2009-2012
Cuyahoga County Comprehensive HIV/STD Prevention Plan

October 2009

Cuyahoga County Comprehensive
HIV/STD Prevention Plan
2009 - 2012

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Acknowledgements

This Comprehensive Prevention Plan is the result of the work and input of many contributors from our community. The members of the Cuyahoga County HIV Prevention Regional Advisory Group (RAG) provided input throughout the process. RAG members include: *AIDS Taskforce of Greater Cleveland, AIDS Funding Collaborative, Antioch Development Corporation, Care Alliance Health Center, Cleveland Metropolitan School District, Cleveland Treatment Center-Project Safe, Community Members (infected and/or affected by HIV/AIDS epidemic), Cuyahoga County Board of Health, The Free Medical Clinic of Greater Cleveland, Hispanic UMADAOP, LGBT Community Center of Greater Cleveland, The May Dugan Center, NorthEast Ohio Neighborhood Health Services, Inc. (NEON), Northeast Ohio Recovery Association, Inc. (NORA), Planned Parenthood of Northeast Ohio, Nueva Luz Urban Resource Center-Proyecto Luz, Recovery Resources, Ryan White Part A Program, Salvation Army, and Transitional Housing, Inc.*

The RAG Needs Assessment Committee had the ultimate responsibility for the conceptualization and development of this assessment process. We specifically thank Committee members:

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We appreciate the input of the Ryan White Part A Planning Council. On behalf of our community, we thank Dr. Sonia Alemagno and Peggy Shaffer King for their expertise and commitment of extraordinary resources. Lastly, this plan was supported by a grant from the Saint Luke's Foundation of Cleveland.

Part I: Introduction

Overview of HIV/STD Prevention Community Planning

Prevention planning is an ongoing and evolving process whereby county and city public agencies, community based organizations and representatives of groups at risk for or affected by HIV and STDs develop a comprehensive prevention plan.

A prevention plan has the goal of identifying priority populations and formulating recommendations for prevention for each target population. Target populations are prioritized and prevention interventions chosen based on their ability to prevent as many new infections as possible.

Key information necessary for the comprehensive HIV/STD Prevention Plan can be found in the epidemiologic profiles, community research (surveys, focus groups data, etc.) and the community services assessment.

The community planning process is a flexible process. There is no single "right way" to achieve prevention goals; however, this plan recognizes that a process based on informed and shared decision making is more likely to accomplish goals and objectives of prevention in our community.

The elimination of racial and ethnic disparities in the delivery of prevention and health care services is a priority for our public health departments. We are led by Federal efforts (such as Healthy People 2000 and Healthy People 2010), the American Public Health Association and others who have made a great effort to identify and strategically attack identified disparities. It is through community planning that these disparities have the best chance to be identified and addressed. The principles of parity, inclusion and representation guide effective community planning and ensure that all affected communities, including people of all racial/ethnic backgrounds, genders, and life experiences have a voice in our process.

Cuyahoga County HIV Prevention Planning Efforts

The Cuyahoga County HIV Prevention Regional Advisory Group (RAG) is the HIV Prevention Community Planning group that is charged by the Ohio Department of Health to develop a comprehensive HIV prevention plan for the Greater Cleveland area.

Local residents determined to fight the spread of HIV founded the Cuyahoga County RAG in 1993, and in fact committed HIV/AIDS activists and community based organizations are the region's greatest strength.

The Cleveland Department of Public Health (CDPH) Office of HIV/AIDS Services is the administrator of the Cuyahoga County RAG. The CDPH is the local health district for the City of Cleveland, and although Cleveland is the focus of the CDPH, much of its work occurs through grants that include Cuyahoga and other Northeast Ohio Counties.

This HIV/STD Prevention Plan is the result of the work and commitment of a community planning process in Cuyahoga County that began in the fall of 2007. **The goal was to develop a comprehensive HIV and STD prevention plan for Cuyahoga County that will result in programs to respond to high priority, community-validated needs within defined populations.**

Beginning in the fall of 2007, the RAG Needs Assessment Committee (see "Acknowledgements") met monthly to determine the scope of the plan and the process by which it would be developed, review and discuss data, and come to consensus on recommendations that were presented to the full RAG along the way. In June 2008, in response to a syphilis outbreak, the alarming incidence of Chlamydia and gonorrhea, and recognition of the need among HIV prevention program participants for STD information, the committee determined that the community's comprehensive prevention plan must integrate both HIV and STD prevention.

Additionally, the community is increasingly focused on the intersection between HIV prevention and care and treatment for those living with HIV/AIDS. As such, the Ryan White program was involved in the process, and data collection included input from those who provide care and services to people living with HIV/AIDS. The community recognizes the critical role HIV testing plays in linking prevention and care and while HIV testing is not a central element in our data analysis for this plan, a thorough assessment of HIV testing in the community will follow.

The collaborating organizations, governmental representatives, and community members involved in the process accept the role as partners in the design, delivery and evaluation of HIV and STD prevention. In order for governmental agencies, community organizations, and the medical/health care communities to be successful in achieving prevention goals, all partners must strive for a shared vision. As part of this process, the Cuyahoga County HIV Prevention Regional Advisory Group-Needs Assessment Committee is pleased to share the 2009-2011 Cuyahoga County HIV/STD Prevention Plan with the Community.

Part II: Local Research & Surveillance

Purpose

This section presents the epidemiology of HIV, AIDS and STDs in Cuyahoga County. The information represents the scientific evidence upon which Cuyahoga County's prevention priorities begin. It gives information on who is affected by HIV, AIDS and STDs and patterns of infection in the community. For more information, interested readers can go to www.clevelandhealth.info to read the City of Cleveland Department of Public Health surveillance reports.

History

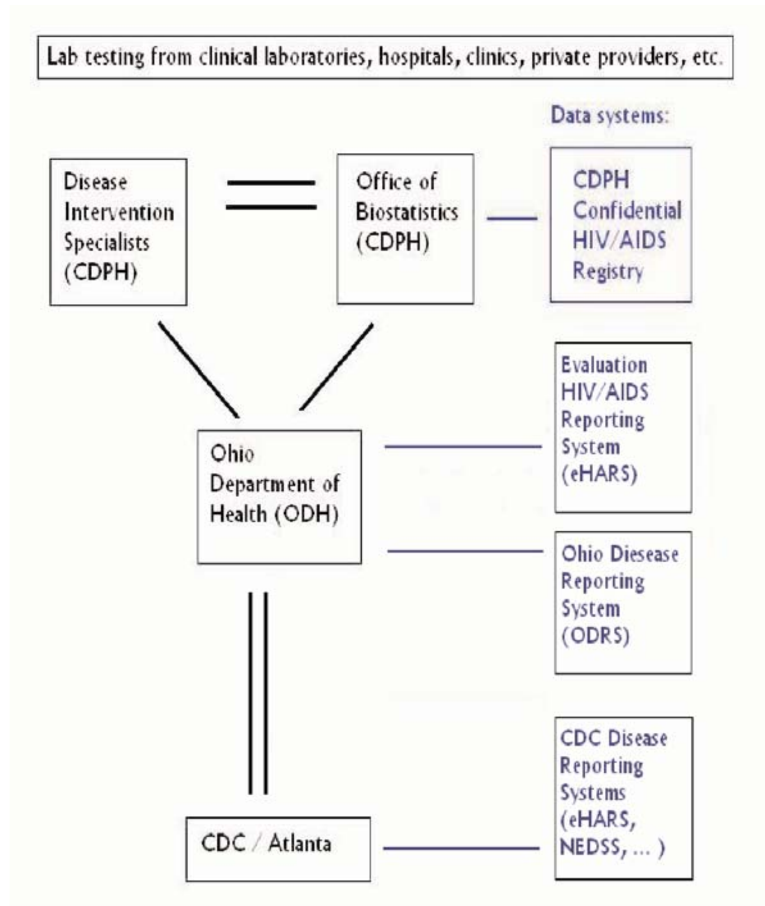
Cuyahoga County has been one of the hardest hit counties in Ohio by HIV/AIDS. Cases of HIV were initially reported in the early 1980's, soon after initial cases were reported in San Francisco, Los Angeles, and New York City by the Centers for Disease Control and Prevention (CDC). This makes HIV a "mature epidemic" (CDC, 2001) in Cleveland and Cuyahoga County, in that the patterns of those infected with HIV are very similar to what has been reported nationally in this decade.

As seen in national trends, initial cases were among men who have sex with men (MSM) and bisexual men, generally between the ages of 30 and 45. Cases among women were rarely seen. White and Black males were represented equally, but soon the percentage of Black males with HIV outpaced cases among white males. By the late 1990's, two-thirds of all new cases, regardless of behaviors, were Black. In addition, the percentage of HIV among heterosexual couples began to increase sharply, mostly among Black and Hispanic residents. Whites tended to be mostly MSM males; 20% were females.

