	Martha Jessen
La Clinica de la Esperanza/Iowa Health - Des Moines	Des Moines	Mary Martin
Linn County Public Health	Cedar Rapids	Vickie Smith
Mid-Iowa Community Action	Ames`	Janelle Durlin
Monona Co PHN Service/ HCCMS Family Services	Onawa,	Marjorie Erickson RN
Nebraska AIDS Project	Omaha	Brandi Walkling
NEICAC Health Services Family Planning	Decorah	Lori R. Egan RN, BSN
New View Substance Abuse Treatment and Prevention	Carroll	Shannon Mahannah
North Iowa Community Action Organization	Mason City	Rosemary Brady
Northeast Iowa Mental Health Center	Decorah	Patrick Smith
Peoples Community Health Clinic, Inc.	Waterloo	Jennifer Lightbody
Planned Parenthood of Greater Iowa	Des Moines	Melissa Grant
Planned Parenthood of Southeast Iowa	Burlington	Karen Kemp
Polk County Health Department	Des Moines	Scott Slater
Prairie Ridge Addiction Treatment Services	Mason City	Jay Hansen
Primary Health Care, Inc.	Des Moines	Pam Arnold Powers
Scott County Health Department	Davenport	Roma Taylor
Siouxland Community Health Center	Sioux City	Darla Peterson
Siouxland District Health Department	Sioux City	Dan Weakley
South Iowa Area Detention Service Agency	Chariton	Mike Lamb
Southern Iowa Family Planning	Ottumwa	Vicki Palm
Southern Iowa Family Planning	Ottumwa	Wanda Besco
St. Luke's Hospital	Cedar Rapids	Valerie Campbell
Synergy Center/Behavioral Health Management Service	Cherokee	Larry Niemeier
Unity Public Health University Of Iowa HIV Program	Muscatine Iowa City	Kaia Petersen Kristine Davis

University of Nebraska Medical Center	Omaha	Tacy Kirkendall
Upper Des Moines Opportunity, Inc.	Graettinger	Julie Erskine
Visiting Nurse Association of Pottawattamie County	Council Bluffs	Lillian Jeppesen
Visiting Nurse Services	Des Moines	Jen Van Liew
Webster County Health Department	Fort Dodge	Webster County Health Department
Webster County Health Department/HIV AIDS Coalition	Fort Dodge	Kari Ruden
Youth and Shelter Services, Inc.	Ames	Pam Carnine

HIV Prevention Program Coordination

The overall purpose of coordination and linkage is to facilitate the accomplishment of state and local HIV prevention goals through enhanced communication and planning between regions, agencies, and individuals. Health jurisdictions and communities throughout the state organize and plan HIV prevention and early intervention activities based on their local resources (including skills, fiscal, and personnel) and culture. Coordination activities are intended to maximize the use of local and state resources to strengthen prevention efforts and stop the spread of HIV in Iowa.

1. Linkage of Primary and Secondary Prevention Services

The following mechanisms for coordination between primary and secondary prevention services currently exist within IDPH and will continue into the years 2007-2009 (see Table #1, Page 6-76.

Ryan White CARE Act and ADAP
In 2006, with the allocation of funds from the Ryan White CARE Act, IDPH continues to support a system of medical and essential support services for persons living with HIV. The AIDS Drug Assistance Program (ADAP) is administered by IDPH through one contracted centralized pharmacy that distributes drugs to clients statewide. The HIV/AIDS/Hepatitis Program provides funding to 11 providers that provide essential health and support services to financially eligible clients living with HIV. The services are publicized to providers of health care and HIV support services throughout the state. The HIV/AIDS Services Directory is distributed to Counseling Testing & Referral (CTR) sites, prevention and care providers, clients, and the general public. One important linkage to these services is provided through the state's Counseling Testing & Referral and Partner Counseling and Referral Services program

HIV/AIDS Conference (sponsored by IDPH, IDE, and the CPG) include workshops that specifically address care issues. The workshops provide updates on care issues for prevention providers, update care providers on prevention issues, demonstrate the linkage between care and prevention activities, and provide a networking opportunity for care and prevention providers. This capacity building conference was first identified as a priority by the CPG in 1998.

Iowa's collaboration between prevention and care offers multiple benefits. One outcome is the establishment of better linkages between prevention counseling/testing programs and care's early intervention services. Collaboration links HIV positive clients being served through the Ryan White system into primary and secondary prevention services while, at the same time, establishing referral linkages to assure that HIV positive clients have access to primary care and social support services.

