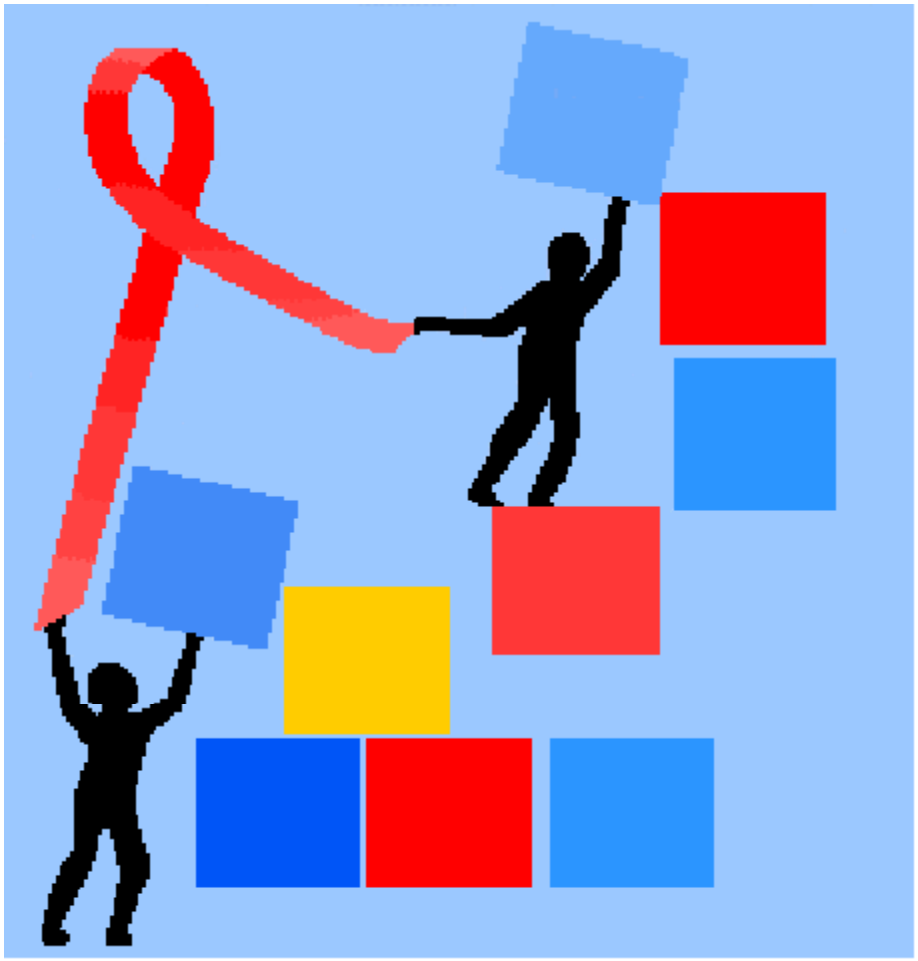
CHAPTER 7

Attachments



Attachment 1

Iowa HIV Community Planning Group Charter

July 25, 1994

Revised July, 2003

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IOWA HIV/AIDS COMMUNITY PLANNING GROUP CHARTER

Article I. Name

The name of the Planning Group shall be the Iowa HIV/AIDS Community Planning Group. (CPG). The headquarters shall be located at the Iowa Department of Public Health in Des Moines, Iowa, hereafter referred to as IDPH.

Article II. Mission

The mission of the Iowa CPG is to develop a comprehensive HIV/AIDS plan, which provides for an effective and efficient continuum of services including prevention/education, early intervention, and patient care within the State of Iowa.

SECTION 1: **Goals:** The goals of the Iowa CPG are to:

1. Implement and maintain through an ongoing participatory process an effective prevention, early intervention and care planning process.

2. Promote community participation and involvement in HIV/AIDS related planning activities.

3. Strive to maximize the effectiveness of prevention and care services through effective planning among service providers and other concerned community members.

4. Strengthen local and statewide coordination in the fight against HIV disease.

SECTION 2: **Accomplishment of Mission:** This mission will be carried out in accordance with the guidelines specified in the Centers for Disease Control and Prevention (CDC) Announcement for Human Immunodeficiency Virus Prevention Projects and the HIV Prevention Community Planning Guidance (July 2003), the Healthy Iowans 2010 Objectives, and the Health Resources Services Administration (HRSA) Ryan White Care Act. The mission of the CPG will be accomplished in collaboration with IDPH by carrying out the following steps:

1. Assess the present and future extent, distribution, and impact of HIV/AIDS in defined populations.

2. Assess existing community resources for HIV prevention and care to determine the community's capability to respond to the epidemic. These resources should include fiscal, personnel, and program resources as well as support from public (federal, state, county, municipal), private, and volunteer sources. This assessment should identify all HIV/AIDS prevention and care programs and activities according to definitions of high-risk behaviors and increased-risk behaviors as determined and set forth by CDC and HRSA.

3. Identify unmet HIV prevention and patient care needs within defined high-risk and increased-risk target populations.

4. Identify barriers to HIV prevention and care services within defined high risk and increased risk target populations.

5. Define the potential impact of specific strategies and interventions to prevent new HIV infections in defined populations.

6. Prioritize HIV prevention and care needs by defined at-risk populations and specific strategies and intervention type as defined by the CDC and HRSA.

7. Develop and update a comprehensive HIV Plan for prevention and care, consistent with the high priority HIV prevention and care needs identified through the Community Planning process.

8. Evaluate the effectiveness of the HIV/AIDS prevention and care planning process.

Article III.Roles and Responsibilities

SECTION 1: **Iowa Department of Public Health: The role of IDPH in the planning process is to:**

1. Administer and coordinate public funds from a variety of sources, including federal, state, and local agencies, to prevent HIV transmission and reduce associated morbidity and mortality.

2. IDPH selects an employee to be co-chair of CPG.

3. Review available epidemiological, evaluation, behavioral and social science, cost-effectiveness, and needs assessment data and other information required to prioritize HIV prevention and care needs and collaborate with the IDPH HIV/AIDS Program on how best to obtain additional data and information.

4. Administer HIV prevention and care funds, ensuring that funds are allocated to providers in a timely manner, monitoring provider activities, and documenting provider compliance.

5. Review, distribute, and secure HIV/AIDS surveillance and other relevant data and analyses of statewide, and/or local data to assist the HIV/AIDS community planning process in establishing program priorities based on the current and future extent, distribution, and impact of the HIV/AIDS epidemic.

6. Collaborate with state, local, and community partners to determine the most effective means for implementing and managing community planning in their jurisdiction.

7. Ensure that specific policies are in place articulating the roles and responsibilities of the various components of the Community Planning process.

8. Provide expertise and technical assistance, including ongoing training on HIV/AIDS prevention and patient care planning and the interpretation of epidemiological and evaluation data, to ensure that the planning process is comprehensive and scientifically valid.

9. Promote linkages among the local community HIV/AIDS services providers, public health agencies, community members, persons affected by or infected with HIV, and behavioral and social scientists who are either in the local area or who are familiar with local prevention and care needs, issues, and at-risk/affected populations.

10. Develop applications for HIV prevention and care funds based on the Comprehensive HIV Plan developed through the HIV community planning process.

11. Ensure that technical assistance is provided to meet the needs of community-based providers in the areas of program planning, intervention, and evaluation as identified in the Comprehensive Plan.

12. Allocate resources based on the Comprehensive Plan.

13. Ensure planning and program effectiveness through specific evaluation activities, including conducting process, impact, and outcome evaluation studies; and providing or ensuring the provision of technical assistance for evaluation to funding recipients.

14. Assure support for the CPG, the working committees and workgroups. This includes timely distribution of the meeting notices, agendas and minutes of the general meeting to all members.

SECTION 2: **Role of the Community Planning Group:** The role of the HIV/AIDS Community Planning Group in the planning process is to:

1. Delineate technical assistance and capacity-building development needs for effective community participation in the planning process.

2. Select Community Co-Chair for the CPG. The Community Co-Chair will serve a two-year term and may be re-appointed for additional terms.

3. Assess existing community resources to determine the communities capability to respond to the HIV epidemic.

4. Identify unmet HIV prevention and care needs within defined populations.

5. Prioritize HIV prevention and care needs by target populations and geographic areas, and propose high-priority strategies and interventions.

6. Identify the technical assistance needs of governmental, private, and community-based HIV providers in the areas of program planning, implementation, management, and evaluation.

7. Address in the HIV/AIDS comprehensive plan the linkages among:
    a. Primary and secondary prevention;
    b. Counseling, testing, referral, and partner counseling and referral;
    c. Surveillance;
    d. Early intervention and primary care services;
    e. Sexually transmitted disease prevention and treatment;
    f. Tuberculosis prevention and treatment;
    g. Substance abuse prevention and treatment;
    h. Mental health services;
    i. Dental care services;
    j. Case management; and
    k. Other public health and social service needs.

8. Evaluate the HIV/AIDS Community Planning process and assess the responsiveness and effectiveness of the grantee's application in addressing the priorities identified in the comprehensive HIV/AIDS Plan.

9. Indicate concurrence/non-concurrence on the comprehensive Statewide HIV Prevention Plan and application.

SECTION 3: **Shared Responsibilities:** Responsibility will be shared between IDPH and the CPG to:

1. Ensure that the CPG reflects the population characteristics of the current epidemic in state and local jurisdictions, respectively, in terms of age, race/ethnicity, gender, sexual orientation, geographic distribution, and HIV risk exposure category.

2. Develop procedures that address policies and provisions for reaching decisions on attendance at meetings, resolution of disputes identified in planning deliberations, and resolution of conflict(s) of interest for members or proxies of CPG.

3. Determine the distribution of planning funds to support HIV/AIDS Community Planning Group meetings, public meetings, and other activities necessary for obtaining community input.

4. Ensure the development of parity, inclusion, and representation of community representatives through training and information sharing.

5. Provide technical assistance to IDPH, and the Community Planning Group.

6. Establish policies that address CPG membership, composition, selection, appointment, and terms of office, in consultation with state and local health authorities and community leaders.

7. Support the community planning infrastructure for the HIV community planning process.

8. Collect and/or analyze and disseminate relevant data.

9. Assess the present and future extent, distribution, and impact of HIV/AIDS in defined populations in Iowa.

10. Develop and periodically update the comprehensive HIV/AIDS Plan, including the provision of technical assistance to meet the needs of the IDPH and community-based providers in the areas of program planning, implementation, and evaluation.

11. Develop goals and measurable objectives for priority HIV/AIDS prevention and care strategies and interventions.

SECTION 4: **CDC Responsibilities:** The role of the CDC in the community planning process is to:

1. Provide leadership in the national design, implementation, and evaluation of HIV prevention community planning.

2. Collaborate with health departments, CPGs, national organizations, federal agencies, and academic institutions to ensure the provision of technical/program assistance and training for the community planning process.
   - Work with the health department and the community co-chairs to provide technical/program assistance for the community planning process, including discussing roles and responsibilities of community planning participants, disseminating CDC documents, and responding to direct inquiries to ensure consistent interpretations of the guidance.

3. Provide technical/program assistance through a variety of mechanisms to help recipients understand how to:
   - Analyze epidemiologic, behavioral, and other relevant data to assess the impact and extent of the HIV/AIDS epidemic in defined populations;
   - Analyze community services assessments and compile analyses of prevention program gaps;
   - Prioritize target populations, and interventions based on their ability to result in the greatest decrease in new HIV infections;
   - Identify and evaluate effective and cost-effective HIV prevention activities for these priority populations;
   - Provide access to needed behavioral and social science expertise;
   - Ensure PIR in the community planning process;
   - Identify and manage dispute and conflict of interest issues; and
   - Evaluate the community planning process.

4. Alert health departments and CPGs about emerging trends or changes in the HIV/AIDS epidemic.

5. Provide leadership in the coordination between health departments, CPGs, directly-funded community-based organizations (CBOs). CDC will provide leadership for internal collaboration that may impact HIV prevention programs and funding.

6. Monitor the HIV prevention community planning process for implementation of the three goals and eight core objectives.

7. Collaborate with health departments in evaluating HIV prevention programs.

8. Collaborate with other federal agencies and offices (particularly the Office of HIV/AIDS Policy, National Institutes of Health, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, and the federal Office on Minority Health) in promoting the transfer of new information and emerging prevention technologies or approaches (i.e., epidemiologic, biomedical, operational, behavioral, or evaluative) to health departments and other prevention partners, including non-governmental organizations.
9. Develop goals and measurable objectives for priority HIV/AIDS Prevention and Care strategies and interventions.

SECTION 5: **Individual Responsibilities:** The specific responsibilities of the CPG members and proxies, co-chairs, and department staff are outlined in job descriptions developed by IDPH and approved by the Community Planning Group; these job descriptions will be updated or revised as agreed upon by the CPG and the department every two years.

Article IV. Membership

SECTION 1. **Number**

The CPG shall consist of no less than 17 members and no more than 33. A vacancy shall not prevent the CPG from conducting business.

SECTION 2. **Appointment and Removal**

Nominations for membership are identified through an open process to all persons and recommendations are made by the Membership/Orientation/ByLaws Committee (MOB Squad) to the Selection Committee based on Parity, Inclusion and Representation.

Members shall commit to a three-year term with the option of being re-appointed by the IDPH Selection Committee for a subsequent three-year term. The CPG shall have the right to remove CPG members for inappropriate or abusive behavior or falsification of "Conflict of Interest" Disclosure Form or of the "Nomination Application Form". In these instances, a two-third (2/3) majority is required for removal.

Automatic removal is considered when a member misses three consecutive meetings or four meetings in a 12-month time period.

Exemption: In consideration of the need for representation of persons with HIV, those individuals shall be exempt from the above termination clause for absences due to illness.