Regardless of race and ethnicity, at least half of all cases were and continue to be MSM and bisexual males.

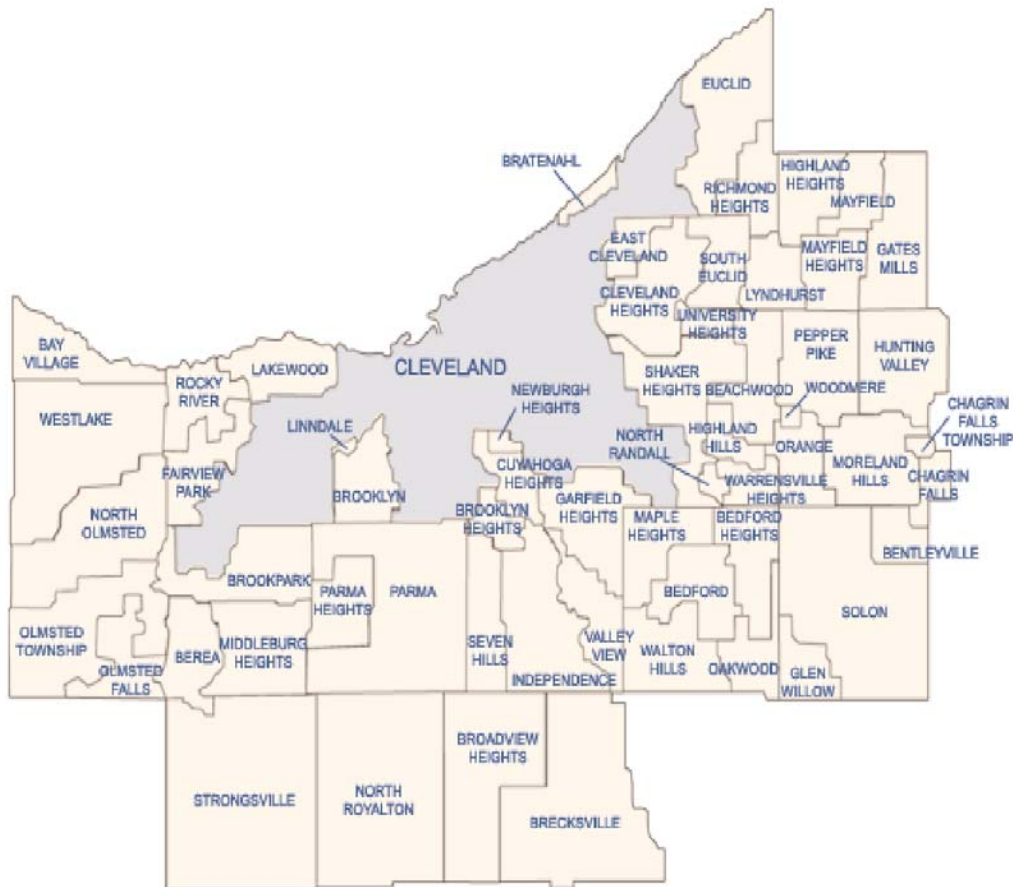
Census levels of Black residents in Cleveland were nearly 45% in the 1990's and over 50% in the 2000's. Yet the levels of new HIV cases in those decades surpassed their demographics. During those decades, about 45% and 20% of new cases, on average, were among Black males and Black females, respectively.

ROUTES OF HIV/AIDS AND STD SURVEILLANCE DATA AND DATA SYSTEMS AMONG PUBLIC HEALTH AGENCIES.



The Cleveland Department of Public Health has a Confidential HIV/AIDS Surveillance Registry used to collect these surveillance lab reports. The Office of Biostatistics also confirms its data against those collected by DIS. This confidential registry is the source for epidemiological reporting and the data for this section.

Overview of Cuyahoga County



Socioeconomic Diversity

According to 2008 Cuyahoga County population estimates, 1,283,925 people reside within the county. Of these, 6.2% are under 5 years of age, 17.5% are between the ages of 5 and 17, 61.2% are 18-64, and 15.1% are 65 and above. Females represent over half of the population (52.6%). The county is racially and ethnically diverse with Whites (66.9%), African-American (29.3%), Asians (2.3%), American Indian and Alaska Native (0.2%), and Native Hawaiian/Pacific Islander (0.1%). Hispanic or Latino origin is reported as 4.1% of the population. Within the county, education achievements are: less than high school 18.4%, high school graduates (including equivalency) 30.0%, some college or associate's degree 26.4%, bachelor's degree 5.6%, and Master's, professional or doctorate degree 9.6%.

HIV/AIDS and STDs in Cuyahoga County: An Overview

The Needs Assessment process of the Regional Advisory Group (RAG) relied on HIV/AIDS and STD surveillance data for Cuyahoga County. Trends in the most current new (incident) cases reported from 2004-2005 to 2006-2007 identified populations that are in most need of referral, counseling and integration into care services. Naturally, these groups are also those in greatest need for prevention education to reduce new cases occurring in the future.

Since the community anticipates STD messaging to be added as part of a more comprehensive prevention message, recent surveillance data on syphilis, Chlamydia and gonorrhea are included. Surveillance of a recent syphilis outbreak does include risk behavior (for example, MSM, heterosexual, bisexual activity, oral, vaginal, anal intercourse, multiple partners). Syphilis-positive cases and their potential contacts were interviewed by CDPH intervention specialists (DIS). However, surveillance for Chlamydia and gonorrhea does not include information on risk behavior, and CDPH staff can only use age, race and location information from these cases.

Prevalence is the number of persons living with HIV/AIDS at a point in time. This number may be standardized and reported per 100,000 persons in a population, or per 100 persons as a percent in a population at a single point in time. US Census Bureau is the source for the population count. Standardized prevalence is useful since it allows one to compare the prevalence across different groups or geographic areas.

Incidence is the number of new diagnoses occurring over a specified period of time. Incidence rates are the number of new diagnoses in a specific population (e.g. per 100,000) over a specified period of time. Annual incidence rates are routinely reported as the, HIV (non-AIDS) diagnoses per 100,000 population per year, or HIV-with-AIDS (or "doorstep" AIDS) diagnoses per 100,000 population per year. With this definition, the AIDS diagnosis occurred within 12 months of the initial HIV diagnosis.

Proposed Ranking of 2009 HIV Prevention Target Populations based on Epidemiological Data

1. Persons Living with HIV/AIDS
2. Black/African American Males (MSM, Bisexual)
3. Black/African American Heterosexual, Non-Intravenous Drug User Females
4. White Males (MSM, Bisexual)
5. Youth 13-24 years
6. Older Persons, age 50 and over, with HIV
7. Black/African American Heterosexual, Non-Intravenous Drug User Males
8. Intravenous Drug Users
9. Hispanics
10. White Heterosexual Males/Females

How were HIV rankings developed?

Priority rankings were based on incidence, reported here as a percentage of new cases. Risk behavior and race/ethnicity were used initially to determine exclusive groups in an objective manner. Two additional groups were identified solely by age - youth age 13 to 24 and adults age 50 and over. Recent trends showed increases in cases in these two groups.

The Office of Biostatistics collected data of new (incident) HIV and HIV-with-AIDS diagnoses from the past four years. Incident cases were split into two periods for comparison - New cases diagnosed in 2004-2005 versus 2006-2007.

Two years in each group were used to have enough cases among groups by sex, race and risky behavior. HIV/AIDS surveillance data is unique since it includes the risk behavior associated with acquiring HIV. By comparing the trends or changes in new cases between these two periods, CDPH staff can determine the trends in which groups of people are being diagnosed recently. CDPH staff first grouped cases by sex and behavior because behavior determines risk. (The CDC recommends this approach.) Then, the staff looked for patterns in race and ethnicity among these groups. Non-overlapping groups were defined and objectively ranked by the percentage of new (HIV and HIV-with-AIDS) diagnoses that occurred in each period. Then, the staff added the two age groups into the ranking based on their incidence, with some subjectivity because these age groups may overlap other groups by risk/sex and race.

Demographics and HIV/AIDS Cases

About 75% (about 2,900) of all persons in Cuyahoga County currently living with HIV are male, and about 25% (over 900) are female. More than half are currently between 35 and 54 years of age. Fifty-six percent (56%) are Black, 31% white, 10% Hispanic. Cleveland has about 2,800 persons living with HIV or AIDS. On average, about 70% of all cases in Cuyahoga County were Cleveland residents when diagnosed.

The prevalence rate of HIV/AIDS for Cleveland is about 0.6% or 639 per every 100,000, with half that rate for Cuyahoga County (0.3% or 300 per 100,000). Forty-four percent (44%) are HIV (non-AIDS) and 56% have been diagnosed with AIDS at some time.

The following table shows the self-reported route most likely associated with exposure to HIV for males who were residents of Cleveland when diagnosed and do not differ significantly in data for all of Cuyahoga County.