In 2006, the CPG 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 this survey are described in the previous part of this chapter.

The results of the 2005 HIV/AIDS Consumer Needs Assessment Survey were presented to the CPG in August 2006. This survey assessed client demographics, HIV risk, perception of stigma, housing and transportation needs, health and medical care, supportive services and prevention needs. The survey was distributed to 800 clients by the Ryan White Part B providers and Part C Clinics and, some private physicians. See Chapter 5.

2. Coordination among HIV/AIDS, Hepatitis, STD and TB Services

The HIV/AIDS/Hepatitis (Surveillance, Prevention and Care), and STD and TB Programs of the IDPH are located in the Division of Acute Disease Prevention and Emergency Response, Bureau of Disease Prevention and Immunization. In a rural state, in which program resources are limited, close interaction between programs is a necessity.

The HIV/AIDS/Hepatitis and STD Program Managers oversee and manage all STD and HIV activity in the state. This includes STD/HIV PCRS and control activity. STD and HIV/AIDS/Hepatitis program planning, application input, delivery of services, and sharing of data are integrated. Staff executes all activities with a cross-program approach in mind.

Many persons initially seeking HIV testing are also at risk for hepatitis and STDs. Often, persons seeking HIV testing are at relatively low risk for HIV, but at very high risk for STDs. Since the establishment of HIV counseling and testing in 1985, the HIV and STD programs have collaborated to provide CTR and PCRS services in all funded CTR sites. STD and HIV CTR and PCRS staff are cross-trained by both the HIV and STD programs so that counselors are familiar with STD and HIV issues and protocols.

The Tuberculosis (TB) Program is also located in the Bureau of Disease Prevention and Immunization. This organizational structure provides flexibility within the bureau and eliminates most barriers to program operations. The primary areas of collaboration between the HIV/AIDS/Hepatitis and TB programs are referral of seropositive clients for TB testing and a match of the AIDS and TB registries to monitor the co-incidence of the two diseases. All seropositive clients of publicly supported counseling and testing sites are referred follow-up skin testing as a routine part of post-test counseling. In some areas, the local TB and HIV programs work together to provide follow-up skin testing at the HIV CTR site.

The HIV/AIDS, STD and TB sections operate distinct surveillance systems and prepare and distribute program-specific statistical reports. Data is shared among the three programs and each program provides data upon request. STD prevalence data are fully incorporated in the Iowa Epidemiological Profile of HIV/AIDS and STD (Chapter 3). Data from all three programs are used by the communities to plan local programs and prioritize resources.

Hepatitis Prevention and Treatment Program

In 2006, eight counseling and testing sites received funds to provide integrated HIV and HCV testing and offer HAV and HBV immunizations when appropriate.

The success of this integration of services allowed the Viral Hepatitis Task Force to approach state legislators and request additional money to expand the program. In 2006, $158,000 was allocated to the Iowa Department of Public Health to provide expanded hepatitis services. In 2007, community-based organizations, including substance abuse facilities, will be able to apply for integrated HIV/HCV testing, counseling, and referral services with Hepatitis A and B immunizations for persons at risk.

Training on Hepatitis C counseling and testing is fully integrated into the Fundamentals of HIV Prevention Counseling course.

3. Coordination/Linkages to Reproductive Health Care Services

Reproductive health care services are health care services provided in a hospital, clinic, physician's office, or other facility, and include medical, surgical, counseling or referral services relating to the human reproductive system, including services relating to pregnancy or its termination. As these services deal directly with sexual intercourse and its potential results, there is a very strong parallel between HIV prevention interventions and reproductive health care interventions.

While HIV care, substance abuse and STD testing and treatment are performed in a relatively limited number of settings, reproductive health care services are conducted by a much wider variety of public and private health clinics, community based organizations, educational facilities and local government-funded programs. Some programs are coordinated by Iowa's Title X Family Planning Program within the Iowa Department of Public Health and the Family Planning Council of Iowa. These programs are required to counsel clients on STD/HIV risk and prevention.

Private providers or agencies such as Planned Parenthood provide the majority of services. Because of this, most linkages to reproductive health care services occur at the local level, and the role of this Plan is to encourage and lead local providers to propose HIV prevention activities that are linked to local reproductive health services.

4. Coordination with Substance Abuse Prevention and Treatment Programs

The HIV/AIDS/Hepatitis and STD Programs collaborate with the IDPH Division of Behavioral Health and Professional Licensure**.** The HIV/AIDS/Hepatitis Program collaborates with this division in various ways.