SECTION 3. **Proxies**

CPG members may designate a proxy to attend a meeting and vote in his or her absence. The CPG member is responsible for briefing the proxy on current issues under review, as well as the roles, responsibilities and other norms the CPG may have adapted. Proxy representation two months in a row will require re-evaluation of commitment of the member to the CPG.

SECTION 4. **Vacancies**

A new CPG member shall be named by the IDPH Selection Committee from the pool of applications maintained by the IDPH HIV/AIDS Program.

SECTION 5. **Chairs**

IDPH will select an employee, or a designated representative as one co-chair, and CPG will select the community Co-Chair. The community Co-Chair will serve a term of two years. The Co-Chairs share responsibility for guiding the CPG in accomplishing its mission and goals. If a Co-Chair cannot attend a meeting of the CPG, said Co-Chair will
designate a committee member to assist in leading the conduction of business at said meeting. A Co-Chair elect will be selected on the alternate year. This person will be "in training" prior to taking office of the community Co-chair.

Article V. Governance of Meetings

All business that may come before the Community Planning Group shall be addressed with an open, consensus building decision process. Should consensus building activities fail to facilitate the effective conduct of any business at hand, CPG Co-chairs may elect to conduct a meeting or any part thereof according to the procedures established in Robert's Rules of Order.

SECTION 1. **Attendance**

A record of attendance shall be kept for each meeting of the CPG and of committees.

Members who are unable to attend a particular meeting are responsible for:

1. Notifying the IDPH Co-Chair or other responsible party in advance.

2. Sending reports, material, etc. to the meeting.

3. Updating self on meeting business.

SECTION 2. **Quorum**

A quorum of the CPG must be present at any regular or specially scheduled meetings in order for the CPG to engage in formal decision-making. A quorum is defined as more than one half of the membership.

SECTION 3. **Agenda**

An agenda will be developed for each meeting by the Co-Chairs.

Members of the CPG may request items be added to the agenda through a request to the Co-Chairs.

SECTION 4. **Open to Public**

CPG meetings shall be open to the public; there will be an open forum for discussions. Interested parties will be required to submit to the Co-chairs a written outline or summary of issues.

SECTION 5. **Decision-Making**

1. All committee processes shall be directed by the CPG Ground Rules.

2. Each member is encouraged to participate in the decision and stay within the ground rules regarding time limits.

3. 50% of membership plus 1 (one) constitutes a quorum.

4. Decisions shall be made by Robert's Rules of Order. (Most require only a majority vote, but motions concerning the rights of the group or its members need a 2/3 vote to be adopted or as addressed in Ground Rules #3.)

SECTION 6. **Conflict of Interest**

1. Definition of Conflict of Interest.

   Conflict of interest occurs when: (1) an appointed voting member of the CPG has a direct or fiduciary interest, (which includes ownership; employment; contractual, creditor, or consultative relationship to; or Board or staff membership) in an organization (including any such interest that existed at any time during the twelve months preceding her/his appointment), with which the CPG has a direct, financial and/or recognized relationship and (2) when a member of the CPG knowingly takes action or makes a statement intended to influence the conduct of the CPG in such a way as to confer any financial benefit on the member, family member(s) or on any organization in which she/he is an employee or has a significant interest.

2. Members shall abstain from voting when there is a "Conflict of Interest" as defined in Appendix A.

3. Oversight Responsibility. The Membership/Orientation/Bylaws Committee (MOB Squad) of the CPG shall be authorized to formulate CPG policy, review all concerns, and make recommendations to the full CPG regarding conflict of interest issues.

   All CPG members are encouraged to identify conflict of interest, or request a review of a potential conflict of interest of another member.

4. Disclosure Form. All members must sign, upon appointment to the CPG, a "Conflict of Interest Disclosure Form" which shall be formulated by the MOB Squad and approved by the full CPG. The completed Disclosure Forms shall be kept on file at the IDPH HIV/AIDS Program office and made available for public inspection.

   CPG members shall review and update their Disclosure Forms on an annual basis, or as otherwise precipitated by a change in employment, Board service, consultative relationship, or other status.

5. Determination of Conflict. All concerns regarding conflict of interest shall be recorded in the CPG meeting minutes and referred to the MOB Squad for review. The full CPG shall take, based on the recommendations of the committee, whatever actions it deems appropriate and are in compliance with standing CPG regulations.

6. Participation and Voting. In the event of a conflict of interest and/or during the period of review of said conflict of interest, member(s) may participate in the discussion of the matter in conflict/question but shall abstain from voting on that matter.

7. A member shall be terminated from service on the CPG and any of its committees for refusing to cooperate in a conflict of interest review, or when it is determined that she/he knowingly took action(s) intended to influence the conduct of the CPG in a manner as defined in Article 5, Section 6, #1 of these Bylaws.

Books and Records

The CPG shall keep minutes of all proceedings of the CPG and such other books and records as may be required for the proper conduct of its business and affairs. The Iowa Department of Public Health will assign a recording secretary to take and prepare minutes of each meeting. The minutes of each meeting shall be distributed to CPG members. CPG co-chairs shall select someone to keep other books and records as may be required.

Amendments

This charter may be amended at any regular or special meeting of the CPG. Written notice of the proposed Charter change shall be mailed to each member. Charter changes require a majority vote of the CPG members.

Ratification

This Charter goes into effect upon a majority vote.

Iowa Department of Public Health
HIV/AIDS Community Planning Group
Conflict of Interest Disclosure Form

The Iowa CPG has members who are professionally or personally affiliated with organizations that have, or may request, or receive funds for HIV prevention activities. Because of the potential for conflict of interest, the CPG has adopted this Disclosure Sheet, which all current and future CPG members must complete and provide to the CPG record-keeper.

The reputation and credibility of the CPG rests on its ability to make fair, objective and impartial decisions. Accordingly, it is essential to avoid situations where a conflict of interest may influence, or appear to influence, the decision-making process. There are two (2) types of conflict of interest situations:

1. *Where a member (or a relative or partner, etc.) has a financial interest, or appears to have a financial interest, in the outcome of a decision and,*
2. *Where a member has an affiliation or other conflict of loyalties that may lead to or suggest influence over the outcome of a decision.*

The following guidelines are intended to help the CPG avoid both types of conflicts.

GENERAL

From time to time, a member may serve as an officer, staff member, director, trustee, active volunteer or consultant to an organization with a vested interest in the outcome of the decision-making process. Situations may also arise where a member's business or personal interests may be affected by the outcome of a decision. In all such cases, the potential for conflict should be recognized and disclosed, and appropriate steps taken to prevent influence or favoritism by such members in the decision-making process.

DISCLOSURE

Each member is under an obligation to the CPG and to the other CPG members to inform them of any position they and/or a family member and/or household member serve or have served in the past twelve (12) months in a staff, consultant, officer, board member, advisor capacity, and the investment in any business, or any volunteer activities that may result in a possible conflict of interest with the following organizations that received, may seek, and/or are eligible for HIV Prevention funding within the scope of CPG influence. A member should also disclose any activity or interest that may cause bias for or against a particular action or policy being considered by the CPG.

Each member is asked to file a Disclosure Statement.

Organization: _____
Title: _____ Period of Affiliation: _____

Organization: _____
Title: _____ Period of Affiliation: _____

Organization: _____
Title: _____ Period of Affiliation: _____

(Please attach additional pages if necessary)

Group Member Name *(Please print)*: _____
Signature: _____ Date: _____
Date Form Received by the Planning Group: _____

Iowa Department of Public Health
HIV/AIDS Program
HIV/AIDS Community Planning Group

LETTER OF COMMITMENT

As a member of the Iowa HIV Community Group (CPG) I,_____ commit to the following:

- *Attend all meetings of the CPG convened by the HIV/AIDS Program of the Iowa Department of Public Health;*
- *Thoroughly prepare for each meeting by carefully reading all pre-distributed material;*
- *Actively participate in all CPG convened meetings from beginning to adjournment;*
- *Actively participate in all assigned committee work (telephone conference calls, face-to-face meetings, material review, report writing);*
- *Facilitate communications among local community groups and members with the CPG;*
- *Act on behalf of all HIV infected and affected communities in Iowa in decision-making;*
- *Understand that my participation is an Iowa-wide planning process and to make decisions based on that understanding.*

Given the responsibilities and time commitment of participation on the CPG, and its committees:

_____ YES, I will participate as a member.

_____ I cannot participate at this time.

_____ _____

Signature *Date*

Iowa HIV Community Planning Group

Roles and Responsibilities for Member

I. ROLE STATEMENT

As a member of the Iowa HIV Community Planning Group (CPG), it is your role to:

- ☒ Make a commitment to this process and it's results.
- ☒ Participate in all decisions and problem solving.
- ☒ Undertake special tasks, as requested by the CPG.
- ☒ Gather data and information as needed.
- ☒ Spread the word about the planning process.

II. LENGTH OF COMMITMENT

CPG members are asked to serve for 3 years, subject to reappointment.

III. ESTIMATED TIME REQUIRED

- ☒ Monthly meeting of 5-7 hours plus special called meetings when needed.
- ☒ Possible monthly meetings of subcommittees.
- ☒ 4-6 hours per month for specific task completion.
- ☒ Committee Chair may require additional hours of committment.

IV. MAJOR DUTIES AND TASKS

- ☒ Delineate technical assistance/capacity development needs for effective community participation in the planning process.
- ☒ Review available epidemiologic, evaluation, behavioral and social science, cost-effectiveness, and needs assessment data and other information required to prioritize HIV prevention needs, and collaborate with the health department on how best to obtain additional data and information.
- ☒ Assess existing community resources to determine the community's capability to respond to the HIV epidemic.
- ☒ Identify unmet HIV prevention and care needs within defined populations.

- ☒ Prioritize HIV prevention needs by target populations and propose high priority strategies and interventions.
- ☒ Identify the technical assistance needs of community-based providers in the areas of program planning, intervention, and evaluation.
- ☒ Consider how (a.) counseling, testing, referral, and partner notification (CTRPN), early intervention, primary care, and other HIV-related services; (b.) STD, TB, and substance abuse prevention and treatment; (c.) mental health services; and (d.) other public health needs are addressed within the Comprehensive HIV Plan.
- ☒ Develop goals and measurable objectives for HIV prevention strategies and interventions in defined target populations.
- ☒ Evaluate the HIV Prevention Community Planning process and assess the responsiveness and effectiveness of the Health Department's application for Federal HIV Prevention funds in addressing the priorities identified in the Comprehensive HIV Plan.
- ☒ Observe and assist agenda development by Co-Chairs.
- ☒ Observe and assist briefings prior to Committee meeting.
- ☒ Participate in debriefings after each meeting.
- ☒ Observe management and resolve of conflict within the CPG.
- ☒ Become knowledgeable regarding Co-chair roles and responsibilities, duties, and tasks.

Iowa HIV Community Planning Group

Roles and Responsibilities for Co-Chair Elect

I. ROLE STATEMENT

As a member of the Iowa HIV Community Planning Group (CPG), it is your role to:

☒ Make a commitment to this process and it's results.

☒ Participate in all decisions and problem solving.

☒ Undertake special tasks, as requested by the CPG.

☒ Gather data and information as needed.

☒ Spread the word about the planning process.

II. LENGTH OF COMMITMENT

Co-Chair elect will serve 1 year followed by 2 years as Co-Chair.

III. ESTIMATED TIME REQUIRED

In addition to the time requirements outlined for all CPG members, the community co-chair elect can expect to spend an estimated 8 hours per month on CPG business.

IV. MAJOR DUTIES AND TASKS

☒ Delineate technical assistance/capacity development needs for effective community participation in the planning process.

☒ Review available epidemiologic, evaluation, behavioral and social science, cost-effectiveness, and needs assessment data and other information required to prioritize HIV prevention and care needs, and collaborate with the health department on how best to obtain additional data and information.

☒ Assess existing community resources to determine the community's capability to respond to the HIV epidemic.

☒ Identify unmet HIV prevention and care needs within defined populations.

☒ Prioritize HIV prevention needs by target populations and propose high priority strategies and interventions.

☒ Identify the technical assistance needs of community-based providers in the areas of program planning, intervention, and evaluation.

- ☒ Consider how (a.) counseling, testing, referral, and partner notification (CTRPN), early intervention, primary care, and other HIV-related services; (b.) STD, TB, and substance abuse prevention and treatment; (c.) mental health services; and (d.) other public health needs are addressed within the Comprehensive HIV Plan.

- ☒ Develop goals and measurable objectives for HIV prevention and care strategies and interventions in defined target populations.

- ☒ Evaluate the HIV Prevention Community Planning process and assess the responsiveness and effectiveness of the Health Department's application for Federal HIV Prevention funds in addressing the priorities identified in the Comprehensive HIV Prevention Plan.

- ☒ Observe and assist agenda development by Co-Chairs.

- ☒ Observe and assist briefings prior to Committee meeting.

- ☒ Participate in debriefings after each meeting.

- ☒ Observe management and resolve of conflict within the CPG.

- ☒ Become knowledgeable regarding Co-chair roles and responsibilities, duties, and tasks.

Iowa HIV Community Planning Group

Roles and Responsibilities for Co-Chair

I. ROLE STATEMENT

As co-chair of the Iowa HIV Community Planning Group (CPG), it is your role to:

- ☒ Develop an agenda, based on input from the CPG and in conjunction with the other co-chair, for each meeting.
- ☒ Co-chair each meeting of the CPG, dividing responsibilities between co-chairs.
- ☒ Participate in briefings prior to each meeting.
- ☒ Participate in debriefings after each meeting.
- ☒ Manage and resolve CPG conflicts.
- ☒ Coordinate subcommittee work and reports.
- ☒ Represent the CPG to the public.
- ☒ Advocate for the work of the CPG.

II. LENGTH OF APPOINTMENT

The community co-chair is elected by the CPG to serve a 2-year term.