Self-Reported Exposure to HIV among Cleveland Males Living with HIV, as of September 30, 2008

	MSM	Bisexual	Heterosexual	Any Injection Drug Use
White males	68%	9%	11%	11%
Black males	44%	15%	27%	12%
Hispanic males	18%	5%	28%	42%

Percentage excludes all those not reporting exposure route or where risk is unknown. Other risks, including blood product and perinatal exposure are not shown. Data reported by the Cleveland Department of Health, "Cleveland (Only) HIV/AIDS Exposure Report: Reported persons living with HIV/AIDS as of September 30, 2008".

Self-Reported Exposure to HIV among Cleveland Females Living with HIV, as of September 30, 2008

	Heterosexual	Any Injection Drug Use
White females	77%	23%
Black females	76%	15%
Hispanic females	65%	21%

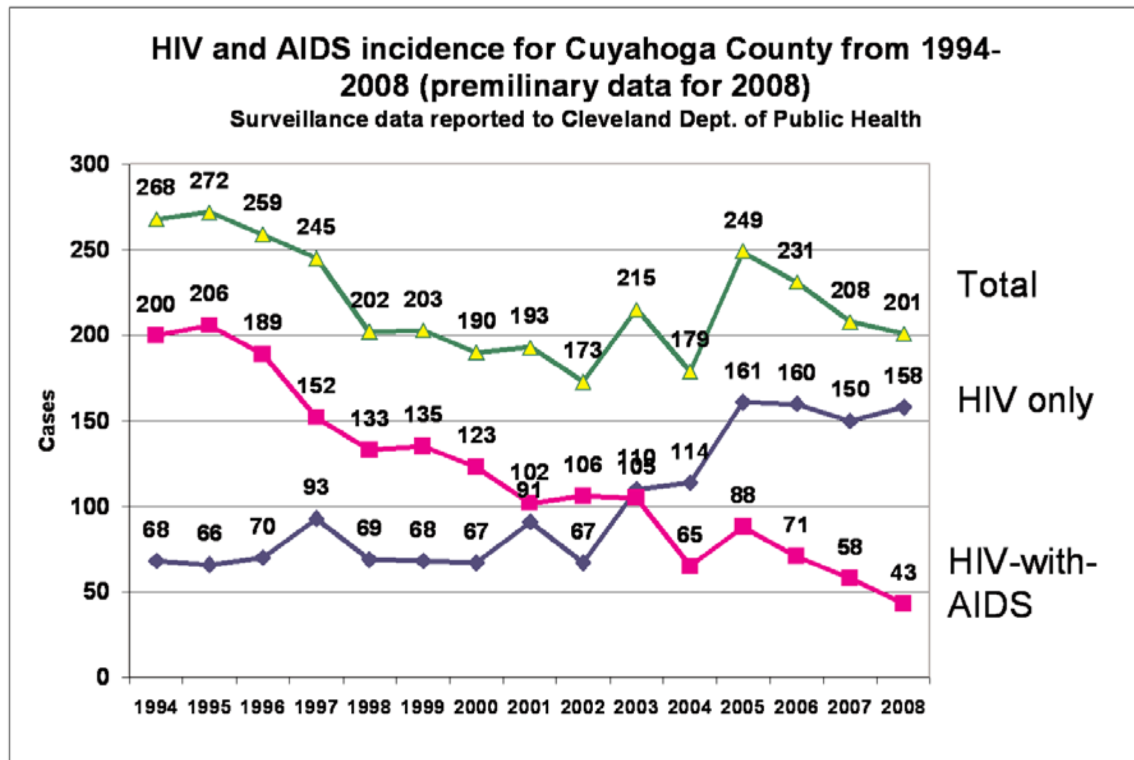
Percentage excludes all those not reporting exposure route or where risk is unknown. Other risks, including blood product and perinatal exposure are not shown. Data reported by the Cleveland Department of Health, "Cleveland (Only) HIV/AIDS Exposure Report: Reported persons living with HIV/AIDS as of September 30, 2008".

A chapter in Dr. Sana Loue's book , "Health Issues Confronting Minority Men Who Have Sex with Men" details the epidemiology of HIV/AIDS among African American and Latino males. This chapter is titled, "HIV/AIDS in Cleveland: A Case Study of One Community," written by David Bruckman of the Cleveland Department of Public Health and is available as public record at www.clevelandhealth.info.

Recent trends – HIV/AIDS

As persons live longer with HIV and AIDS, the prevalence increases each year, outpacing deaths. Incidence of HIV-only has been increasing while cases of HIV-with-AIDS have been decreasing.

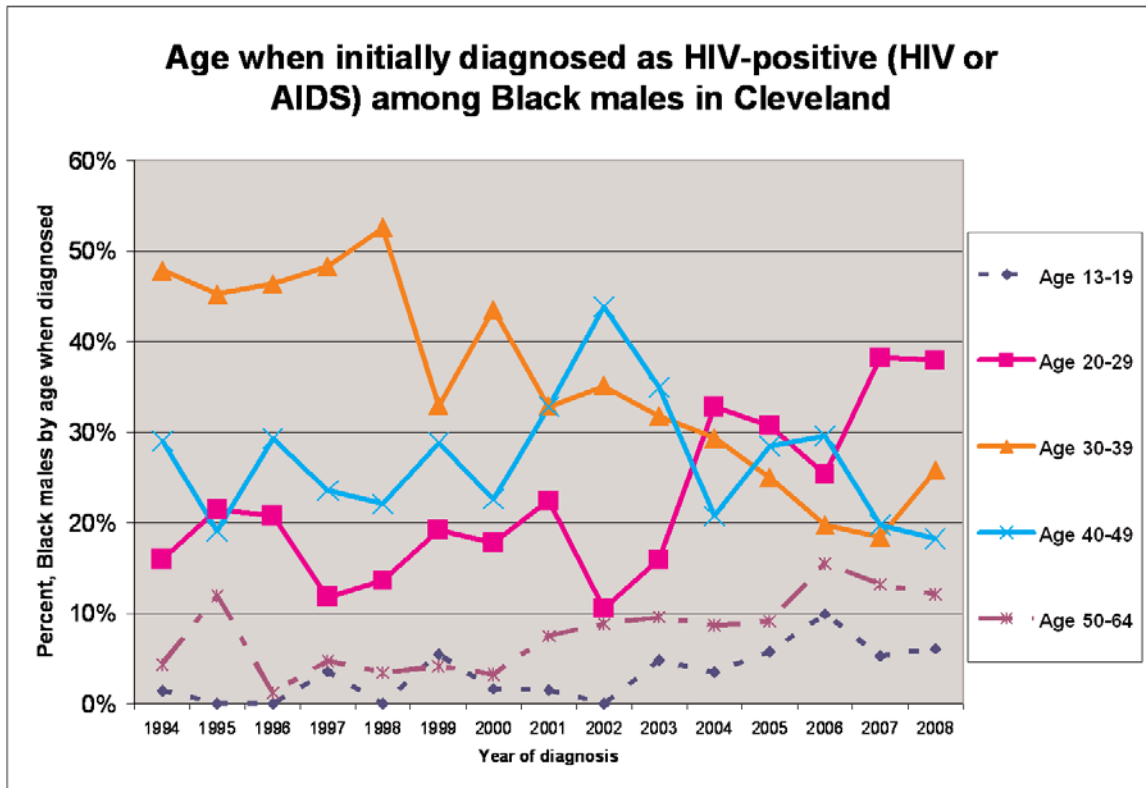
Counts of incident HIV-only and HIV-with-AIDS (doorstep AIDS) diagnoses for Cuyahoga County, by year of diagnosis, data from 1994 to 2008 (using preliminary data for 2008.) Source: Cleveland Department of Public Health.



The most significant trend has been the change in age groups among Black males reported with HIV. In the 1990's, most of the Black males were age 30-49. However in the past six years, an increase in the number of youth and young males age 13 to 24 and older males over 50 has been observed and reported by CDPH. The results in the figure below are for Cleveland. This pattern does not change when using data for all of Cuyahoga County.

Loue, Sana, ed., Health Issues Confronting Minority Men Who Have Sex With Men (New York: Springer-Verlag, LLC), 2007.

Percentage of Black males by age at diagnosis across the year of initial diagnosis of HIV (or HIV-with-AIDS), for Cleveland. Data are from 1994 to 2008 (using preliminary data for 2008.) Source: Cleveland Department of Public Health.



Proposed Ranking of 2009 STD Prevention Target Populations based on Epidemiological Data

1. Black/African American Females	ages 15-24
2. Black/African American Males	ages 20-24
3. Black/African American Males	ages 15-29
4. Black/African American Females	ages 25 to 29
5. Black/African American Males	ages 25 to 29
6. Hispanic Females	ages 15 to 24
7. White, non-Hispanic Females	ages 15 to 24
8. Children	ages 10 to 14

How were STD rankings developed?