- The program worked with two methadone clinics to incorporate HIV testing.

- The program received funding from the Tides Foundation to examine syringe access in Iowa. Representatives from substance abuse prevention and treatment are represented on the stakeholders group.

- Substance abuse counselors attend the IDPH sponsored "Fundamentals of HIV Prevention Counseling Workshop".

- The HIV/AIDS Conference has a specific track dealing with substance abuse/HIV issues.

- Funded prevention projects targeting Injection Drug Users and other substance abuse clients work jointly with their local substance abuse facilities.

- Some CTR sites offer outreach testing at substance abuse facilities.

5. Coordination Between Public and Non-Governmental Programs

The department works with various public and non-governmental agencies to provide coordinated HIV prevention programs to both at-risk populations and the population at large.

The department has established and maintains liaison with HIV/AIDS Prevention and Care Projects in the state. The projects work in their communities to coordinate and provide HIV prevention programs and services for infected persons. The membership of prevention and care projects includes representatives from the community and units of local government. Many of the projects have developed resource guides, and activity is monitored by site visits, telephone contact and review of quarterly project reports.

Iowa Department of Education (IDE)

IDPH and the HIV Community Planning Group recognize that the primary responsibility for prevention activities for school age children in Iowa lies with the Department of Education and the CDC funding it receives for that purpose. HIV/AIDS prevention education in all Iowa school districts continues to be necessary in achieving this objective.

The IDPH HIV/AIDS/Hepatitis Program and the IDE have a long-standing collaborative relationship that includes:

- providing training on evidence-based curricula to health educators in both public and private educational systems and youth-serving organizations ;
- joint funding and support of peer education programs in juvenile detention centers;
- a joint Educational Materials Review Committee;
- the IDE HIV project coordinator is a CPG member;
- joint sponsoring of youth focus groups ; and
- the IDE is a co-sponsor of the HIV Conference.

Iowa Department of Corrections (IDOC) Program

The HIV/AIDS/Hepatitis Program collaborates with the Iowa Department of Corrections (IDOC) in various ways.

- IDOC counselors/nurses attend the "Fundamentals of HIV Prevention Counseling" workshop.
- All inmates entering the state correctional system are tested for HIV.
- Discharge coordination between Corrections Medical Services staff and the Ryan White case managers includes pre-release linkages of positive clients to RW case managers, the AIDS Drug Assistance Program (ADAP), and other services.
- Workshops dealing with HIV prevention in correctional facilities are provided at the HIV/AIDS Conference.
- The IDPH continues to enter into an agreement with IDOC for the administration of a peer education program (Reach One, Teach One) which includes recruitment, training and monitoring of HIV peer educators.
- An IDOC Nurse Program Manager serves as a member of the CPG and the IDOC Medical Director serves as a member of the Viral Hepatitis Task Force.

Midwest AIDS Training and Education Center (MATEC)

MATEC is affiliated with the National AIDS Education and Training Centers Program which is a network of 17 regional centers with more than 70 local performance sites throughout the nation. MATEC is one of these regional centers and serves Illinois, Indiana, Missouri, Iowa, Minnesota, and Wisconsin. MATEC's mission is the provision of training designed to increase the number of health care providers effectively educated and motivated to counsel, diagnose, treat and manage individuals who are HIV+ and to assist in the prevention of high-risk behaviors that may lead to infection. The Iowa Department of Public Health HIV/AIDS/Hepatitis Program maintains contact with the Iowa site of this program, located at the University of Iowa College of Medicine. The HIV/AIDS/Hepatitis Program Manager is a member of MATEC's Advisory Committee.

Local Health Department Programs

Each of the 99 counties has a board of health and in each county there is some degree of health care service provided at the local level. However, there are only 12 sizable local health departments in the state, and of those, only Black Hawk County (Waterloo), Polk County (Des Moines), Scott County (Davenport), Linn County (Cedar Rapids), Cerro Gordo County (Mason City), and Woodbury County (Sioux City) have health department-operated STD/CTR clinics. All STD/CTR clinics in Iowa offer HIV prevention counseling and testing. Pottawattamie County (Council Bluffs) and Des Moines County (Burlington) provide STD/HIV clinical services under contractual arrangement with private physicians. Black Hawk County Health Department (Waterloo), Polk County Health Department (Des Moines), Linn County Health

Department (Cedar Rapids), and Scott County Health Department (Davenport), employ STD/HIV prevention personnel in addition to the state disease prevention specialists.