III. ESTIMATED TIME REQUIRED

In addition to the time requirements outlined for all CPG members, the community co-chair can expect to spend an additional 8 hours per month on CPG business.

IV. MAJOR DUTIES AND TASKS

In addition to the Duties and Tasks outlined for Planning Group members, co-chairs will be asked to perform or participate in the following duties.

- ☒ Decide how co-chairs will share their joint responsibilities.
- ☒ Seek input from the CPG in determining an agenda for each meeting.
- ☒ Review the minutes from each meeting and ensure that an accurate portrayal of the deliberations of the CPG are presented.

- ☒ Help each CPG member air his/her individual agenda then set this agenda aside so that the work of the CPG may proceed unencumbered.

- ☒ Manage CPG conflict and dissent.

- ☒ Ensure that a Comprehensive HIV Plan is developed and periodically updated including the provision of technical assistance to meet the needs of the Department of Public Health and community-based providers in the areas of program planning, implementation, and evaluation.

Iowa HIV/AIDS Community Planning Group

The Mentor Program

The "Mentor Program" is important: the Mentor is the "bridge" between a member and the sometimes confusing process of participating on the HIV Community Planning Group (CPG).

I. What is a "Mentor" Program?

A "mentor" is responsible for helping a member to become familiar with the way the CPG works, and for helping the member to meet his or her responsibilities on the CPG.

II. Who is responsible for the "Mentoring Program"?

The Membership, Orientation, Bylaws Committee will be responsible for implementing this program at the request of the CPG member. Any seasoned CPG member may serve as a Mentor.

III. How can the "Mentor Program" be implemented?

After orientation or at anytime, a member may determine the "Mentoring Program" could assist them in serving on the CPG. At such time, the CPG member will contact the Membership, Orientation, Bylaws Committee for assistance.

IV. How does the Mentor help the new member become familiar and participate in the CPG?

After the initial contact, the Mentor may assist in:

- explaining and reviewing the process,
- driving to meetings together,
- introducing new member to other members,
- frequently checking to make sure the new member understands the terms being used, the meeting, the process, etc.

Attachment 2

Chapter 19
Sexually Transmitted Diseases and Human Immunodeficiency Virus Infection

Introduction

Sexually transmitted diseases (STDs) refer to the more than 25 infectious organisms that are primarily transmitted through sexual activity. STD prevention is an essential primary care strategy that is integral to improving reproductive health. Despite the burden, costs, and preventable nature of STDs and their complications, they remain an under-recognized health problem by the American public, policymakers, and public health and health care professionals.

The proposed set of objectives for the year 2010 reflects the extensive problem analysis and recommendations published in 1997 by the National Academy of Sciences' Institute of Medicine in a report entitled, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*.

"STDs are hidden epidemics of tremendous health and economic consequence in the United States. They are hidden from public view because many Americans are reluctant to deal with sexual health issues in an open way and because of the biological and social factors associated with these diseases. STDs represent a growing threat to the nation's health and national action is urgently needed…."

The principal conclusion of the Institute of Medicine is that the United States needs to establish a much more effective national system for STD prevention.

Before proceeding, some sexually transmitted disease terms are defined.

Sexually transmitted diseases (STDs) -- bacterial and protozoal -- refer to curable sexually transmitted infections caused by such microorganisms as *Chlamydia trachomatis* (*Chlamydia*), *Neisseria gonorrhoeae* (gonorrhea), *Treponema pallidum* (syphilis), *Haemophilus ducreyi* (chancroid), *Trichomonas vaginalis* (trichomoniasis), *bacterial vaginosis*, and other organisms. *Chlamydia* and gonorrhea cause an inflammatory reaction in the host. In women, these organisms can ascend into the upper reproductive tract where inflammatory reactions (pelvic inflammatory disease) can cause irreparable damage to the organs of reproduction. In its early stages, syphilis causes genital ulcers and other infectious lesions (tissue wounds). Left untreated, syphilis enters a stage that damages the internal organs over a prolonged period of time. Acute bacterial STDs in a pregnant woman can cause potentially fatal congenital infections or perinatal complications, such as eye and lung infections, in the newborn. There are effective single dose antimicrobials that can cure *Chlamydia*, gonorrhea, and syphilis.

Provider referral -- (previously called contact tracing) is the process whereby health department personnel directly and confidentially notify the sexual partners of infected individuals of their exposure to a sexually transmitted disease for the purposes of education, counseling, and referral to health care services.

Viral STDs -- refer to the sexually transmitted viral infections: human immunodeficiency virus (HIV) infection, herpes simplex virus type 2 (genital herpes), human papillomavirus (HPV infection) and hepatitis B (HBV). Initial infections with these organisms may be asymptomatic (with no symptoms) or cause only mild symptoms. There are treatments but no cures for these infections that appear to remain in the body indefinitely. HIV infection is the virus that causes AIDS. Herpes can cause periodic outbreaks of painful genital lesions. Some strains of HPV cause genital warts, and others are important risk factors for cervical dysplasia (abnormal cells) and invasive cervical cancer. Hepatitis B virus is another acute viral illness that can be transmitted through sexual activity. Most persons who acquire it recover and have no complications, but sometimes it becomes a chronic health problem.

STD complications -- refer to serious health problems that occur following an acute bacterial or viral STD. Among the most serious of these complications are:

Pelvic inflammatory disease (PID), which can cause permanent damage to the female reproductive tract and lead to ectopic (located away from the normal position) pregnancy, infertility, or chronic pelvic pain.

Pregnancy complications – either infect the fetus or newborn directly or lead to a pre-term birth (prior to 37 weeks of gestation).

Cancers -- such as cervical cancer (due to some strains of HPV) and liver cancer that can result after chronic infection with HBV (hepatitis B virus)

HIV infection transmission -- acquired sexually, HIV is facilitated by the presence of an inflammatory or ulcerative STD in one or both sex partners.

The generally recognized symptomatic STDs that may cause only mild initial illnesses are only part of a very large public health problem. These organisms also cause many other harmful, often irreversible, and costly clinical complications such as reproductive health problems, fetal and perinatal health problems, and cancer. In addition, studies of the Human Immunodeficiency Virus (HIV) pandemic from

around the world link other STDs to a causal chain of events in the sexual transmission of HIV infection.

STDs are behavior-linked diseases that result from unprotected sex with infected partners. Transmission of STDs is sustained by the complex interaction between biological and social factors. There are seven major interactions: 1) the asymptomatic nature of STDs; 2) lag time between infections and complications; 3) gender and age; 4) *s*ocial and behavioral factors; 5) access to health care; 6) substance use; and, 7) STD/HIV interaction.

The majority of STDs either do not produce any symptoms or signs or produce only mild symptoms. Asymptomatic or mild infection results in a low level of suspicion among infected persons who should, but often do not, seek medical care. For example, as many as 85% of women and up to 50% of men with *Chlamydia* have no symptoms. HIV infection is another example of a well-known problem that may be asymptomatic and transmitted to others for years before symptoms occur. Most people are not aware of how frequently STDs are asymptomatic. Many falsely believe that they can tell if a potential sex partner is infected. Likewise, many infected persons fail to recognize their infections and fail to take precautions that would prevent disease transmission to their sex partners.

There is often a long interval (sometimes years) between acquiring a sexually transmitted infection and the recognition of a clinically significant health problem. Examples are cervical cancer caused by the human papillomavirus, liver cancer caused by hepatitis B virus infection, and infertility and ectopic pregnancy resulting from unrecognized or undiagnosed *Chlamydia* or gonorrhea. The original infection is often asymptomatic, and as a result, there is frequently no perceived connection between the original sexually acquired infection and the resulting health problem. People are less motivated to take initial preventive precautions because most people are unaware of this connection.

Gender and age are associated with increased risk for STDs. Compared to men, women are at higher risk of acquiring most STDs. For some STDs, young women are more susceptible than older women. Due to cervical ectopy (vulnerability), which is extremely common in adolescent females, the cervix of adolescent females is covered with cells that are especially susceptible to STDs such as *Chlamydia*. However, there are fewer of these cells on the cervix of older women. In addition, traumatic sexual practices predispose one to STDs. This has been well documented for receptive rectal intercourse; and in the case of many young women who report their first intercourse as not being voluntary, sexual trauma to the external and internal genitalia may also predispose one to acquiring an STD.

Some social and behavioral factors directly affect the spread of STDs, especially in certain vulnerable subpopulations. Other social factors create serious obstacles to STD prevention by adversely influencing social norms regarding sex and sexuality. Substance use, occupational sex, and STDs are closely connected, and substance use and occupational sex are frequently a cause for arrest and detention. Demonstrations are now beginning to show that comprehensive screening of incarcerated (jailed) populations can be done successfully and safely within the criminal justice system. Additionally, several interconnected themes are relevant to any discussion of poverty and marginalization. Marginalization refers to high-risk behaviors that result in a lesser likelihood of a person seeking needed health care.

Access to high-quality health care is essential for early STD detection and treatment, as well as for receiving counseling about behavior changes designed to reduce the likelihood of contracting or transferring STDs. Frequently, groups with the highest rates of STDs are also the same groups in which access to health services is poor or limited. It is essential that high-quality STD services are provided in health care programs designed to assist poor people and those with marginal health care.

Many studies document the association of substance use, especially alcohol and drug use, with STDs. At the population level, the introduction of new illicit substances into communities can often dramatically alter sexual behavior in high-risk sexual networks, leading to epidemic spread of STDs. Other substances, including alcohol, may affect an individual's cognitive and negotiating skills before and during sex, lowering the likelihood that preventive action will be taken to protect against STDs and pregnancy.

The spread of HIV infection in the United States through heterosexual transmission has closely followed in the footsteps of other STD epidemics. For example, the geographic distribution of heterosexual HIV transmission in the South closely parallels that of other STDs. There is compelling evidence from all over the world that the presence of other STDs increases the likelihood of both transmitting and acquiring HIV infection. Prospective epidemiological studies from four continents, including North America, have repeatedly demonstrated that when other STDs are present HIV transmission is at least two to five times higher than when other STDs are not present.

Biological studies demonstrate that when other STDs are present, an individual's susceptibility to HIV infection is increased, and the likelihood of a dually infected person (having both HIV infection and another STD) infecting other people with HIV infection is increased. Conversely, effective STD treatment can slow the spread of HIV. The early detection and treatment of other STDs can substantially reduce HIV transmission at both the individual and community levels.

There are three major personal behavior factors involved in STD infections: 1) initiating behaviors; 2) modifying behaviors; and, 3) transmission dynamics.

In 1996, 15 to 19-year-old teenagers had the highest reported rates of both *Chlamydia* and gonorrhea. Also, the herpes infection rate among white youth aged 12 to 19 was recently shown to have increased nearly fivefold from a decade before. However because not all teenagers are sexually active, the actual rate of sexually transmitted infection among teens is even higher than the observed rates

suggest. In 1995, 50.4% of 15 to 19-year-old females interviewed for the National Survey of Family Growth indicated that they experienced sexual intercourse. In the same year, 51.7% of adolescent males in high school reported having sexual intercourse by age 16.

Recent analyses of sexual activity among adolescent females not only illustrate the frequency of such behaviors, but also bring to light that not all sexually experienced young females enter a sexual relationship as a willing partner. In fact, sexual coercion is a significant problem for America's young women. In 1995, 16.1% of females whose first intercourse occurred when they were 15 years old or younger indicated that their first intercourse was not voluntary. This is an aspect of sexual behavior affecting adolescents that demands increased national and local attention, both for social justice and for health reasons. Sexual violence against women contributes both directly and indirectly to transmission of STDs. Directly, women experiencing sexual violence are less able to protect themselves from STDs or pregnancy. Indirectly, research demonstrates that women with a history of involuntary intercourse are also more likely to have voluntary intercourse at earlier ages, a known risk factor for STDs.

Correct and consistent condom use interferes with STD transmission. While condom use has been on the rise in the United States over the past few decades, women who use the most effective forms of contraception (sterilization and hormonal contraception) are less likely than other women to use condoms for STD prevention.

According to the Institute of Medicine Report, *The Hidden Epidemic: Confronting Sexually Transmitted Diseases,* "Because no single method of preventing STDs or pregnancy confers the maximum level of protection against both conditions, use of dual protection -- that is, a condom and another effective contraceptive for pregnancy -- is especially important. It is not clear, however, how well the public understands the need for dual protection against STDs and pregnancy." Dual methods could help avoid both unwanted pregnancy and STDs. However, most sexually active young people today do not employ this strategy.

Identifying and treating partners of persons with curable STDs has always been an integral part of organized control programs. Theoretically, this can break the chain of transmission in a sexual network. Early antimicrobial prophylaxis of the exposed partner interferes with transmission and thwarts infection. Partner treatment benefits the index (original) patient by reducing the risk of reinfection by an untreated partner, and the partner benefits by avoiding acute infection and potential complications.

Also, future sex partners are protected; thus, as a strategy, this also benefits the community. Active partner notification and partner treatment have been the traditional responsibility of personnel in public STD clinics. Because the majority of STD care in the United States is delivered in the private sector, it is especially important that private health care providers, managed care organizations, and health departments work together in the future to overcome barriers to rapid and effective treatment of sex partners.

Screening and treatment of STDs affect both transmission and duration factors. For curable STDs, screening and treatment can be cost effective or even cost saving in altering the period during which infected persons can infect others. Screening for STDs clearly meets the criteria for an effective preventive intervention. For STDs that are frequently asymptomatic, screening and treatment also benefit those likely to suffer severe complications (especially women) if infections are not detected and treated early.

STDs involve health disparities (differences), with certain populations being at increased risk. All racial, cultural, economic, and religious groups are affected by STDs. Nevertheless, some groups are disproportionately affected by STDs and their complications. These include women, infants, adolescents, and racial and ethnic groups.