Priority rankings for STD's were based objectively on incidence rates by sex and age groups, race and ethnicity.

The Office of Biostatistics obtained Chlamydia and gonorrhea surveillance data from 2002 through 2007 for Cuyahoga County from the Ohio Department of Health. CDPH obtained lab-reported syphilis data from 2002-2005, and DIS investigated surveillance data from 2006 through mid-2008. Only syphilis data investigated by DIS has information on risk behavior associated with acquiring syphilis.

For Chlamydia and gonorrhea:

- Incidence rates per 100,000 were developed.
- Age, sex, race/ethnicity were used to define groups at risk.
- CDPH staff objectively ranked these groups by incidence rates to get the final ranking. These groups are exclusive, meaning that they do not overlap.
- CDPH observed that incidence patterns among groups changed little from 2005 through 2007.

For syphilis:

- Incidence rates and case counts for syphilis were determined for groups by risk behavior, age, sex and race/ethnicity.
- A recent outbreak of syphilis, beginning in July 2007, was used to determine groups at risk.
- Syphilis data were not used directly in the rankings but helped the CDPH to determine where specific prevention messages are needed.

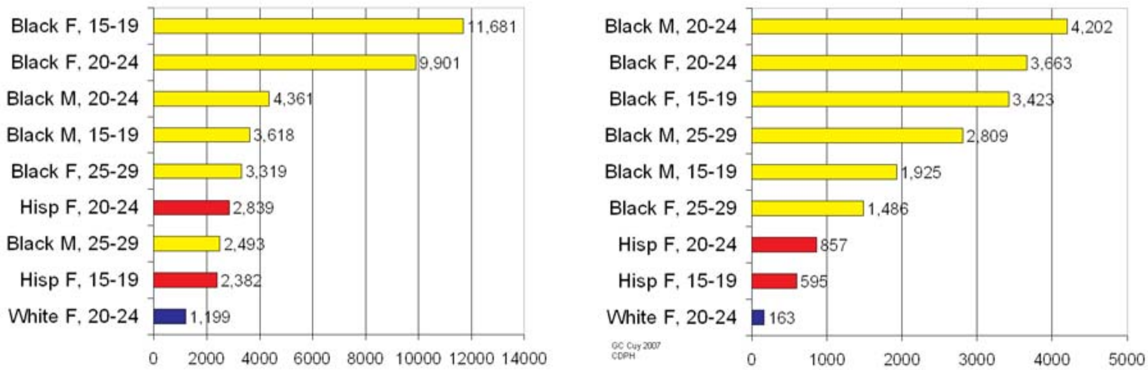
Recent Trends – STD's:

In the past 5 years of surveillance, teens ages 15 to 19-years-old represent over 40% of all reported cases of Chlamydia and 28% of gonorrhea for Cuyahoga County.

Over 85% of Chlamydia cases occur among youth and young adults ages 15 to 29-years-old. Black/African American teens and young adults ages 15 to 24-years-old have the highest rates of Chlamydia. The graph below illustrates incidence rates for Chlamydia in 2007 for Cuyahoga County. Rates are presented as cases per 100,000 population group. Nearly 1 in 9 Black teen females were reported as infected with Chlamydia in 2007 in Cuyahoga County.

Over 70% of gonorrhea cases occur among youth and young adults age 15 to 29, with most cases reported among Black/African Americans age 15 to 29. The graph below illustrates incidence rates for gonorrhea in 2007 for Cuyahoga County. Rates are presented as cases per 100,000 population group. Risk behavior is not included in surveillance data.

Chlamydia incidence rates (LEFT) and Gonorrhea rates (RIGHT) per 100,000 population group in 2007 for Cuyahoga County.



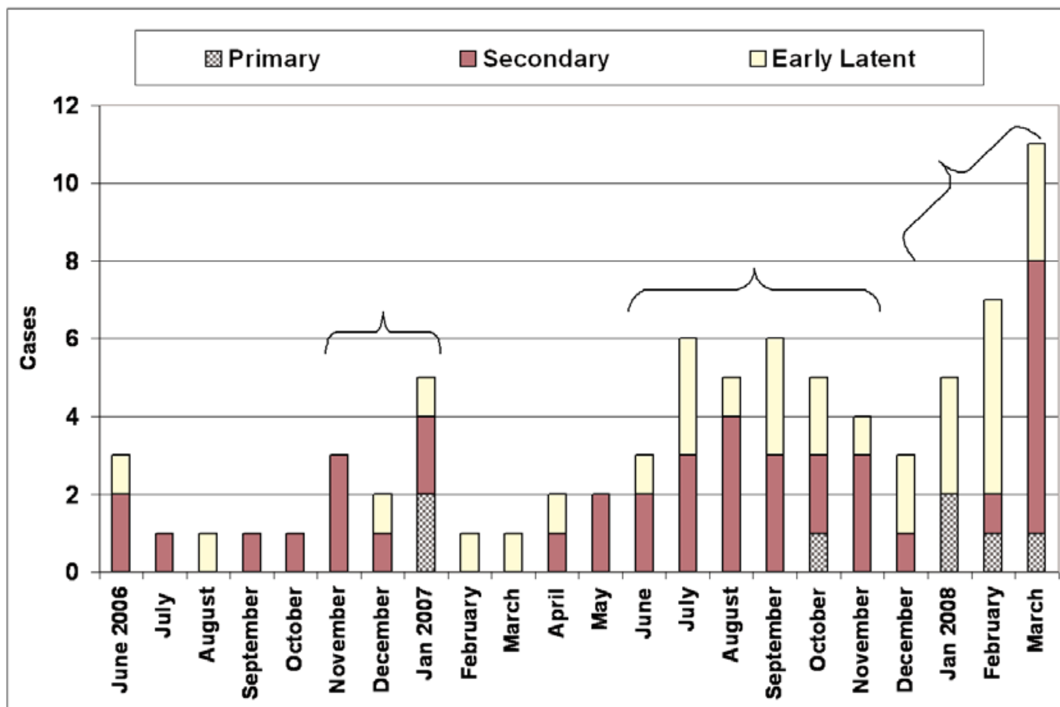
Syphilis

Since July 2007, an expanding outbreak of 123 cases of early syphilis (i.e. primary, secondary and early latent syphilis) among two populations in Cuyahoga County has brought together a coalition of city, county and state public health officials and involved parties. The populations at risk are 1) heterosexual males and females, 90% of whom are Black and 2) MSM/bisexual males of all races and ethnicities. Since July 2007, 67 cases were MSM/bisexual males, 52 were heterosexual. Current cases (reported April-Nov 2008) are split evenly among these two populations.

Two-thirds of reported cases were among Cleveland residents, the major city within Cuyahoga County.

Annualized rates are 4.5 times greater in past eight months (71 cases, 8.2 per 100,000 population, April-Nov 2008) than in baseline period (26 cases, 1.8 per 100,000, from June 2006 - June 2007). November 2008 had the largest case count of 16 cases. Normal case load is 1 to 2 per month for Cuyahoga County. See figure below.

Syphilis diagnoses, limited to active (primary, secondary) and early latent diagnoses for Cuyahoga County, by month of diagnosis, June 2006-March 2008.



Of the heterosexual cases more than half (55 percent) were aged 14 to 24 years when diagnosed and 70% of the most current cases were 14 to 34 years of age. Twenty cases were aged 14 to 24, with 18 of them reporting as heterosexual by behavior and orientation. Ninety percent (90%) were Black/African American. Seventy percent (70%) were diagnosed with secondary syphilis. Ninety percent (90%) reporting unprotected oral sex. Condom use was rare: 79% using them sometimes and 21% never using condoms.

Condom use was higher among Black/African American MSM/bisexual males compared to heterosexuals. Interviews by Disease Intervention Specialists provided evidence of female-to-female transmission of syphilis. This rare occurrence necessitated expanded and novel messaging to the lesbian community. We have observed Black/African American and Latino males who self-report as heterosexual but are having sex with other men likely leading to infection.

City, county and state officials initiated a joint Action Plan in July 2008, when the initial cases were examined. Their responding actions included temporarily prioritizing DIS to syphilis cases over HIV cases for partner notification, working with media sources, LGBT (lesbian, gay, bisexual, transsexual) community and with agencies funded for HIV prevention. Additional data are forthcoming to follow-up into 2009.

Part III: Community Assessment

It is estimated that in 2008 Cuyahoga County received approximately $3,464,556 in specific HIV and STD Prevention funding. It is essential to note that this figure does not represent the complete picture of funding as numerous agencies integrate prevention activities into larger organizational budgets. Other funding streams (e.g. Title X family planning dollars, Medicaid, Mom's First, etc.) have an impact on HIV/STD prevention but are not exclusively targeted for that purpose, and as such are not included in this chart.