Public Information

The Iowa *Facts About HIV/AIDS, HIV/AIDS Services Directory, What is HIV Testing? and Important News for Pregnant Women* continue to be the most popular AIDS information brochures. The brochures have been distributed to agencies, schools, physicians, and clinics and, during programs, handed out by providers and program personnel. The National Prevention Information Network brochures and information are also distributed. The HIV/AIDS/Hepatitis Program maintains a video lending library through the State Medical Library. Videos are available to requesting organizations, agencies, and individuals. The HIV/AIDS/Hepatitis Program maintains a list of Program Review Panel-approved audiovisuals and printed materials. These lists are maintained on the IDPH website at http://www.idph.state.ia.us/adper/hiv_aids_programs.asp#clearinghouse . Other resources and links are also located on this web site.

Table #1: Shared Information and Collaborative Efforts

Programs	Div or Bureau within IDPH	Member-ship on Planning Bodies	Epi. Profile	Needs Assessment	Trng & Curr. Dev.*	Outreach Efforts	IDPH or Joint Funding of Programs	Resource Inventory
1. Primary & Secondary Prevention Services								
• CARE Act and ADAP	X	X	X	X		X		X
• HIV Providers		X	X	X		X		X
• Statewide Coordinated Statement of Need		X	X	X				X
2. HIV/AIDS, STD, TB	X	X	X	X	X	X	X	X
3. Hepatitis Services	X	X		X	X	X	X	
4. Reproductive Health Services	X	X	X	X	X	X	X	X
5. Substance Abuse	X	X		X	X			
6. Public and Non-governmental programs								
• Iowa Dept. of Education		X	X	X	X		X	X
• Iowa Dept. of Corrections		X	X	X	X		X	X
• MATEC		X	X	X	X			
• Public Information							X	

*Curriculum Development

Support Activities

Data collection and information management are foundations of the state HIV/AIDS/Hepatitis and STD Programs, with active input from local health departments, the state laboratory, various private laboratories, and the HIV/AIDS/Hepatitis and STD Programs active surveillance systems. In July 1998, Iowa law was changed to include requiring positive HIV tests be reported by name. The HIV/AIDS Surveillance Coordinator is responsible for investigations of all reported HIV and AIDS cases with no identified risks. When the investigation is complete, information is added to the computerized case report and the interview form is sent to CDC. Case counts are entered into the HIV/AIDS Reporting System for monthly, quarterly and yearly reports (See Chapter 3, Epidemiological Profile). These reports, resulting from surveillance activities, have assisted the department and the CPG in judging how the allocation of prevention resources should be balanced between those who are currently infected and those who will be infected in the future. The data have also been useful to the CPG in identifying populations in need of prevention and care services.

The IDPH has consistently measured the ability of its HIV and other prevention programs to meet goals and objectives by assessing program participation, service levels, and dissemination activities. Program evaluation, training, and quality assurance activities are conducted for prevention programs funded by IDPH through the HIV/AIDS/Hepatitis Program.

Technical Assistance

Ongoing technical assistance has been received from the Centers for Disease Control and Prevention (CDC), Academy for Educational Development (AED), the National Alliance of State and Territorial AIDS Directors (NASTAD) and local service providers. Topics have included priority setting, social marketing, evaluation, behavioral interventions and social learning theories, community planning for the long haul, combining qualitative and quantitative data, methamphetamine use in Iowa, training to improve cultural competence, prevention for HIV positive persons, priority setting, youth participation in the CPG process and "Developing an HIV Prevention Comprehensive Approach for Injecting Drug Users".

HIV/AIDS Conference

An annual HIV/AIDS Prevention Conference has been held in Des Moines, Iowa starting in November 1998. The IDPH, IPE and CPG co-sponsor the conference. The conferences serve as a means to provide technical assistance to HIV prevention and care providers. Technical assistance needs were identified through the CPG process and from feedback from providers and information received from the STD/HIV/AIDS Provider Resource Survey. Workshop speakers have addressed such topics as behavioral change theory, cultural diversity, treatment and care issues, HIV testing including rapid testing technology, interventions targeting high-risk populations, social marketing, community collaboration, linking prevention and care, and emerging issues and challenges for the future.

Technical Assistance Plan

Each year the HIV/AIDS/Hepatitis Program compiles information from the Provider Survey, provider quarterly reports, site visits and at CPG meetings to draft a technical assistance and training plan.