Women suffer more serious STD complications and they occur more frequently in women than in men. Among the most serious STD complications that occur among women are pelvic inflammatory disease, ectopic pregnancy, infertility and chronic pelvic pain. Women are biologically more susceptible to infection when exposed to a sexually transmitted disease agent

Frequently, STDs are more easily transmitted from a man to a woman than from a woman to a man. This is further complicated by the fact that acute STDs (and even some complications) are often very mild or completely asymptomatic in women. This combination of increased susceptibility and "silent" infection frequently results in women being less suspicious of having an STD, which results in delayed diagnosis and treatment

STDs in pregnant women can cause serious health problems or death in the fetus or newborn. Sexually transmitted organisms in the mother can be transmitted across the placenta to the fetus or newborn, resulting in congenital infection; or it can reach the newborn during birth, resulting in perinatal infections.

For a variety of behavioral, social, and biological reasons, STDs also disproportionately affect adolescents. In 1997, teenagers 15 to 19 years of age had the highest reported rates of both *Chlamydia* and gonorrhea.

Many teenagers are, in fact, sexually active and at higher risk for STDs. In the 1997 Iowa Youth Risk Behavior survey, 43% indicated they had sexual intercourse at some time in their lives. In the same year, 5.6% of adolescent males in high school reported having sexual intercourse by age 13.

Teenagers are more likely than older individuals to have sex partners who are active in sexual networks whose members are already highly infected with untreated STDs.

Sexually active teenagers are often reluctant to -- or face serious obstacles when trying to -- obtain STD services. In addition, health care providers are often uncomfortable discussing sexuality and STD risk reduction with young people.

Surveillance data show high rates of STDs for some minority racial or ethnic groups (mainly African American and Hispanic populations) compared with rates for whites. Race and ethnicity in the United States are risk markers that correlate (have a connection) with other more fundamental determinants (influencing factors) of health status such as poverty, access to quality health care, health care-seeking behavior, illicit drug use, and living in communities with a high prevalence of STDs.

National surveillance data may over-represent STDs among racial and ethnic groups who are more likely to receive STD services from public-sector STD clinics where timely and complete morbidity (disease) reporting is generally the rule. However, serosurveys using random sampling techniques document higher rates of STDs among marginalized populations, particularly African Americans, compared with whites. Recent surveillance data provides the following information on certain STDs.

Chlamydia: An estimated 4 million new chlamydial infections occur in the United States every year, 2.6 million of which are in women. *Chlamydia* is extremely common in sexually active adolescents and young adults. The highest annual rates are reported among 15- to 19-year-old females. In 1998, *Chlamydia* continued to be the most frequently reported communicable disease in Iowa, with 5,173 cases reported.

Reported *Chlamydia* rates have increased dramatically since 1984. The increase in the number of reported cases reflects the growing availability of inexpensive, accurate diagnostic tests and the gradual acceptance of *Chlamydia* screening and reporting, particularly for asymptomatic women.

Reported rates of *Chlamydia* for women greatly exceed those for men. This is primarily because detection of asymptomatic infection in women is discovered through screening. Low rates in men suggest that many of the sex partners of women with *Chlamydia* are not diagnosed or reported. The incremental impact of screening and treating men to reduce complications in women is unknown.

Chlamydia was made a reportable disease in Iowa in 1986. On the basis of medical research and national projection, Iowa began developing a *Chlamydia* control program -- much like the successful gonorrhea control program initiated in 1972. With the advent of new testing procedures that are inexpensive, rapid, and specific, an aggressive screening and detection program aimed at individuals at risk has become a reality. The STD/HIV prevention *Chlamydia* screening project now provides testing for almost 60,000 individuals each year.

Gonorrhea: In the United States, an estimated 600,000 infections with gonorrhea occur each year. Most infections among individuals with symptoms will cause them to seek curative treatment soon enough to prevent serious results from the infection, but this may not be soon enough to prevent transmission to others.

Gonorrhea morbidity in Iowa continues to reflect the influence of state-supported screening. In 1989, there were 2,800 reported cases; and in 1998, 1,615 reported cases, a 42% decrease. The success of this program is clear; however, many problems remain. Of the 1,615 cases reported in 1998, 749 were reported in African Americans (46% of all reported cases).

Syphilis: Syphilis is a systemic disease caused by the bacteria *Treponema pallidum*. Patients who have syphilis may seek treatment for signs or symptoms of primary infection (such as an ulcer or chancre at the infection site); secondary infection (such as other manifestations including rash, mucocutaneous (mucous membranes or skin) lesions, and adenopathy -- any disease of the glands -- or tertiary infection; for example, of the heart, neurologic, ophthalmic (eyes), auditory, or certain types of lesions). Infections also may be detected by serologic testing during the latent stage.

Syphilis, like other sexually transmitted diseases, reflects an over-representation in minority populations. Those diagnosed with early syphilis are older than those diagnosed with gonorrhea and *Chlamydia*.

In 1998, there were five primary and secondary and 20 early latent cases of syphilis (0.9 cases per 100,000 population) reported to the STD/HIV Prevention Program in Iowa.

Early syphilis morbidity in Iowa is now at its lowest level since the disease became reportable in the late 1940s. The state of Iowa now has a realistic opportunity to eliminate endemic syphilis. This goal of syphilis elimination has become one of the STD/HIV Prevention Program's most important objectives before the year 2010.

Goal statements and action steps in this chapter are related to reducing illness and death by preventing cases and complications of specific sexually transmitted diseases such as syphilis; AIDS (Acquired Immunodeficiency Syndrome); gonorrhea and resistant strains of gonorrhea; *Chlamydia* trachomatis; and the severe complications of pelvic inflammatory disease. Since both inflammatory and ulcerative STDs facilitate the transmission of HIV infection, treating these conditions lowers both the individual and community risks of sexually transmitted HIV infection and are also chapter objectives.

Goal Statements and Action Steps

19-1 Goal Statement

Reduce the prevalence of *Chlamydia trachomatis* infections to no more than 140 per 100,000 population by 2010. (Baseline: it was 186.3 per 100,000 population in 1998.)

Rationale

This action step can be achieved by the expansion of existing screening programs to reach individuals at higher risk. These include persons from 15 to 24 years of age,

minority populations and those in the juvenile justice system as well as other identified high-risk youth.

19-1.1 Action Step

Accomplish the following:

a. conduct by 2002 a contact interview and case follow up of 50% of all reported *Chlamydia* cases, and generate morbidity activity reports to provide the number of investigations performed, and the total number of contacts elicited; the reports will list by investigator the number of contacts who have been located, tested, and treated;

b. increase *Chlamydia* screening to 65 provider sites and test 65,000 individuals annually by 2003.

(An Iowa Department of Public Health action step.)

19-2 Goal Statement

Reduce the incidence of gonorrhea to no more than 43 cases per 100,000 people by 2010. (Baseline: in 1998, the gonorrhea rate in the general population in Iowa was 58.2 per 100,000.)

Rationale

Reduction of gonorrhea morbidity can be achieved by improving both access to health care by minority populations and education of individuals to recognize the symptoms of gonorrhea and to seek treatment quickly when symptoms appear.

19-2.1 Action Step

Accomplish the following:

a. provide 80% of all reported gonnorhea cases with contact interview and case follow-up by 2002, and generate monthly activity reports to give the number of investigations these reports will list, by investigator, the number of contacts who have been located, tested, and treated;

b. increase by 2003, gonorrhea screening to 55 provider sites and test 35,000 individuals performed and the total number of contacts elicited; annually by 2003.

(An Iowa Department of Public Health action step.)

19-3 Goal Statement

Eliminate transmission of primary and secondary syphilis by 2010. (Baseline: in 1998, the primary and secondary syphilis rate in the general population was 0.9 per 100,000.)

Rationale

The early stages of syphilis cause recognizable genital ulcers and other infectious lesions. Left untreated, syphilis enters a latent phase that damages the internal organs over a prolonged time period. Detected and treated in its early stage prevents both its transmission and patient morbidity.

19-3.1 Action Step

Conduct a contact interview and case follow-up on 100% of all locatable syphilis positive individuals, and generate monthly activity reports to give the number of investigations performed and the total number of contacts elicited; these reports will list, by investigator, the number of contacts who have been located, tested, and treated. (An Iowa Department of Public Health action step).

19-4 Goal Statement

Maintain the number of public health jurisdictions with populations of 50,000 or more that have at least one dedicated sexually transmitted disease clinic that provides comprehensive, sexually transmitted disease care by 2010.

Rationale

Many individuals will not seek STD/HIV diagnosis by their primary physician. By maintaining the number of public health jurisdictions with populations of 50,000 or more that have at least one dedicated STD clinic, most individuals statewide will have access to confidential diagnosis and treatment.

19-4.1 Action Step

Maintain the STD/HIV Prevention Program so it will support local STD/HIV testing and treatment at local public health clinics in jurisdictions with populations of 50,000 or more; with support consisting of laboratory supplies, laboratory services, and treatment drugs; and when partner notifications are not maintained by local jurisdictions, (if possible) it should be provided by the state STD/HIV Prevention Program by 2001.

(An Iowa Department of Public Health action step.)

19-5 Goal Statement

Increase to 50% the proportion of sexually active women under the age of 25 who are screened annually for *Chlamydia* and gonorrhea infections in primary health care settings by 2010.

Rationale

Screening and treatment of STDs affect both transmission and duration factors. For curable STDs, screening and treatment can be cost effective, or even cost saving, by altering the period during which infected persons can infect others. Screening for STDs clearly meets the criteria for an effective preventive intervention. For STDs that are frequently asymptomatic, screening and treatment also benefit those likely to suffer severe complications (especially women) if infections are not detected and treated early. For example, *Chlamydia* screening in a large metropolitan managed care organization reduced the incidence of subsequent pelvic inflammatory diseases in the Pacific Northwest; the burden of disease in the population was reduced by 60% in five years. When combined with a new generation of sensitive and rapid diagnostic tests, some of

which can be performed on a urine specimen, STD screening of specific high-risk populations in nontraditional settings appears to be a promising control strategy that will gain strength in the next decade.

Chlamydia infection rates among men are highest among the 20- to 24-year-old age group. While there is insufficient evidence to recommend for or against routine screening in sexually active men, in situations where asymptomatic *Chlamydia* infection is high in males, screening using urine-based tests may be recommended to prevent spread of the infection (United States Preventive Services Task Force, 1996.)

Infertility due to STDs is a preventable condition. Diagnosis and treatment of infertility are very costly, time-consuming, and invasive; and they can place immense stress on marital and family relations. Furthermore, such costs are likely to rise because more and more infertile couples seek expensive infertility services. This is due to such trends as delaying childbearing (because fertility becomes increasingly impaired with age), the fact that fewer infants are available for adoption, and the development of new drugs and treatment procedures.

19-5.1 Action Step

Survey by 2001 primary health care settings for actual clients seen, ages, and number of clients screened. (An Iowa Department of Public Health action step.)

19-6 Goal Statement:

Increase to 60% by 2010 the proportion of pregnant women screened for STDs including HIV infection during prenatal health care visits, according to recommendations in the most recent edition of the *Guide to Clinical Preventive Services***.**

Rationale

Early diagnosis and treatment of STDs including HIV can prevent complications, both future and present, for mother and child. Early diagnosis of HIV in pregnancy can prevent infection in the newborn infant.

19-6.1 Action Step

Conduct and publicize the results of the following:

a. survey by 2002 all health care practitioners who see pregnant women regarding their screening practices for STDs, including HIV infection, during prenatal health care visits;

b. publicize and disseminate results of the survey.

(An Iowa Department of Public Health action step).

19-7 Goal Statement

Increase to 50% the number of youth detention facilities and adult city and/or county jails in which screening for common bacterial STDs is conducted within 24 hours of admission by 2010; and treat before release.

Rationale

Youth and adults in detention and correction facilities have some of the highest rates of STD/HIV in Iowa. Screening, treatment, and counseling for this population will have the greatest impact on disease if done in a timely fashion so that intended clients receive counseling and treatment prior to release.

19-7.1.Action Step

Initiate by 2002 a collaborative process with the Iowa Department of Human Services juvenile facilities and local health departments to establish routine screening of common STDs upon entry into the juvenile justice system. (An Iowa Department of Public Health and Iowa Department of Human Services action step.)

19-8 Goal Statement

Increase to 90% the proportion of all STD clinic patients treated for bacterial STDs (*Chlamydia*, gonorrhea, and syphilis) who are offered provider referral services for notification of sexual partners by 2010.

Rationale

Active partner notification and partner treatment have been the traditional responsibility of personnel in public STD clinics. New approaches for getting more partners treated by involving index (original) patients in the process of referring their partners for evaluation and treatment or for using different approaches to sexual network analysis are currently being assessed both in traditional and nontraditional STD treatment settings.

19-8.1 Action Step

Provide by 2002 training to STD/HIV prevention partners and/or provider sites for the process of training medical staff on how to counsel infected patients to refer their sexual contacts for medical diagnosis and treatment. (An Iowa Department of Public Health action step.)

19-9 Goal Statement

Increase to 75% the proportion of health care providers who initiate a discussion of HIV and sexually transmitted disease prevention during initial visits with female patients who request reproductive health services by 2010.

Rationale

Changing sexual behaviors and sexual norms will be an important part of any long-term strategy to develop a more effective national system of STD prevention in the U.S. It will be necessary to establish a new sexual openness as the norm in America. It must be an openness that will both allow and expect parents to talk frankly and comfortably with their children about preferred sexual behavior and avoiding risks, for sex partners to talk openly about safe sex behaviors, and for health care providers to talk comfortably and knowledgeably with patients about sexuality and sexual risk, to counsel them about risk avoidance, and to regularly screen them for STDs when indicated.

19-9.1 Action Step

Collect and disseminate results of the following:

a. survey all health care providers by 2005 as to their current practices for assessing their patients' sexual history; and

b. publicize and disseminate the results.