Funder	Amount of Funding Allocated for			Focus of Funding	Source of Funds
	2006	2007	2008		
Community Development Block Grant (CDBG) [administered by Cleveland Dept of Public Health][1]	$534,000	$489,000	$482,000	Prevention programs, capacity building, HIV Counseling & Testing	City of Cleveland allocation of Federal HUD funds
Federal HIV Prevention Grant [administered by Cleveland Dept of Public Health]	$817,656	$817,656	$827,656	Prevention Programs, DEBIs, DIS, HIV Counseling & Testing	Centers for Disease Control and Prevention grant directed to Cuyahoga County by Ohio Dept of Health
AIDS Funding Collaborative[2]	$289,752	$260,404	$244,150	Prevention programs, HIV testing, and capacity building for organizations engaged in prevention programs	Pooled dollars from public funder, foundations, and United Way
Alcohol & Drug Addiction Services Board of Cuyahoga County (ADASBCC)[1]	$582,000	$582,000	$532,372	HIV prevention and testing within treatment programs	Ohio Department of Alcohol & Drug Addiction Services
STD Grant [administered by Cleveland Dept of Public Health]	$103,378	$103,378	$103,378	STD testing and treatment and DIS	Ohio Department of Health
DIRECT FEDERAL GRANTS TO COMMUNITY AGENCIES					
Funder	**2006**	**2007**	**2008**	**Focus of Funding**	**Recipient Agency**
Centers for Disease Control and Prevention	$445,000	$442,000	$442,000	Beyond Identities Community Center (BICC)--Empowerment for minority youth	AIDS Taskforce of Greater Cleveland[3]
SAMHSA's Center for Substance Abuse Treatment	$0	$500,000	$500,000	Targeted Capacity Expansion for Substance Treatment and HIV focused on women with children	Northeast Ohio Recovery Association[4]
SAMHSA's Center for Substance Abuse Prevention	$0	$0	$333,000	Youth	Northeast Ohio Recovery Association[5]

NOTES:

[1] *CDBG and ADASBCC funds are allocated on a July 1-June 30 funding cycle. Therefore, 2006 dollars are for 7/1/06-6/30/07, etc.*

[2] *AIDS Funding Collaborative allocated additional dollars in each of these years for other non-prevention focused HIV services and*

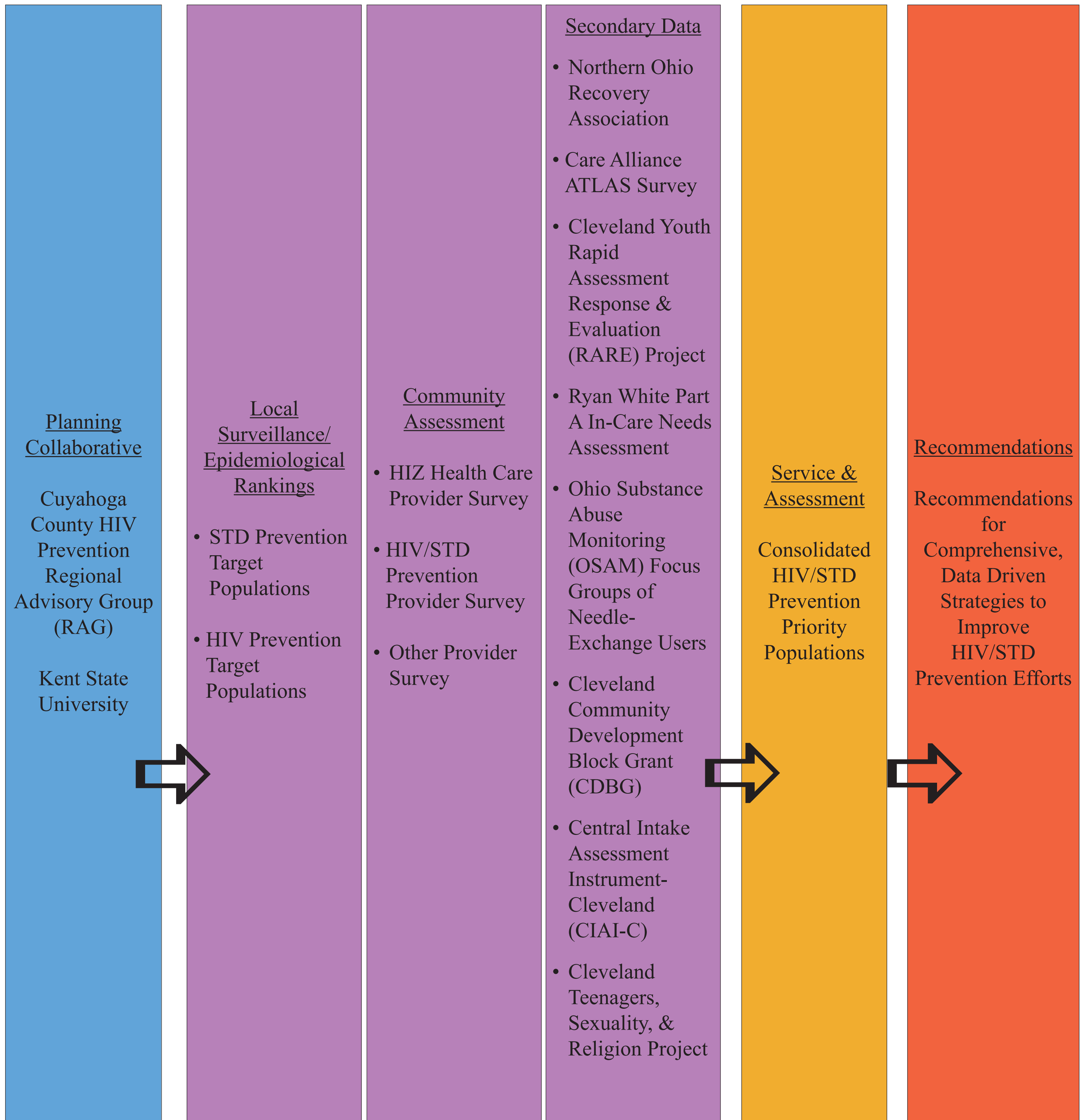
[3] *AIDS Taskforce Grant for BICC is a 5-year grant on the federal government's fiscal year, 10/1-9/30*

[4] *NORA's CSAT grant is a 5-year grant @ $500,000 per year. Grant cycle is on the federal government's fiscal year 10/1-9/30.*

[5] *NORA's CSAP grant is a 5-year grant @ $333,000 per year. Grant cycle is on the federal government's fiscal year, 10/1-9/30*

Below is a graphic display of the overall Cuyahoga County HIV/STD prevention needs assessment process. With the local surveillance/epidemiological rankings as the first source of data, the process also included a community assessment (local surveys) and the integration of local data taken from other sources (secondary data). Once all data was accumulated, the consolidated HIV and STD prevention priorities were developed. This, then, leads to recommendations for comprehensive, data driven strategies to improve HIV/STD prevention efforts in Cuyahoga County.

Cleveland/Cuyahoga County HIV/STD Prevention Needs Assessment



* Survey Instruments available upon request.

HIV Health Care Provider Survey

People living with HIV/AIDS are a primary target of HIV prevention activities. The Needs Assessment Committee surveyed physicians, social workers, nurses and case managers who care for patients diagnosed with HIV/AIDS in Cuyahoga County. The goal of these surveys was to document the HIV and STD prevention services that they provide, get their assessment of the most critical HIV prevention needs in the community, and elicit their suggestions on how to improve prevention efforts.

Email requests to participate in the survey were sent to 111 doctors and nurses and 45 case managers and supervisors known to provide care and treatment to those living with HIV/AIDS. A total of 67 (42.9%) health care professionals responded to the survey.

Role in Caring for those living with HIV/AIDS (n=67)

38.8% Physician/Specialty
23.9% Social Worker
16.4% Case Manager
13.4% Nurse
4.5% Nurse Practitioner/Physician Assistant
3.0% Other (Infectious Disease Fellow, Specialty program in nursing facility)

Respondents were asked to describe the prevention services they provide to HIV+ clients. The majority indicated that they discuss risk reduction strategies with their patients/clients and encourage HIV testing for partners. The majority also responded that they educate HIV positive patients about STD risk and co-morbidity/co-infection, refer HIV+ patients to support groups, and screen and refer patients for other social services. Services provided less often included helping patients with disclosure communication, providing medical treatment that helps keep HIV viral loads low and screening HIV positive patients for STDs.

HIV/STD Prevention Services Provided (Check all that apply) (n=67)

92.5% discuss risk reduction strategies
91.0% encourage HIV testing for partners
86.6% educate HIV+ patients about STD risk and co-morbidity/co-infection
86.6% refer HIV+ patients to support groups
85.1% screen HIV+ patients for other social service needs and refer them as appropriate
70.1% help patients with disclosure communication
58.2% provide medical treatment that helps keep HIV viral loads low
53.7% screen HIV+ patients for STDs

There was minimal consensus among the respondents when asked who should be primarily responsible for providing prevention services for those with HIV. Half of the respondents felt that this responsibility should be with health care providers, while others felt that this responsibility should be with case managers, community based organizations, the public health department or others.

Who should be primarily responsible for providing prevention services for HIV+ persons? (Check only one) (n=67)

50.7% health care providers
13.4% case managers/social workers
13.4% other (e.g. team effort)
11.9% community-based organizations with HIV prevention programs
7.5% public health department
1.5% disease intervention specialists (DIS)
1.5% people living with HIV

Respondents provided recommendations for how to improve HIV/STD prevention efforts in the community. Half of the respondents felt that it would be helpful to provide training about the most effective prevention with positives strategies that can occur in a clinical setting. More than one quarter of the clinicians who responded felt that they need more time with patients in order to address prevention needs and also need patient education materials. Respondents reported equal but relatively low interest in a referral system for patients to "prevention for positives" program and in forums for health care professionals to share best practices in prevention with positives.

Most helpful ways to improve HIV/STD prevention efforts in the community (Check only two) (n=67)

49.3% training about the most effective prevention with positives strategies in a clinical setting
28.4% more time with patients
28.4% patient/client education materials
22.4% a checklist or protocol
20.9% more case managers
14.9% referrals for patients to "prevention for positives" programs
14.9% forums for health care professionals to share best practices in prevention with positives

It is important to note that 77.6% of professionals report not following a specific protocol or standardized checklist for HIV/STD prevention with HIV positive patients.

In terms of the frequency of delivering prevention messages to HIV positive patients, 61.2% professionals report addressing HIV/STD prevention with HIV positive patients at least every three visits.

When asked as an open-ended question to list the most critical HIV/STD prevention needs in the community (response categories were not provided), the most common response was community education. Other responses include access to services and outreach targeted to high risk populations.

What do you think are the most critical HIV/STD prevention needs in the community? (n=67)

	n	%
Education is Most Central	**48**	**71.64% (48/67)**
Community Education/Workshops/Prevention	22	
Education within Schools	8	
Patient Education (condoms, oral sex)	7	
Prevention, Compliance, & Co-infection Education for HIV Positive People	4	
Community Stigma Reduction/Reconstruction	3	
Female Empowerment/Education	2	
Mentioned Once: Education on Disclosure/Partner Notification; Countywide Prevention Approach	2	
Access	**42**	**62.69%**
Condom Availability	13	
Access to Testing (HIV & STD)	5	
Access to Health Care & Services	4	
Access to Health Materials	3	
Financial Help to Patients/Clients	4	
Mental Health Services	2	
Early Diagnosis & Prevention	2	
Time for Private Discussions	2	
Mentioned Once: Referrals to Care; Housing; Needle Exchange Programs; Drug Rehabilitation Programs; and Access to Psychologists for Positives and Their Families; Patient Follow-up; Need for Protocols for Handling HIV Positives	7	
Target High Risk Populations	**35**	**52.24%**
Overall Outreach to High Risk Populations	8	
Teens	6	
Drug Users	6	
MSM/Gay Men	4	
Minorities	4	
Homeless	2	
HIV Positive People	2	
Mentioned Once: People Over Age 50; Activity at Flex; Jails	3	
Case Workers/Case Managers	**6**	**8.96%**
Need for More Trained Caseworkers	3	
Case Managers Overloaded	2	
Mentioned Once: Communication among Case Workers	1	
Other	**4**	**5.97%**

When asked if there was anything else they would like to share about HIV/STD prevention needs in the community (response categories were not provided) the responses focused on access to services (31.3%), community education (22.4%), high risk populations (10.5%), and case worker issues (7.5%).

Is there anything else that you'd like to share about HIV/STD prevention needs in the community? (n=67)

	n	%
Don't Know	**30**	**44.78% (30/67)**
Access	**21**	**31.34%**
More Resources Are Needed	6	
Condom Availability	2	
Prevention Services are Very Important	2	
Mentioned Once: City Sponsored STD Clinics; Immediate Appointments in Clinic; Need for More Pediatric Outreach Nurses; Clinic Nurses Overloaded; More Time Spent in Clinics Explaining Medications; Access to Psychologists for Positives and Their Families; Access to Free Health Care; Need for More Prevention Programs; Mental Health Services; Access to Testing (HIV & STD); Needle Exchange	11	
Education	**15**	**22.39%**
High School Sex Education Instead of Abstinence Only	5	
Community Education/Workshops/Prevention	5	
Education of HIV Risk and Condom Usage	2	
Mentioned Once: Prevention, Compliance, & Co-infection Education for HIV Positive People; Mistrust of Medical Community within Urban Settings; More Volunteers are Needed	3	
Target High Risk Populations	**7**	**10.45%**
Outreach is Needed for All High Risk Populations	3	
Teens	2	
Mentioned Once: MSM Often Do Not Use Condoms; Programs to Focus on Women	2	
Case Workers/Case Managers	**5**	**7.46%**
Mentioned Once: Effective & Efficient Screening Instrument; Need for More Trained Caseworkers; Case Managers Overloaded; Communication & Cooperation among Case Workers; Protocols/Checklists for All Points of Contact	5	
Other	**4**	**5.97%**
Collaboration Among Agencies & Professionals	3	
Mentioned Once: Funded Programs within the Area are Poor	1	

HIV/STD Prevention Provider Survey

The HIV/STD Prevention Provider Survey was designed to examine programs within organizations that provide HIV and STD prevention services. Surveys were completed by program managers who oversee the daily operations of a prevention program for the organization. Some organizations completed multiple surveys, one for each unique program providing prevention services. Using primary HIV/AIDS prevention funding sources, a list of 36 HIV/AIDS prevention programs was identified.

All of the programs completed the survey for a 100% response rate. Providers were asked to list their geographic service area, 47.2% stated they delivered services throughout Cuyahoga County.

HIV/STD Prevention Provider Survey

Geographic Service Area

	n	%
Cuyahoga County	17	47.22%
Neighboring Counties	5	13.89%
City of Cleveland	4	11.11%
East Cleveland	4	11.11%
Greater Cleveland Area	4	11.11%
West Cleveland	2	5.56%
Inner Ring Suburbs	1	2.78%
City of Cleveland CMSD Students	1	2.78%
Cuyahoga County Corrections	1	2.78%
Downtown Cleveland	1	2.78%
Stockyard Community	1	2.78%
Ward 14	1	2.78%
Not Provided	1	2.78%

Which of the following best describes your organization?

	n	%
Non-Profit	25	69.44%
CBO (Community Based Org)	14	38.89%
ASO (AIDS Service Organization)	12	33.33%
Community-Based	8	22.22%
Faith-Based	7	19.44%
Clinic	4	11.11%
Treatment Program	4	11.11%
School-Based	2	5.56%
LHD (Local Health District)	1	2.78%
Family/Community Center	1	2.78%
Health Center	1	2.78%
Latino Serving	1	2.78%

When asked to provide their hours of operation, of the 36 programs, the majority have daytime hours (88.9%), with 13.9% being open during the evenings without an appointment, and 2.8% open on weekends.

Hours of Operation (n=36)

	n	%
M-F daytime hours (8/9am-4/5pm)	32	88.89%
Evenings	5	13.89%
Evenings & weekends by appointment	2	5.56%
Early Mornings (6:30-8am)	1	2.78%
Weekends	1	2.78%
24 hours	1	2.78%

To examine the qualifications of current employees, providers were asked to specify how many of their current employees fell into the provided categories of education and experience. Across the 36 programs, a total of 230 employees provide prevention services. Of the full-time employees at least 40.8% have not completed post secondary education.

How many employees in your program who currently provide prevention services (HIV or STD) possess any of the following qualifications? (n=36)

	# Full-Time	# Part-Time	# Volunteers	TOTAL
1-2 years professional experience, without college degree	9	3	5	17
3-5 years professional experience, without college degree	22	7	2	31
5+ years of professional experience, without college degree	18	5	5	28
B.A./B.S. level	25	1	6	32
M.S.W./M.P.H. or Master's Level	26	3	5	34
R.N. or medical degree	1	4	3	8
Other*	19	1	60	80
TOTAL	120	24	86	230

**Other Includes: State of Ohio Prevention Specialists, Certified Medical Assistant, JD, PT, Red Cross Trained, Intern, College Students*

Providers were asked to answer how many of their current employees have completed specific training programs. Across the 36 programs, the professional trainings completed by the most employees are: Ohio Department of Health, HIV Counseling and Testing Services (30.8%); AIDS Taskforce of Greater Cleveland Capacity Building (27.6%); and Red Cross, HIV Prevention Program (21.2%).