(An Iowa Department of Public Health action step.)

The overall goal for HIV is to prevent its transmission and associated illness and death by ensuring that: 1) all persons at risk for HIV infection know their serostatus; 2) those persons not infected with HIV remain uninfected; 3) those persons infected with HIV do not transmit HIV to others; and (4) those infected with HIV are accessing the most effective therapies possible. . Before proceeding further, some definitions are needed.

AIDS: Acquired Immune Deficiency Syndrome, the most severe phase of infection with the Human Immunodeficiency Virus (HIV). People infected with HIV are said to have AIDS when they get certain AIDS indicator diseases (opportunistic infections and certain cancers) or when their CD_4+ cell count drops below 200.

CD_4+ cell count: A type of T cell (also known as T helper cells) involved in protecting against viral, fungal, and protozoal infections. These cells normally orchestrate the immune response, signaling other cells in the immune system to perform their special functions. Because HIV infection kills these cells, their numbers provide a good way to track the progress of an HIV infection. A higher number usually means better health. The CD_4+ cell count is an indicator of which opportunistic infections a patient is at risk for developing.

HIV: Human **I**mmunodeficiency **V**irus, the virus that causes AIDS.

Opportunistic infections: Infections that take advantage of the opportunity offered when a person's immune system has been weakened by HIV infection. Opportunistic infections could be bacterial, fungal, or viral.

Serostatus: The result of a test for the antibodies that the immune system creates to fight specific diseases.

Seropositive: Indicates that a person's blood contains antibodies revealing an HIV diagnosis.

Viral load (or viral burden): refers to a measurement of the number of HIV particles. The total viral load is the amount of HIV in the blood lymph nodes, spleen, and other parts of the body. If the viral load measurement is high, it indicates that HIV is reproducing, and that the disease will likely progress faster than if the viral load is low.

It also may be helpful to focus on the effect HIV/AIDS has had on the United States in the context of terms that are common to other Healthy Iowa 2010 chapters.

Cost effective: Means that dollar costs of the intervention compare favorably to life-saving interventions associated with other diseases usually costing less than $50,000 per quality-adjusted life year saved.

Cost-saving: Means that the intervention averts health care costs in excess of the cost of the intervention.

Disability: An indicator of the extent to which an individual is forced to cut back on his or her activities of daily life. Although people with an asymptomatic HIV infection are able to go about their every day business in a routine manner, the degree of HIV-associated disability can range from slight to severe.

Incidence: A measure of the number of *new* cases reported in a given amount of time, usually within a year. Because HIV infection often is without clear early symptoms, most persons fail to recognize their infection until some period has passed, often years. It is estimated that approximately 40,000 new HIV infections occur each year in the United States.

Morbidity: The term often used in the place of *illness* or *disease*. In the case of HIV, morbidity is usually measured in illnesses that are part of a group referred to as AIDS indicator diseases.

Mortality: A measure of the number of *deaths* directly attributed to an HIV infection or AIDS indicator diseases. There has been a marked decline in the number of deaths among people with AIDS nationally compared to 1996 (44% during the first six months of 1997 compared to the first six

months of 1996.). These surveillance data suggest that new therapies, coupled with the success of comprehensive prevention efforts begun in the 1980s, not only are delaying progression from the diagnosis of AIDS to death but, with early diagnosis and treatment, also are helping to delay the progression from HIV infection to an AIDS diagnosis for many individuals.

Prevalence: A measure of the number of people who are infected, at any one point in time, with HIV or diagnosed with AIDS. Because HIV infection is not a reportable condition in all states, the number of persons with HIV infection in the United States can only be estimated and ranges from 650,000 to 900,000. In Iowa, the number of persons with HIV infection is estimated to be between 1,000 and 1,300. It has also been estimated that perhaps one-third of these people do not know they are infected with HIV. As the number of new AIDS cases has stabilized and as the number of deaths has begun to decrease, the number of people living with AIDS has risen 10% since mid-1995. As prevalence increases, it underscores the increasing need for medical and other services for people living with AIDS, and the importance of continued prevention efforts to reduce the number of new HIV/AIDS infections.

Survival rates: A measure of the time that elapses between a person's infection with HIV and the time of death. The HIV or AIDS survival rate has been of interest to researchers from the earliest days of the AIDS epidemic. There is much that is thought to contribute to a person's ability to survive after infection, and the ability to stay alive seems to vary considerably among individuals. Some persons appear to get sick quickly and die quickly while others have remained disease free for nearly 20 years. Many researchers believe that receiving good medical care and treatment with the new combination therapies may extend a person's time and quality of life after infection with HIV.

The HIV/AIDS epidemic is a relatively recent public health phenomenon in the United States and globally. The disease was first recognized in the United States in 1981 and in Iowa in 1983.

In the early years of the epidemic, a majority of AIDS cases occurred in men, with only 5% occurring in females in 1982. In late 1982, cases of AIDS traceable to blood transfusions were first reported in the United States. Very soon thereafter, interagency recommendations to prevent AIDS were published, with specific guidance focused on blood donations. As the nation continued to learn more about AIDS and HIV disease, precautions and guidelines continued to be developed, with recommendations designed to protect health care workers and to test donated blood. In late 1985, recommendations for the prevention of AIDS in the work place and in perinatal transmission were published.

By the early 1990s, many changes in the epidemic were apparent. AIDS cases were being reported from every state and most large cities. Nationally, the proportion of AIDS cases in white homosexual men declined, while the proportion in minority men and women began to increase. Nationally, cases also appeared to be increasing among injecting drug users and their partners. This trend was not reflected in Iowa until the mid 1990s and the proportion of cases in minority men and women slightly increased in the mid 1990s.

AIDS cases in females have increased steadily and now make up nearly 20% of total cases. Incidence of AIDS cases in Iowa in females has remained low. In 1992, AIDS became a leading cause of death; first, among African-American females; and later, among all Americans in this age group. Today, it is the second leading cause of death among Americans 25 to 44 years old and remains the leading cause of death for African-Americans in this age group. In contrast, AIDS is not one of the five leading causes of death in any age group in Iowa.

AIDS cases have been reported from 84 of Iowa's 99 counties. The eight most populous counties (>50,000) account for 67% of the total AIDS cases reported in Iowa. They do not include cases where patients resided and were diagnosed outside of Iowa but then later moved to Iowa to receive care. The numbers of cases do not indicate how many are living or dead or reflect the movement of people within the state.

Effective July 1, 1998, Chapter 141 of the *Code of Iowa* required the use of names in reporting HIV infection to the Iowa Department of Public Health by both the involved laboratory and the health care provider. Infection reporting by name in Iowa helps in the following ways: 1) it improves the ability to track the epidemic; 2) use of names provides the data needed to design targeted prevention and/or intervention and care programs; 3) it helps to identify exposed individuals who have become infected and helps them get counseling, treatment and partner counseling and referral.

Since the early 1980s, it has become clear that there are at least four distinct HIV/AIDS epidemics of public health significance:

- An epidemic among *men who have sex with men*, facilitated by both frequent changes of sex partners in highly infected sexual networks and high-risk (traumatic) sexual practices.
- An epidemic among *injecting drug users and their sexual partners*, facilitated by persons sharing the use of needles and syringes that are contaminated with HIV-infected blood.
- An epidemic among *heterosexual persons*, facilitated by: 1) high rates of other sexually transmitted diseases (STDs) that can increase both susceptibility to and the transmissibility of HIV infection; and 2) high-risk sexual practices (mainly unprotected sex) associated with certain addictive substances such as crack cocaine.
- A *perinatal* epidemic among infants caused by undetected and untreated HIV infection in pregnant women.

According to the *MMWR*, Feb. 28, 1997, issue: "In 1996, for the first time, deaths among persons with AIDS decreased

substantially in the U.S. This decrease in AIDS deaths reflects both the leveling of AIDS opportunistic infection (OI) incidence and improved clinical survival among persons with AIDS. This decline reflects the combined impact of the comprehensive prevention efforts instituted in the 1980s, which have helped slow the epidemic in recent years, and the success of new therapies in lengthening the healthy life span of people with HIV. At the same, time, there has been a substantial increase in AIDS prevalence.

"Prevalence is a function of both the rate of new infections and the duration of illness. The increase in AIDS prevalence reflects declines in AIDS deaths and stable AIDS incidence. The increased prevalence of AIDS indicates the need for medical and other services for persons with HIV infection and for prevention programs to reduce the number of persons becoming infected with HIV."

In Iowa, of the 1,135 total AIDS cases reported through 1998, 87% (n=981) are white non-Hispanic; 9% (n=104) are black, non-Hispanic; 3.2% (n=36) are Hispanic; 0.4% (4) are Asian/Pacific Islander; and 0.2% (2) are American Indian. When examining the population according to its racial distribution -- although the numbers reported are small -- minority groups seem to be disproportionately infected.

An analysis of data by five-year aggregates reveals that between 1983 and 1987, 2.9% of total cases (n=103) were reported in black non-Hispanic populations and 0.9% for Hispanic. In the years 1988 through 1992, 6.3% of the total cases (n=488) reported were in black non-Hispanic, 2.4% were Hispanic and 0.6% were Asian. Between the years 1993 and 1998, 13% of AIDS cases (n=542) were in black non-Hispanic, and 4.2% in Hispanic. Although the racial group most affected by the epidemic continues to be white non-Hispanic, an analysis by five-year aggregates reveals that the numbers of HIV-infected individuals within racial minority groups have increased slightly.

The disproportionate impact of HIV/AIDS underscores the importance of implementing and sustaining effective prevention efforts for all communities of color. HIV prevention efforts must take into account not only the multiracial and multicultural nature of our society, but also other social and economic factors that impact health status such as: underemployment, poverty, and poor access to the health care system.

Nationally, deaths from AIDS continued to decline throughout 1998 (23% decline compared to 1995), and the number of people living with AIDS increased 11%. If declines in newly diagnosed AIDS cases continue, in the coming years there will also be an increasing number of people living with HIV infection who have not yet developed AIDS. In Iowa, deaths from AIDS have decreased from 103 in 1992 to 15 in 1998.

Paradoxically, as people live longer the lifetime costs of health care associated with HIV, in light of recent advances in HIV diagnostics and therapeutics, have grown from $55,000 to $155,000 or more per person. HIV prevention efforts can be cost effective and even result in a cost saving to society. These efforts include 1) counseling, testing, referral, and partner counseling and referral services for HIV infection; 2) health education and/or risk reduction activities; and 3) information for clients at high risk for HIV infection.

Interventions for combating HIV are both biomedical and behavioral. Recent advances in antiretroviral therapy have been credited with dramatic declines in mortality associated with HIV and AIDS. However, declines in AIDS incidence and prevalence, particularly in early epicenters (focal points) of the epidemic such as San Francisco and New York, predate the advent of antiretroviral therapies and support the belief that behavior-based prevention programs are effective. In San Francisco, for example, AIDS incidence among men who have sex with men began dropping in 1992, suggesting that sustained, comprehensive prevention activities started in the 1980s have succeeded in reducing HIV transmission in this group.

Behavioral interventions vary nationwide, depending on the audience for whom the program is designed, who designed it, and available funds. The most successful strategies as prioritized by the Iowa HIV Prevention Community Planning Group include small group-level counseling, street and community outreach, use of opinion leaders and individual level counseling.

Following the 1994 finding that perinatal HIV transmission rates could be substantially reduced with zidovudine therapy, the Public Health Service issued guidelines recommending that HIV counseling and voluntary testing be a part of routine prenatal care for all pregnant women. This policy ensures that HIV-infected women have access to important health care for themselves and also have the opportunity to reduce the risk of HIV transmission to their infants. Subsequent declines in AIDS incidence among children offer promising hope that these strategies are showing success in reducing mother-to-infant transmission. In Iowa, HIV infection rates among pregnant women appear to be low. There were no reports of pediatric HIV infection caused by transmission from infected mothers during 1998. Moreover there were no AIDS cases reported in children in 1998.

19-10 Goal Statement

Monitor the reporting of AIDS cases to measure improvement in the rate on an annual basis.

Rationale

Planning of targeted prevention interventions and care and treatment activities can only be done with adequate information about disease patterns. The long interval between infection and disease and the emotional reaction to AIDS complicate the assessment process. Since the majority of individuals who will be diagnosed with AIDS in the year 2010 are already infected with HIV, it is clearly necessary to assess more broadly than simply monitoring the number of diagnosed cases.

19-10.1 Action Step

Monitor the annual rate of AIDS cases. (An Iowa Department of Pubic Health action step.)

19-11 Goal Statement

Reduce the annual incidence (new cases) of diagnosed AIDS cases among adolescents and adults to no more than 2 per 100,000 population by 2010. (Baseline: there were 2.5 cases per 100,000 population in 1998.)

Rationale

Reducing the incidence of new cases of AIDS is an indicator that behavioral prevention activities are working and/or that HIV drugs are working to stop or lengthen the time before development of AIDS. Unknown factors include treatment availability, available resources to provide that treatment, and possible drug resistance.

19-11.1 Action Step

Monitor the annual incidence (new cases) of diagnosed AIDS cases. (An Iowa Department of Public Health action step.)

19-12 Goal Statement

Reduce the annual number of diagnosed AIDS cases among adolescents and adults to no more than 30 cases by 2010. (Baseline: there were 63 diagnosed AIDS cases in 1998.)

Diagnosed Cases by Exposure Category	1998	2010 Target
Male exposure category		
Men who have sex with men	41	21
Injecting drug use	3	2
Men who have sex with men and inject drugs	2	1
Heterosexual contact	***2***	***1***
Female exposure category		
Injecting drug use	2	1
Heterosexual contact	8	4

19-12.1 Action Step

Reducing the number of annual AIDS cases can be tracked and accomplished by the following activities:

a. monitoring the annual number of diagnosed AIDS cases among adolescents and adults;

b. Implementing prevention programs that target specific at-risk populations as designated in the Iowa HIV Prevention Comprehensive Plan and as developed by the HIV Prevention Community Planning Group.