How many employees in your agency have completed the following Trainings? (n=36)

	# Full-Time	# Part-Time	# Volunteers	TOTAL
Ohio Department of Health, HIV Counseling & Testing Srvs.	68	4	5	77
AIDS Taskforce of Greater Cleveland, Capacity Building	59	10	0	69
Red Cross, HIV Prevention Program	41	6	6	53
Diffusion of Effective Behavioral Interventions	31	4	2	37
Black AIDS Institute, African American HIV University	4	0	0	4
Other	5	2	3	10
TOTAL	208	26	16	250

Across the 36 programs, when asked for some examples (response categories were not provided) of training needs of their staff, the responses provided were specific trainings, trainings to assist special populations and funding to access trainings.

What are some examples of training needs for your staff in providing HIV and STD prevention? (n=36)

	n
Specific Trainings	
Continued updates/trends	7
Access to DEBI trainings	5
Access to training	4
Ongoing prevention trainings/refresher courses	3
Better record keeping/documentation	3
Culturally specific trainings	3
Special populations trainings	3
Evaluation	3
Access to state and national conferences	2
Evidence-based HIV programs and training	2
Technology utilization	2
Mentioned Once: Opscan training; Rapid HIV test training; Stigma; Social skills; Self-esteem; Trainings on how to facilitate groups/workshops; Personal safety; Time management; Case management; Peer review; HIV counseling; HIV testing; Internet partner notification; Expand staff education	14
Special Populations	
Transgender	3
Mental health	2
Substance users	2
Mentioned Once: MSM; Hepatitis; TB; STD; Poverty	5

Providers were asked the number of the prevention clients served by their program that met the client descriptions provided in the table below. Of the 36 programs surveyed, the majority report that they serve multiple populations. On average, each special client population has 24 HIV/STD prevention programs working to serve them.

Description of HIV/STD Prevention Clients Served by the Program (n=36)

	Not at All Served by Agency	**Served by Agency Along with Other Clients**	**Exclusively Served by Agency**
Youth (13-24)	6	26	3
Adults (25-54)	3	31	0
Older Adults (55+)	6	27	0
Men	5	27	2
Women	3	27	4
Persons with HIV/AIDS	6	14	7
Women of Color	3	29	2
Men of Color	5	25	3
Persons with Substance Abuse Disorders	2	25	2
Gay	2	26	1
Bisexual	1	26	1
Lesbian	4	22	1
Transgender	8	18	1
Living at or Below the Poverty Line	0	30	5
Homeless/Seeking Temporary Shelter	4	29	0
Prostitutes/Clients Exchanging Sex for Money/Drugs	2	25	0
Incarcerated/Involved with Corrections (Re-Entry Population)/Probation/Parole	3	28	1
Dealing with a mental health issue	2	26	0
Dealing with or have a history of violence or abuse	1	25	0
Developmentally delayed	5	14	0
Hearing or visually impaired	8	9	0
Other	13	2	0

In an effort to further explore the characteristics of clients served by prevention programs, providers were asked the number of persons served annually by their prevention programs within specified categories (see the table below). Across the 36 programs, 30 agencies report that they serve clientele that are living at or below the poverty line, which accounts for 27.4% of the total population served by the prevention programs.

Estimate the Number Served Annually (n=36)

Clients Served	Number Served	% Served of Total	Number of Programs Serving
Living at or Below the Poverty Line	45,635	27.37%	30
Men	19,642	11.78%	30
Adults (25-54)	19,284	11.57%	31
African American/Biracial Women	17,629	10.57%	32
Youth (13-24)	17,299	10.38%	29
African American/Biracial Men	16,890	10.13%	30
Women	16,661	9.99%	32
Persons with Substance Abuse Disorders	10,869	6.52%	26
Incarcerated/Involved with Corrections (Re-Entry Population)/Probation/Parole	9,625	5.77%	29
Homeless/Seeking Temporary Shelter	8,173	4.90%	28
Dealing with a mental health issue	7,688	4.61%	25
Prostitutes/Clients Exchanging Sex for Money/Drugs	3,671	2.20%	24
Dealing with or have a history of violence or abuse	3,449	2.07%	24
Older Adults (55+)	3,134	1.88%	27
Bisexual	3,124	1.87%	25
Gay	3,108	1.86%	26
Persons with HIV/AIDS	2,368	1.42%	21
Lesbian	1,202	0.72%	21
Developmentally delayed	830	0.50%	13
Transgender	242	0.15%	17
Hearing or visually impaired	143	0.09%	9
Other	110	0.07%	2

Note: Categories are not mutually exclusive

When asked an open-ended question about what groups within the county are not being reached at all, most providers (94.4%) listed specific target populations (response categories were not provided). Of the providers, 16.7% felt homeless youth and youth not in school were not being reached at all by prevention services. Also certain geographic areas were mentioned as not receiving prevention services, with the outer ring suburbs being the largest missed group (13.9%).

What target groups in Cuyahoga County are not being reached AT ALL with HIV or STD prevention services? (n=36)

	n	%
Special Populations	**34**	**94.44%**
Youth (homeless, not in school)	6	
IDU	3	
Older adults	3	
Women at Risk	3	
Latinos/Hispanics	3	
Prostitutes/exchange sex for money/drugs	2	
Lesbian/Bi-sexual females	2	
MSM	2	
African Americans	2	
Mentioned Once: Homeless; Re-Entry Populations; Incarcerated males; Married men with multiple partners; Arabic; Asians; Handicapped; People NOT receiving social services	8	
Geographic Areas	**10**	**27.78%**
Outer suburban rings of Cuyahoga County	5	
Charter schools	2	
Mentioned Once: Online community; Private Schools; Parochial schools	3	
Don't Know	**8**	**22.22%**

When asked if any groups within the county are being well-served with prevention services (response categories were not provided), MSM (27.8%), youth (13.9%) and African American/Biracial persons (11.1%) were the highest reported.

Would you say that there are particular groups being well-served in our county with prevention services? If so, what groups? (n=36)

	n	%
MSM	10	27.78%
None	6	16.67%
Youth/teens	5	13.89%
African American/Biracial persons	4	11.11%
Homosexuals	3	8.33%
LGBT Community	3	8.33%
Bath house clientele	2	5.56%
Lesbians	2	5.56%
Mentioned Once: High risk populations (in general); Central community consumers; Substance users; Homeless youth; HIV+ long-term survivors; Middle class people; Smokers; HIV+ youth; Clients in county drug board funded facilities; Entire community	10	27.80%

The greatest challenges for the clients served (response categories were not provided) are poverty (27.8%), stigmatized status (27.8%), and housing (19.4%).

What are the greatest challenges facing the clients that you serve? (n=36)	n	%
Lack of Resources		
Financial resources/poverty	10	27.78%
Housing	7	19.44%
Transportation	4	11.11%
Employment/job retention	4	11.11%
Access to services	3	8.33%
Poor healthcare	3	8.33%
Low education	3	8.33%
Mentioned Once: Sharing needles; Low skilled; Child care; Poor eating; Lack of social/recreational facilities	5	13.89%
Social/Family/Behavioral Challenges		
People being responsible/following advice	3	8.33%
Fear	3	8.33%
Barriers in daily life	2	5.56%
Involved parents	2	5.56%
Low self-esteem	2	5.56%
Lack of positive role models	2	5.56%
Mentioned Once: Adherence; Lack of information on HIV/STDs; Barriers to partner notification; Social support; Caseworkers are overloaded; Unwilling to change/comfortable with life	6	16.67%
Special Populations		
Stigmatized status (gay, bisexual, HIV+)	10	27.78%
Criminal charges/drug charges	2	5.56%
Mental illness	2	5.56%
Substance use	2	5.56%
Teenagers	1	2.78%

Providers were asked what primary type of service is offered by their specific program. Response categories were provided, however there was an 'other' category that could be selected. Prevention services (58.4%) are the most common primary service offered by the programs surveyed, with HIV prevention being the most common of these (41.7%), followed by other prevention services (13.9%), and STD prevention (2.8%).

Primary service offered (n=36)	
41.7%	HIV Prevention
13.9%	Education
13.9%	Other Prevention Services
11.1%	Other (professional development, self esteem, counseling, needle exchange)
5.6%	HIV Social Services (case management)
5.6%	Faith-Based
2.8%	STD Prevention
2.8%	Crisis Services
2.8%	Substance Abuse Treatment

Examining what services are provided by the prevention programs beyond their primary service, respondents were asked to check all categories of secondary services that were provided by their program. In addition to the overarching primary service of prevention services, education was a key secondary service (55.6%), followed by substance abuse treatment (19.4%).