(An Iowa Department of Public Health action step.)

19-13 Goal Statement

Reduce by 2010 the annual incidence of diagnosed HIV infection among adolescents and adults to 50% of the baseline established in 2001.

Rationale

One of the most important ways to prevent additional AIDS cases is by reducing the number of new HIV infections.

19-13.1 Action Step

A reduction in HIV cases will be helped by the following activities:

a. establishing by 2001a baseline for HIV incidence based on HIV name reporting which became effective in Iowa on July 1, 1998;

b. implementing prevention programs that target specific at-risk populations as designated in the Iowa HIV Prevention Comprehensive Plan and as developed by the HIV Prevention Community Planning Group.

(An Iowa Department of Public Health action step.)

19-14 Goal Statement

Increase to 55% the proportion of sexually active students who reported that a condom was used during the past three months. (Baseline: 48% of students who had sexual intercourse during the past three months used a condom, according to the Youth Risk Behavioral Survey.)

Rationale

Scientific data about the effectiveness of latex condoms in preventing HIV transmission are very clear. Latex condoms are highly effective barriers to HIV when used consistently and correctly. Carefully designed studies among heterosexual couples in which one partner is HIV positive and the other is not demonstrate that latex condoms provide a high level of protection against HIV. Increased condom use is essential for slowing the spread of HIV infection.

19-14.1 Action Step

Improvement in the number of young people using a condom at each sexual intercourse experience can be encouraged and monitored by the following activities by 2001:

a. seek input from young adult roundtables on condom knowledge, attitudes and behavior;

b. increase annually the ability of teachers to effectively handle the subject of condom use through presentations and provision of community resources;

c. monitor the results of the Youth Risk Behavior Survey.

(An Iowa Department of Education and Iowa Department of Public Health action step.)

19-15 Goal Statement

Increase to 70% the proportion of clients who are screened for common bacterial STDs (*Chlamydia*, gonorrhea, and syphilis) and who agree to HIV testing by 2010.

Rationale

Recent data indicate that other STDs substantially increase the risk of HIV transmission. Treating other STDs reduces HIV spread in communities. In the United States, STD rates are high and STD clinical services are inadequate in the face of a changing HIV epidemic. Closely coordinating or integrating HIV prevention and STD prevention services is necessary and cost effective to reduce the transmission of HIV and other STDs, according to the Recommendations of the Advisory Committee for HIV and STD Prevention. Following are some of these methods.

Early detection and treatment of curable STDs should become a major, explicit component of comprehensive HIV prevention programs at the national, state, and local levels.

Screening and treatment programs for STDs that have been shown to facilitate HIV transmission should be expanded in settings where these diseases are prevalent.

Implementation of this strategy should be the joint responsibility of HIV and STD prevention programs.

Persons at risk for HIV infection should know their serostatus. This knowledge is important to understand individual behavioral risks and to enable people to take responsibility for their own actions, including participating in programs that promote behavioral change and healthier lifestyles. This is a primary step for persons whose drug use or high-risk sexual behaviors place them at risk of HIV infection or its transmission to others. Identification of infection and access to medical care can improve health outcomes and also reduce the chances of HIV transmission.

19-15.1 Action Step

Monitor the annual proportion of clients who come to a clinic with STD symptoms and agree to an HIV test. (An Iowa Department of Public Health action step.)

19-16 Goal Statement

Increase to 90% the proportion of facilities providing treatment for injecting drug use that offer HIV counseling and voluntary testing by 2010.

Rationale

In Iowa, injecting drug use has been directly or indirectly involved with 19% of all Iowa AIDS cases from 1983-1998. Of these cases, 83% are injecting drug users while the remaining 17% are sex partners of injecting drug users or newborns infected by their mothers. Sexual contact with an injecting drug user continues to be a factor in expanding the number of heterosexual AIDS cases in Iowa. Gender does not appear to play a deciding role in heterosexual contact with injecting drug users. It is equally distributed between females and males (50% each) -- from *AIDS in Iowa*, *1997*, by the Iowa Department of Public Health. Drug treatment services and risk-reduction programs should offer and promote HIV counseling and voluntary testing of injecting drug users.

19-16.1 Action Step

To increase the number of facilities able to treat injecting drug users accomplish the following:

a. establish a baseline for the proportion of facilities providing treatment for injecting drug use that offer HIV counseling and volunteer counseling by 2001;

b. continue to offer training to all counselors who work with injecting drug users;

c. secure state funding for expanded HIV testing in substance abuse facilities by 2004.

(An Iowa Department of Public Health action step.)

19-17 Goal Statement

Maintain at 100% the proportion of inmates in the state prison system who receive HIV testing and appropriate counseling during incarceration by 2010. (Current law now mandates HIV testing on intake to the state correctional system.

Rationale

Incarceration provides an environment in which early interventions and risk-reduction behaviors can be taught and reinforced over time. It also provides an opportunity to provide the support and continuity of care when the individual is released and returns to his or her home community. Early access to care reduces both immediate and long-term health care costs for correctional institutions and the community. State prison systems provide access to treatment and care to those individuals identified as infected with HIV. Due to the number of prisoners in county facilities, it is important that this population also be offered the opportunity to be tested so they will know their serostatus.

19-17.1 Action Step

Monitor current law to maintain testing in prison systems.

(An Iowa Department of Corrections and Iowa Department of Public Health action step.)

19-18 Goal Statement

Increase to 90% the proportion of county jail inmates who will be offered HIV testing and appropriate counseling while incarcerated in jails located in counties with a population of over 50,000 by 2010. (An Iowa Department of Public Health action step.)

Rationale

Since there are many county inmates incarcerated in county jails, they should also be tested for HIV and offered counseling.

19-18.1 Action Step

To control spread of HIV among the county jail inmate population, the following activities need to occur:

a. establish a baseline by 2001 for the proportion of county jail inmates that are offered HIV testing and appropriate counseling while incarcerated in jails located in counties with a population of over 50,000;

b. secure state funding by 2002 for expanded HIV testing in jails in counties with a population of over 50,000;

c. offer training on counseling for HIV by 2003.

(An Iowa Department of Public Health action step).

19-19 Goal Statement

Increase to 50% the proportion of people at risk for HIV with reported tuberculosis (TB) and who also have knowledge of their HIV serostatus by 2010. (Baseline: Currently, 35% of reported adult TB cases are also at risk for HIV infection.

Rationale

The rapid rate of progression to active TB disease among HIV-positive patients after infection with *M. tuberculosis* has been well documented. A TB-AIDS case registry match for 1993-94 showed that 22% of United States TB cases in the 25 to 44 age group also had HIV infection. (This is likely a minimum estimate due to case register matching methodologies.)

In Iowa, since 1983 there have been 18 cases of HIV-TB co-infection. Early detection of HIV in TB patients also allows for early intervention and treatment that may prevent or delay the development of other HIV-related illnesses and AIDS. In fact, many individuals who are diagnosed with TB that is related to compromised immunity caused by HIV are unaware of their HIV status. TB patients receive HIV testing only after counseling and informed consent from the patient. Because testing is voluntary, some patients may decline HIV testing. The Iowa Department of Public Health and the Centers for Disease Control and Prevention (CDC) collect data on reported TB cases that have information on HIV status.

19-19.1 Action Step

Monitor and offer clients who have TB an HIV test. (An Iowa Department of Public Health action step.)

19-20 Goal Statement

Increase the proportion of high school students in grades 9 through 12 who receive classroom education on HIV and other STDs to 97% by 2010. (Baseline: 93% in 1997 received this education, according to the Iowa Youth Risk Behavior Survey (YRBS) and the School Health Education Profile (SHEP).

Rationale

AIDS education in grades 1 through 12 is required under Iowa Department of Education, Chapter 12, General Accreditation Standards, 281-12.5 (356) 10 (5). However, the form for the AIDS education is a local school district and/or school board decision. According to the 1997 YRBS, a total of 92% of the students in grades 9 through 12 stated they had been taught about HIV infection or AIDS in school

In the 1998 SHEP, 92% of the lead health education teachers surveyed indicated that they taught about HIV infection and/or AIDS in their required health education classes. Surveyed principals, in the 1998 SHEP indicated that HIV and/or AIDS education is primarily taught in 7th and 8th grade (middle school), 7th to 10th grades (junior and senior high) and 9th and 10th (senior high); less than 50% indicated that HIV and/or AIDS was taught in grade 12.

19-20.1 Action Step

Monitor the results of the Iowa Youth Risk Behavior Survey and the School Health Education Profile Survey. (An Iowa Department of Education action step).

19-21 Goal Statement

Increase the percentage of HIV-infected adolescents and adults accessing care who receive treatment consistent with current United States Public Health Service treatment guidelines by 2010.

Treatment/Prophylaxis	1997	2010 Target
CD_4 testing	97%	99%
Viral load testing	*Not available*	99%
Antiretroviral therapy	82%	90%
Tuberculin skin testing (TST)	*Not available*	95%
Pneumococcal vaccination	*Not available*	95%
Pneumocystiscarinii pneumonia(PCP) Propylaxis with CD_4 less than 200	74%	90%

Rationale

Targets of 90-99% allow reasonable flexibility to account for those who do not access care, who refuse these services, or whose medical records are incomplete and do not document such services. The treatments and interventions measured are changing as research and treatment advances are made. Therefore, it may be advisable to adjust this goal in the future. The preventive interventions listed in this goal should be the standard of care for all eligible persons with HIV/AIDS.

19-21.1 Action Step

To ensure that educational needs are met including provider awareness of HIV drug treatment, the following must be accomplished:

a. increase provider awareness of Highly Interactive Antiretroviral Therapy;

b. survey physicians who treat clients with HIV regarding their use of treatment guidelines by 2003;

c. provide training to deal with unmet educational needs by 2004.

(An Iowa Department of Public Health and Midwest AIDS Training and Education Center.)

19-22 Goal Statement

Reduce mortality due to HIV infection to no more than 0.4 per 100,000 population by 2010. **(Baseline: current HIV mortality is now 0.5 per 100,000 population.)**

Rationale

In 1998, there was a decrease in the number of deaths attributed to AIDS: three deaths reported in 1998 compared to 15 deaths reported in 1997. The treatments, along with targeted, effective prevention interventions, will reduce the incidence of new HIV infection and its resulting mortality.

19-22.1 Action Step

Monitor annual mortality rate and length of time from identification of HIV infection to initiation of treatment. (An Iowa Department of Public Health action step.)

19-23 Goal Statement

Increase by 2010 the years of healthy life of an individual infected with HIV by extending the interval between an initial diagnosis of HIV infection and AIDS diagnosis, and between AIDS diagnosis and death.

Rationale

The impact of new drug therapies was first reported in 1997, when AIDS deaths dropped for the first time. This decline has continued, with deaths attributable to AIDS in the first six months of 1997 down 44% from the first six months of 1996.

19-23.1 Action Step

Monitor the interval between an initial diagnosis of HIV infection and AIDS diagnosis, and between AIDS diagnoses and death (An Iowa Department of Public Health action step).

19-24 Goal Statement

Eliminate any annual incidence of HIV cases acquired perinatally by 2010. (Baseline: there were 0 cases per 100,000 population acquired perinatally in 1998.)

Rationale

The National Institutes of Health sponsored an AIDS clinical trial, ACTG-076, that was stopped early in 1994 after it showed that the risk of perinatal HIV transmission could be reduced by as much as two-thirds with the use of zidovudine (AZT) therapy for HIV-positive pregnant women during pregnancy and childbirth and for their newborns for 6 weeks after birth. Additional research data confirmed what earlier research indicated -- that routine and universal counseling and voluntary testing, combined with AZT therapy, are highly effective in preventing HIV. In 1996 in Iowa, an Iowa Department of Public Health task force recommended that all pregnant women receive education about HIV prevention and risk reduction as early as possible during the prenatal period, and be offered voluntary testing in the presence of any risk factors or if the women requested the test.

Although the incidence of perinatally-acquired HIV infection among infants in Iowa is low, continuing the following strategies are necessary to ensure that HIV-infected women don't pass the disease to their children: 1) adequate prenatal care and timely HIV counseling and voluntary testing; 2) ready access to HIV-related care and services; 3) chemoprophylaxis to reduce perinatal transmission; and 4) avoidance of breastfeeding.

19-24.1 Action Step

Monitor the annual incidence of perinatally-acquired HIV. (An Iowa Department of Public Health action step.)

STD/HIV Chapter Team

Team Leader
John Olds
Wellmark, Inc.

Facilitators
Patricia A. Young
Iowa Department of Public Health

John Katz
Iowa Department of Public Health

Team Members
Joe Mahrenholz
Iowa Department of Human Services

David Yurdin
Broadlawns Medical Center

Karen Robinson
Johnson County Department of Public Health

Mike Lammer
University of Iowa Hospitals and Clinics

Jack Stapleton
University of Iowa Hospitals and Clinics

Pat Breckenridge
Polk County Health Department

Patricia Quinlisk
Iowa Department of Public Health

Dena Dillon
University of Iowa Hospitals and Clinics

Jane P. Getchell
University of Iowa Hygienic Laboratory

Sally Shelton
Blue Grass, Iowa

Peter Cannice
Des Moines, Iowa

Sara Peterson
Iowa Department of Education

Gloria Jorgensen
Quad Cities Regional Virology Center

Rob Sheldahl
Fort Dodge, Iowa

Attachment 3

M E M O R A N D U M

DATE: _____

TO: _____

FROM: HIV Prevention Community Planning Group Member **PHONE:** _____

RE: HIV Prevention - Key Informant Survey

A comprehensive community needs assessment is being conducted by the Iowa Department of Public Health HIV Prevention Community Planning Group (CPG) across the state of Iowa to gather information on the health status of targeted populations, and identify available prevention resources and services, as well as gaps in prevention resources and services in your area.

I am going to be asking you a variety of questions that have been designed to gather information about the HIV prevention needs in your community. For the purpose of this interview, HIV prevention services includes the entire spectrum of educational, community norms, and supportive activities directed at the individual, group and community levels designed to change behaviors and attitudes that lead to the transmission of HIV.

Information shared from the Key Informants will be analyzed; issues, themes and considerations will be determined and discussed among committee members for presentation in a final report. Participation from the community is critical to the community planning process, and to the development of relationships for the implementation of effective prevention strategies in the future.

The phone interview is designed to take approximately thirty minutes of your time. A member of the CPG will contract you on _____ to record your answers to the questions. Your participation is greatly appreciated. Thank you for your consideration.

HIV PREVENTION COMMUNITY PLANNING GROUP

KEY INFORMANT SURVEY

Interviewer_____

1. Initial contact made:_____
Date & Time

2. Interview to be completed:_____
Date & Time

3. Interview:_____
Date & Time

NAME _____ AFFILIATION _____

ADDRESS _____

_____

PHONE/FAX _____

INTRODUCTION

A comprehensive community needs assessment is being conducted by the Iowa Department Public Health (IDPH) HIV Prevention Community Planning Group (CPG) across the state of Iowa to gather information on the health status of targeted populations, and identify available prevention resources and services, and gaps in prevention resources and services in your area. We are trying to identify best practices to share throughout the state and to identify areas that could be improved and where existing resources can be directed.

I am going to be asking you a variety of questions that have been designed to gather information about the HIV prevention needs in your community. For the purpose of this interview, HIV prevention services include the entire spectrum of educational, community norms, and supportive activities directed at the individual, group, and the community levels designed to change the behaviors and attitudes that lead to the transmission of HIV.

Information shared from the interviews will be analyzed; issues, themes and considerations will be determined and discussed among committee members for inclusion in the Statewide HIV Prevention Comprehensive Plan. Participation from the community is critical to the community planning process, and to the development of relationships for the implementation of effective prevention strategies in the future.

Target Populations

#1. Youth

- ☐ Gay males, bisexuals
- ☐ Substance abusers
- ☐ Youth in juvenile detention
- ☐ Sex workers
- ☐ Youth that trade sex for drugs or survival
- ☐ Youth of color
- ☐ Youth in "out of home placement" or alternative educational settings
- ☐ Sexually active

#2. Gay males

- ☐ Substance abusers/bar crowd
- ☐ Gay males of color
- ☐ Gay men 18-25 yrs.

#3. Females

- ☐ 18-25 yrs.
- ☐ Females of color
- ☐ Substance abusers (Injection drug users and use of alcohol and other drugs)
- ☐ With sexually transmitted diseases
- ☐ Sex workers
- ☐ In corrections
- ☐ Displaced

#4. Substance Abusers/Partners of Substance Abusers

- ☐ In corrections
- ☐ Injection drug users

I. HOW HAS HIV/AIDS IMPACTED YOUR COMMUNITY AND WHERE IS IT GOING?

1. What groups/populations do you currently serve through your agency's HIV prevention efforts?

2. Of the groups you have identified, which are at highest risk for HIV/AIDS in your community?

Probes:

a) How do you keep informed about the needs of your community?

b) How did your agency identify it's target populations and prioritize.
(Hard or anecdotal data, member of a target group, etc.)

3. What HIV prevention services are you currently providing to your identified target populations? What do you perceive the need in the future?

Probes:

a) How do you keep informed and what is the source of your information? (Hard or anecdotal data, member of a target group, etc.)

4. Are there additional populations in your community in need of prevention services that we haven't talked about?

Probes:

a) What is the basis for your conclusion(s)?

b) What is the source of your information?
(Hard or anecdotal data, member of a target group, etc.)

II. WHAT HIV/AIDS PREVENTION RESOURCES ARE CURRENTLY SERVING TARGET POPULATIONS IN YOUR AREA/COMMUNITY AND HOW?

1. What prevention resources currently exist in your community, and which target populations are they serving?

Probes:

a) *Where do you refer clients if they need further information or assistance.*

2. What resource listing or directory is available to your constituency and can be shared with the CPG?

3. What specific information, education and training needs for your staff that are not getting met?

Probes:

a) *Are there existing networks that share information? If yes are they adequate?*

b) *Does your agency provide training or access to training?*

4. Are there any individuals you would recommend we talk with who may have particular expertise in the area of HIV/AIDS prevention?

III. WHAT PREVENTION ISSUES OR PROBLEMS EXIST IN YOUR COMMUNITY FOR TARGET POPULATIONS?

1. How adequate do you feel the knowledge and information about HIV/AIDS and risk reduction skills are in the population you work with? (Specify needs for each population, if more than one)

Probes:

a) *What do they need to know about HIV/AIDS and safer sex practices?*

b) *What do they need to know about HIV/AIDS and safer drug use practices?*

.

c) *What are their common misperceptions?*

d) *What are the unique needs about the population(s) you working with?*

e) *What has your agency done to increase knowledge and skills with your clients?*

2. Which one of these prevention issues do you consider to be the most important?

3. Are available prevention services appropriate for the populations you have described?

4. What are the barriers to providing effective prevention services in your community?

Probes:

a) *What barriers do clients face?*

b) *What barriers do people working in the HIV/AIDS field face?*

IV. HOW EFFECTIVE ARE EXISTING HIV/AIDS PREVENTION SERVICES?

1. On a scale of 1-5 (1 being not effective and 5 being very effective), in general, how do you feel current prevention efforts are in your community?

Probes:

If effective why? If not effective why? Please give examples.

2. Are the education and prevention needs of any groups or populations not being met? If so, which groups or populations.

3. What prevention strategies could be effective in your community in the future? Why?

V. RECOMMENDATIONS

1. Are there any recommendations you would like to give the HIV Prevention Community Planning Group?

Thank you for your time. You have been very helpful.

Procedure for Key Informant Interviewers

1) Call the identified Key Informants to explain what the process is:

   a) Who we are - IDPH, HIV Prevention Community Planning Group Members.

   b) Why they are important. - You have been identified as a person with particular knowledge about experience with HIV prevention issues and strategies.

2) Set a time for phone interview (try for one week).

3) Mail-out confirmatory letter.

4) Call the person on specified date and time.

5) Fill in sheets.

6) Mail to Patricia Young in a postage paid envelope.

Attachment 4

IOWA HIV PREVENTION COMMUNITY PLANNING GROUP

FOCUS GROUP PROTOCOL

RECRUITMENT:

Recruitment is the process by which you will screen and select participants for the focus groups. As recruiters, you will draw potential participants from the list of priority groups the CPG established in 1994.

In your role as a recruiter, keep in mind that:

- Your goal as recruiter is to introduce the project, but not to reveal so much about the project as to jeopardize the study's validity.
- You should remain as objective as possible, in no way influencing interviewee responses by the way you ask the questions. It is important to help others recognize that this is an opportunity for dialogue (where all responses are valued) rather than a debate.
- Those individuals invited to participate should meet the criteria established, with exceptions being made only in extreme situations--with a youth group, for example, adult advisors are not focus group participants.
- You should make sure to let participants know that the sessions will taped recorded.

LOCATION AND LOGISTICS FOR FOCUS GROUP:

Focus groups can be conducted in many different settings, but all should adhere to a basic set of standards:

- The room should be of adequate size, enough to hold ten people, but not so large that the focus group's area represents only a small section of the room.
- The room should have comfortable seating, preferably arranged in a fashion to encourage open discussion.
- Participants should be provided with pencils and paper and an easel and markers should be available to record points identified by the group during the course of the discussion.
- The presence of observers in the focus group can often inhibit participant responses and hinder the flow of the discussion, and thus must be thought through carefully. Participant preoccupation with observer participant reactions can alter responses. Participants may feel embarrassed about discussing certain topics in front of observers. In many cases pressure is put on the moderator to keep attention focused on the discussion.

Facilitating the Group:

INTRODUCTION - 15 MINUTES

Good morning (afternoon) and thank you for coming. My name is _____ and this is _____, my assistant for this meeting..

I work with an organization that is committed to improving life opportunities for _____ (ex: Latinos) and is interested in finding out the health conditions of _____ in Iowa. We are studying _____ and HIV/STD issues and we would like to get your ideas and opinions to help us understand some things. I will tell you more about what we will be doing as we go along.

Please feel free to say whatever is on your mind on the subject we're discussing today. I want to know what you are thinking and please be assured that what you say will have no effect on any of the services you are now receiving. I am from _____ (place) and I do not work for _____ (Agency). (Explain why you are facilitating - as part of the Community Planning Group in Iowa). Whatever is said in this room will not be reported back to anyone here. Your names will not be used and you will not be identified with remarks you make. With your permission, I would like to tape-record today's session. (Assistant) and I and a typist will be the only ones listening to the tapes. Your comments will be used to help us with an evaluation report.

Because it is my job to get your ideas, Please participate as much as possible, remembering that everyone in the room should have an opportunity to talk. Everyone's participation is important and valued. It is very important that all the people in the group have a chance to talk. In this group, there are no right or wrong answers. We are interested in your ideas and opinions about HIV/AIDS prevention. I may interrupt occasionally to make sure that everyone has the opportunity to speak and to make sure I cover all the material.

We are going to be here until _____ a.m./p.m.. I promise to end on time.

Just a few more things before we begin. I will occasionally be looking at this discussion guide to remind me of the topics I would like to discuss **(hold up discussion guide)**. I may also look at my watch to keep track of time. Assistant will be taking notes, changing tapes, and perform general housekeeping activities. Assistant will not participate in the discussion. Now, let's go around the room and everyone tell their names and where they are from.

DISCUSSION OUTLINE

1. DEFINE PREVENTION.

-What does HIV/AIDS prevention mean to you?

-What would you tell someone about how to prevent HIV/AIDS?

2. HOW HAVE YOU AND/OR YOUR COMMUNITY BEEN IMPACTED BY HIV/AIDS?

-Where have you heard about the risks of HIV? Who? What agency or organization?

-Do you think you are at risk for HIV/AIDS?

-What activities place a person at risk for HIV/AIDS?

-Where and when should you talk about HIV/AIDS?

-When should you talk about AIDS with your family? Your parents? Your children? Your partners?

-If a test showed that you or anybody in your family were infected with HIV, where would you go, what would you do?

-How do you think HIV/AIDS may affect your community in the future?

3. WHAT HIV/AIDS PREVENTION ISSUES OR PROBLEMS EXIST FOR YOU, OR IN YOUR COMMUNITY?

-What HIV/AIDS prevention services are in your community?

-Can you get these services?

-Do you or would you use them?

-What is the best way to find prevention services in your community?

4. HOW EFFECTIVE OR ADEQUATE ARE EXISTING HIV/AIDS PREVENTION SERVICES?

-If you have ever used HIV/AIDS services, do you feel like you could relate to them?

-Was the information helpful?

Where did you go to get services?

-Tell us what happened there.

-What was not helpful?

5. WRAP UP

-What more do you want to know about HIV/AIDS?

-At what age and who should teach children about HIV/AIDS prevention?

-What needs to be done in your community to stop the spread of AIDS?

I think we're ready to wrap things up. Thank you for coming. I think the session went very well, and your responses will be very helpful in writing our report. I hope that you all enjoyed participating.

Attachment 5

2002

Iowa

STD/HIV/AIDS

Provider Services 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 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 your organization/agency? **(Check one)**

- ☐ 1 Community Based Organization (CBO)
- ☐ 2 Public Health Agency
- ☐ 3 College/University/Community College
- ☐ 4 Tribal Clinic
- ☐ 5 Community Mental Health Center
- ☐ 6 Alternative High School
- ☐ 7 Housing/Shelter
- ☐ 8 Hospital "Inpatient"
- ☐ 9 Hospital "Outpatient"
- ☐ 10 Primary Care
- ☐ 11 Religious Institution
- ☐ 12 Gov. Social Service Agency
- ☐ 13 Private, For-Profit Agency
- ☐ 14 Adult/Youth Corrections
- ☐ 15 Migrant Worker Service Provider
- ☐ 16 Community Health Center
- ☐ 17 Gay/Lesbian/Bisexual Service Org.
- ☐ 18 Family Planning Agency
- ☐ 19 Drug and Alcohol Trmt. Service
- ☐ 20 Maternal/Child Health Clinic
- ☐ 21 STD Clinic
- ☐ 22 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. They include a range of activities that focus on individuals, groups, or communities. The activities may include outreach, education, counseling, 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 page 4, question 9

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

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. Which one of the following best describes the population(s) you serve?

☐1 Large Urban (communities 45,000 or over)
☐2 Medium Urban (communities 20,000 to 44,999)
☐3 Small Urban (communities 5,000 to 19,999)
☐4 Rural (communities fewer than 5,000)
☐5 Institutional Setting (e.g., incarcerated, mental health)
☐6 Other (specify):_____

5. What percentage of the people you serve are Hispanic/Latino?
___% Hispanic or Latino
___% Non-Hispanic
100%

6. What percentage of the people you serve are?

___% American Indian or Alaska Native
___% Asian
___% Black or African American
___% Native Hawaiian or Other Pacific Islander
___% White
___% More than one race
100%

7. In 2002, what are the sources and amounts of your HIV/AIDS prevention funding? **(Check all that apply and provide the approximate dollar amount)**

☐1 Private Source(s) $_____
☐2 City/County Grant(s) $_____
☐3 State Grant(s) $_____
☐4 Federal Grant(s) $_____
☐5 Fund-raising Activities $_____
☐6 Fee for Services $_____
☐7 Foundation Grants $_____
☐8 Other (specify):_____$_____
Total $_____

8. In 2001, how many "**unduplicated** HIV prevention clients" did you serve? _____

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

☐1 Yes, go to question 10
☐2 No, go to question 12

10. In 2002, what are the sources and amounts of your STD funding? (**Check all that apply and provide the approximate dollar amount**)

☐1 Private Source(s) $_____
☐2 City/County Grant(s) $_____
☐3 State Grant(s) $_____
☐4 Federal Grant(s) $_____
☐5 Fund-raising Activities $_____
☐6 Fee for Services $_____
☐7 Foundation Grants $_____
☐8 Other (specify):_____ $_____
Total **$_____**

11. In 2001, how many "**unduplicated** STD clients" did you serve? _____

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

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

13. What populations do you reach in your HIV/AIDS prevention-related activities and/or services? **(Check all that apply)**

- ☐ 1 Men who have sex with men
- ☐ 2 Injection drug users
- ☐ 3 Men who have sex with men and inject drugs
- ☐ 4 Young adults (13 – 24)
- ☐ 5 Persons with HIV/AIDS
- ☐ 6 Lesbians
- ☐ 7 Bisexuals (males & females)
- ☐ 8 Transgenders
- ☐ 9 General population
- ☐ 10 Heterosexual sex with someone at risk for or infected with HIV
- ☐ 11 Women who are at risk for or infected w/HIV
- ☐ 12 Pregnant
- ☐ 13 Trading sex for drugs/money/shelter
- ☐ 14 Sex workers (prostitutes)
- ☐ 15 Substance abusers
- ☐ 16 Low social-economic status
- ☐ 17 Incarcerated
- ☐ 18 Mentally ill
- ☐ 19 Visually or hearing impaired
- ☐ 20 Migrant workers
- ☐ 21 Medical professionals
- ☐ 22 Developmentally disabled
- ☐ 23 Infected with STDs
- ☐ 24 Homeless
- ☐ 25 Other (specify)_____

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

14. Does your agency provide **care and support services to persons who are HIV infected or affected?**

- ☐ 1 Yes, go to question 15
- ☐ 2 No, go to page 8, 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

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. Which one of the following best describes the population(s) you serve?

☐1 Large Urban (communities 45,000 or over)
☐2 Medium Urban (communities 20,000 to 44,999)
☐3 Small Urban (communities 5,000 to 19,999)
☐4 Rural (communities fewer than 5,000)
☐5 Institutional Setting (e.g., incarcerated, mental health)
☐6 Other (specify):_____

17. What percentage of the people you serve are Hispanic/Latino?
___% Hispanic or Latino
___% Non-Hispanic
100%

18. What percentage of the people you serve are?

___% American Indian or Alaska Native
___% Asian
___% Black or African American
___% Native Hawaiian or Other Pacific Islander
___% White
___% More than one race
100%

19. In 2002, what are the sources of your HIV/AIDS care funding? **(Check all that apply and provide the approximate dollar amount)**

☐1	Private Source(s)	$_____
☐2	City/County Grant(s)	$_____
☐3	State Grant(s)	$_____
☐4	Federal Grant(s)	$_____
☐5	Fund-raising Activities	$_____
☐6	Fee for Services	$_____
☐7	Foundation Grants	$_____
☐8	Other (specify):_____	$_____
	Total	**$_____**

20. In 2001, how many "**unduplicated** HIV/AIDS clients" did you serve? _____

21-22. Please indicate if the following services are provided by your agency or another agency in your community:

SERVICES FOR HIV INFECTED	provided by your agency		provided by another agency in your community	
	Yes	No	Yes	No
a. Outpatient Health Care Services				
b. Case Management Services				
c. Oral Care				
d. Anti-Retroviral Drug Assistance				
e. Health Insurance				
f. Home Health Care				
g. Hospice Care				
h. Mental Health Care				
i. Nutrition Counseling				
j. Substance Abuse Services				
k. Buddy/Volunteer Program				
l. Support Group				
m. Client Advocacy				
n. Emergency Financial Assist.				
o. Respite Care				
p. HIV Health Ed/Risk Reduction				
q. Housing Assistance				
r. Outreach				
s. Information Referral				
t. Transportation				
u. Food Bank				
v. Legal Services				
w. Treatment Adherence Services				
x. Other (specify):				

23. In your opinion, are there any service needs not being met in your community or agency's service area for persons who are HIV infected?

☐1 Yes ☐2 No

If yes, specify:_____

_____

_____

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.

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

Barriers/Difficulties	Prevention		Care	
	Yes	No	Yes	No
a. Limited funding				
b. Limited staffing				
c. Small size of target population				
d. Target population not aware of services				
e. Problems of accessibility for the target Population				
f. Staff retention				
g. Insufficient coordination, collaboration between providers				
h. Lack of bilingual materials				
i. Lack of culturally and ethnically appropriate staff				
j. Training for staff				
k. Recruiting qualified staff				
Other (specify):				

25. Please indicate (with a check (√)) how you would rate your agency on the following features related to accessibility:

Accessibility Features of Agency	Good	Fair	Poor	Does Not Apply
a. Parking is readily available				
b. Agency is near public transportation				
c. Transportation tokens are provided to clients				
d. Building is handicap accessible				
e. Agency is located near population/predominant community served				
f. Agency is located near other agencies to which your agency refers clients				
g. Agency is located near hospitals/clinics that your clients use				
h. Child care is available for clients				
i. Interpreters/translators are available				
j. Sign language interpreters are available				
k. Staff is representative of the target population(s)				

26. **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.

0 = Not provided at all; potential service gap
1 = Somewhat provided but not in sufficient quantity to meet demand
2 = Adequately provided
3 = Well provided
4 = Excessive; duplication of services

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 "well 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:	**Men Who Have Sex With Men**	**Injecting Drug Users**	**High -Risk Youth**	**Persons With HIV/AIDS**	**At-Risk Women**
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 inter-ventions.					
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 V: Unmet Needs

27. What critical STD/HIV/AIDS training/capacity-building needs does your agency staff or volunteers have?
    Please rate these training needs on a scale from 1-5 (1 being the least, 5 being the greatest)

Training Needs	**1**	**2**	**3**	**4**	**5**	**Not Applicable**
Program development/evaluation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Data collection and analysis	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Effective prevention intervention strategies	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
How to work with the media	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Cultural competence programs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Risk reduction/behavior change	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Prevention counseling	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Living with HIV/AIDS	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Human sexuality	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
HIV/AIDS 101 (Basic Information)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
HIV/AIDS treatment information	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
HIV/HCV co-infection	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Clinician specimen collection technique	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Clinical STD services	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Sexual history taking	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Vaccine administration, scheduling and storage (Hepatitis A & B)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Program implementation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Treatment adherence	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Care case management	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Prevention case management	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Prevention and care linkages	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Prevention with sero-discordant couples	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Writing Measurable Goals and Objectives	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Other (specify):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Capacity Building Needs	**1**	**2**	**3**	**4**	**5**	**Not Applicable**
Board Development	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Fiscal Management	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Marketing/Public Relations	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Resource Development and Grant Writing	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Volunteer Recruitment and Training	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Organizational Development	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Other (specify):	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

28. What additional comments do you have about unmet needs?

_____

_____

_____

29. What other questions do you think we should have asked?

_____

_____

_____

_____

30. Please indicate what other organization(s) in your community offer any type of STD/HIV/AIDS prevention and care activities.

Name of Organization(s)	**Address**
_____	_____
_____	_____

Thank you for completing this survey.

For questions regarding this survey, please call Patricia Young at (515) 242-5838.

Please return it in the enclosed, postage paid envelope.

You may also fax the completed survey to (515) 281-4570.

H:\cpg\nedsases\psurvey2002

Attachment 6

2004-2006 PREVENTION & CARE WORKPLAN FOR CPG

TASK BEGINS	WHAT MILESTONES MUST BE REACHED	WHAT ARE THE KEY TASKS TO ACHIEVE THE MILESTONE OR OUTCOME MILESTONES	RESPONSIBILITY
January	Priority Setting Process	Review priority setting process, introduce the membership on how priority setting will be accomplished.	WET Ones
	Current Epi Profile	Review *Set Goals for next edition *Review comments from Grant	EPIC
	By-Laws, Roles/Responsibilities	Begin review for needed updates & clarifications-ongoing	MOB Squad
	Orientation Guidelines	Review for needed updates & clarifications	MOB Squad
	Prevention: Interventions for PLWH and Youth	Review barriers, strategies, interventions for PLWH & Youth	SPICE
	Care: Adherence	Review literature on adherence	Care
	Award of Prevention Contracts	IDPH notifies contracting agencies	IDPH

TASK BEGINS	WHAT MILESTONES MUST BE REACHED	WHAT ARE THE KEY TASKS TO ACHIEVE THE MILESTONE OR OUTCOME MILESTONES	RESPONSIBILITY
February	Epi Profile Guidelines	Review and work on format issues	EPIC
	? Focus groups	Review and decide if focus groups need to be conducted	NARC
	Review Attendance Log	Review for number of absences, notifying members if needed-Ongoing	MOB Squad
	Ryan White Title II	RWCA Grant Application Due	IDPH Ryan White Coordinator
	Risk Groups, MSM & IDU		Spice
	Prevention Contracts	CPG Members are notified of contracts	IDPH
	Prevention Interventions for MSM & IDU	Review barriers, strategies, interventions for MSM and IDU	SPICE
	Care: Access	Compare Epi data with utilization of RW	Care
March	Contract summaries & IDPH activities review	Information shared & discussed with CPG members	IDPH
	Prevention: Intervention Fact Sheets	Provide definitions of interventions to CPG members	SPICE
	Provider Service Survey	Review analysis with CPG members	NARC
	Co-Chair Elect in Training	Nominate 2005	MOB Squad
	Decision Making Process	Review & adopt method for	WET Ones

TASK BEGINS	WHAT MILESTONES MUST BE REACHED	WHAT ARE THE KEY TASKS TO ACHIEVE THE MILESTONE OR OUTCOME MILESTONES	RESPONSIBILITY
		prioritizing targeted populations (2006).	
	Key Informant Interviews	Determine the need for updating based on provider services survey.	NARC
April	Exit & check-out summaries	IDPH provides summaries from 7/1 to 6/30 to the WET Ones	IDPH/WET Ones
	Community Co-Chair in training	Elect (2 year term starts 4/04)	MOB Squad
	Prevention: Intervention recommendations	Summarize interventions for prioritized target populations	SPICE
	Care: Core Functions	Summarize core functions of Ryan White Title II	Care
	STD Update	IDPH staff review STD trends	IDPH
May	CPG Self Assessment/Membership Survey	Sent with meeting notice, to be completed by members & brought to CPG meeting	IDPH/Members
	Exit & check outs, self assessment	Review & tally, assessing for problems or concerns that have not been addressed	WET Ones
	Prevention: Intervention Priority Setting	Review and vote on priority interventions for prioritized target populations	SPICE
	Care: Core Services	Provide definitions for core services to be offered by Ryan White Title II providers	Care
	Annual EPI Data	Reviewed for significant data changes & submitted to CPG members	EPIC
	Resource Inventory	Updating-ongoing through spring	NARC

TASK BEGINS	WHAT MILESTONES MUST BE REACHED	WHAT ARE THE KEY TASKS TO ACHIEVE THE MILESTONE OR OUTCOME MILESTONES	RESPONSIBILITY
	Attendance Log	Review for number of absences, notifying members if needed-Ongoing	MOB Squad
	RWCA Providers	Report of clients reached, successes and barriers	IDPH, RW Title II Coordinator
June	Workplan & Timeline for Plan	Review with Committee Co-Chairs for finalized workplan and timeline for grant/plan.	WET Ones
	Call for Nominations	Sent to all agencies involved with HIV throughout the state.	MOB Squad
	Prevention: Intervention Summaries	Write intervention section of plan	SPICE
	Care: Care Summaries	Write care section of plan	Care
	Assessment Data (self, exit, check-outs)	Develop narrative summarizing data for grant	WET Ones
July	Conflict of Interest	Signed by members & returned to MOB Squad	IDPH
	Membership update	Sent to each member to be completed & returned	CPG Members/MOB Squad

TASK BEGINS	WHAT MILESTONES MUST BE REACHED	WHAT ARE THE KEY TASKS TO ACHIEVE THE MILESTONE OR OUTCOME MILESTONES	RESPONSIBILITY
August	Attendance Log Review of Prevention Application for concurrence	Review for number of absences, notifying members if needed-Ongoing Concurrence	MOB Squad CPG Members
September			
October	Annual HIV Conference Distribution of Comprehensive Plan	Review previous conference recommendations, CPG contractors, and TA needs. Sent to interested agencies, persons, and provided at HIV conference. New plan developed every 3 years (2004 & 2006). This is also ongoing.	Conference Committee/CPG Members/IDPH IDPH and PR Committee
November	Timeline/WP for next year Attendance Log	Update with Committees & develop a new timeline if needed. Review for number of absences, notifying members if needed-Ongoing	WET Ones MOB Squad
December	New Member Recruitment	Bring new youth to the table	YARTS

TASK BEGINS	WHAT MILESTONES MUST BE REACHED	WHAT ARE THE KEY TASKS TO ACHIEVE THE MILESTONE OR OUTCOME MILESTONES	RESPONSIBILITY
ONGOING	Technical Assistance	Grantees & CPG members assess needs & schedule as needed	IDPH/WET Ones
	Check-Out Summaries	Provided at each CPG Meeting & review at the following meeting	IDPH/WET Ones
	Member Orientation	All new members will attend an organized orientation process & assigned a mentor	MOB Squad
	Exit Summaries	Mailed by IDPH when CPG members resign from Committee	IDPH/WET Ones
	Letter of Commitment	Offered to members whose term is about to expire	MOB Squad