What services are provided by your program beyond the primary service? (n=36)

	n	%
STD Prevention	25	69.44%
Education	20	55.56%
HIV Prevention	18	50.00%
Other Prevention Services	8	22.22%
Substance Abuse Treatment	7	19.44%
HIV Social Services	6	16.67%
Crisis Services	6	16.67%
Political/Community Organizing/Advocacy	6	16.67%
Other*	6	16.67%
Health Care/Medical Care	5	13.89%
Care/Service Coordination	4	11.11%
Faith-Based	4	11.11%
Other Social/Human Services	3	8.33%
Mental Health Services	3	8.33%

**Other includes:* *case management, dental, exercise/healthy living, housing, supportive counseling, youth*

Providers were asked to check-off all of the HIV/STD prevention services offered by their program. The majority of providers offered services in the areas of education (86.1%), risk reduction (86.1%), and culturally-appropriate services (83.3%).

List all of the HIV/STD prevention services offered by this program (n=36)

	n	%
Educational materials-Health Education HIV 101	31	86.11%
Risk Reduction	31	86.11%
Culturally-Appropriate Services	30	83.33%
Skills Building	26	72.22%
Harm Reduction	25	69.44%
Outreach	23	63.89%
HIV Testing and Counseling	22	61.11%
Behavior Change Counseling	21	58.33%
Peer Involvement	18	50.00%
Prevention for Positives	14	38.89%
Partner Counseling and Referral Services	10	27.78%
Social Marketing	9	25.00%
Prevention Case Management	6	16.67%
Syringe Exchange	4	11.11%
Other*	3	8.33%

**Other Includes: ATOD referred; free condoms, professional development*

Respondents were asked to estimate the percentage of services they provide at the individual, group, and community/public education levels. The majority of prevention services are provided at the group level (51.9%).

What service levels are offered in this program? Please estimate the percentage, the total of the three percentages should be equal to 100 (n=36)

	Mean %
Individual Level	33.74%
Group Level	51.94%
Community/public education level	14.03%

When asked about ways to increase counseling and testing among clients (response categories were not provided), provider responses focused largely (44.4%) on expanding access to testing services. They called for modification of types of programming (38.9%), and additional professional training of staff (22.2%).

How might HIV counseling and testing be increased among the population you serve? (n=36)

	n	%
Expand Access to Testing Services	**16**	**44.44%**
Improved access (transportation, incentives)	6	
Availability of rapid testing	3	
Mobile HIV testing	2	
Evening clinics/flexible hours	2	
Mentioned Once: Community testing events; More free services; Bilingual outreach workers	3	
Modification of Types of Programming	**14**	**38.89%**
Community-based education	6	
Support groups/counseling	5	
Social marketing of free, anonymous testing	2	
Single-session education programs	1	
Professional Training Issues	**8**	**22.22%**
More training on HIV stigma/staff training/State trainings	6	
Certification/State oversight of providers	2	
Special Populations	**8**	**22.22%**
Church leader involvement	2	
Mentioned Once: Hispanic youth; Larger target population; Basic education to at-risk groups; Teen centered clinics; Jails; Schools	6	
Funding	**5**	**13.89%**
Funding for increased testing	3	
Funding for increased staffing	2	
Don't know	**1**	**2.78%**

The primary issue or challenge facing most HIV/STD prevention providers (response categories were not provided) is related to limited funding for resources and staffing (69.4%). Programming logistics issues (33.3%), programming/curriculum gaps or deficits (19.4%), and the needs of special populations (16.7%) are other key challenges facing prevention providers.

What are the primary challenges or issues that you face in providing HIV or STD prevention services? (n=36)

	n	%
Funding	**25**	**69.44%**
Limited Staff/Staff turnover (resources to pay for staff)	13	
Limited Resources/funding	12	
Programming Logistics Issues	**12**	**33.33%**
Community outreach/recruitment/education	6	
Program retention of participants and appointment keeping	3	
Accurate data/Documentation standards/Evaluation tool	2	
Getting people to seek information	1	
Programming /Curriculum Gaps/Deficits	**7**	**19.44%**
Community education is needed to reduce stigma of HIV/AIDS	3	
Curriculums does not meet population needs/out of date	3	
Finding best mode of educating	1	
Special Populations	**6**	**16.67%**
Youth	2	
Homeless	2	
Correctional institutions	1	
Programming need to be for young women	1	
Other	**5**	**13.89%**
Mentioned Once: Coordinated care efforts; Need for internet partner notification; Inclement weather; Waitlists; More needle exchange sites	5	
None	**1**	**2.78%**

Providers were asked (response categories were not provided) to list what barriers exist for HIV and STD prevention at the individual and community levels. There was not a limit to the number of barriers that could be listed. The most common barrier reported were stigma and stereotypes (41.7% HIV; 38.9% STD), fear (13.9% HIV and STD), and lack of awareness/ignorance (11.1% HIV and STD).

What barriers exist at the individual level for HIV prevention? For STD prevention? Are they the same or different? What barriers exist at the community level? (n=36)

	HIV Barriers		**STD Barriers**	
	n	**%**	**n**	**%**
Stigma/stereotypes	15	41.67%	14	38.89%
Fear	5	13.89%	5	13.89%
Lack of awareness/ignorance/need for education	4	11.11%	4	11.11%
Access to education	2	5.56%	2	5.56%
Misinformation/fragmented information	2	5.56%	2	5.56%
No cooperation from community	2	5.56%	2	5.56%
Social norms (condoms, testing)	2	5.56%	2	5.56%
Self-esteem (teens and others)	2	5.56%	1	2.78%
Mentioned Once as Both HIV and STD Barriers: Accessibility of testing; Access to services; Drug Abuse; Program retention; Community-wide poverty; Individual Participation; Teens sense of invincibility; Teens lack of knowledge; Teens lack of constructive social activities; Lack of discrete social marketing; Lack large social gathering places; Money spread too thin; Lack of comprehensive training; Low susceptibility; Lack of social support; Preconceived notions about sexuality discussions; Thought that parents will resist sex education and prevention; Client lack of honesty; Resistance to education	19	52.78%	19	52.78%
Mentioned Once as HIV Barrier: HIV partner notification (MSM, doctors)	1	2.78%	0	0.00%

The utilization of Diffusion of Effective Behavioral Interventions (DEBIs) is diverse, with most DEBIs only being implemented by 1 or 2 providers. Those models used more frequently are: Safety Counts (6 providers), SISTA (4 providers) and BART (3 providers). Of the 36 programs, 28.8% (10) are not DEBI programs.

What services are provided by your program beyond the primary service? (n=36)

	n	**%**
This program does not offer any DEBI programs	10	27.78%
Safety Counts	6	16.67%
Other*	5	13.89%
SISTA	4	11.11%
BART	3	8.33%
Healthy Relationships (HR)	2	5.56%
Real AIDS Prevention Program (RAPP)	2	5.56%
VOICES/VOCES	2	5.56%
Focus on Youth + ImPACT	2	5.56%
Be Proud. Be Responsible	1	2.78%
Community PROMISE	1	2.78%
MPowerment	1	2.78%
RESPECT	1	2.78%
Together Learning Choices (TLC)	1	2.78%
Many Men, Many Voices	1	2.78%
Holistic Health Recovery Program (HHRP)	0	0.00%
Popular Opinion Leader (POL)	0	0.00%
Street Smart	0	0.00%

**Other Includes: CRCS, Partner Notification Services, Safer Choices and Making Proud Choices, Training About DEBIs*

Most client contact with the prevention programs is through community outreach (44.4%) and word of mouth (16.7%), with most services being offered either within the community (75.0%) or at the agency (72.2%).

Regarding the HIV/STD prevention services offered, what is the most common way in which your clients come into contact with your program? (Choose one) (n=36)

	n	%
Outreach	16	44.44%
Referral/Word of Mouth	6	16.67%
By Appointment-they get prevention services when they attend clinical appointments	3	8.33%
Community/Public Events	3	8.33%
Mandated (through transitional housing or drug treatment)	2	5.56%
Walk-in	2	5.56%
School/Professional Development Workshops	2	5.56%
During Incarceration	1	2.78%
Direct Contact, In-Person	1	2.78%

In which setting are HIV/STD prevention services offered for this specific program? (Check all that apply) (n=36)

	n	%
Community	27	75.00%
Agency	26	72.22%
Substance Abuse	13	36.11%
Faith-Based Institution	11	30.56%
Correctional Institution	8	22.22%
Mental Health Program	5	13.89%
Community-Based Corrections	5	13.89%
STD Clinic	4	11.11%
Medical Provider	4	11.11%
HIV/AIDS Care	3	8.33%
Maternal/Child Health Care and Service Coordination	3	8.33%
Community Health center	2	5.56%
Shelters/Homeless/Soup Kitchens	2	5.56%
Mentioned Once: TB Clinic; Women's Health; Family Planning or OB/GYN; Perinatal Clinic; Health Fairs; Schools	5	13.89%

Providers were asked to check which behavior theories were utilized to guide their program. Of the 36 programs, nearly all (94.4%) use behavioral theories to guide prevention services. The Stage of Behavioral Change Model and Harm Reduction are the most popular.

What behavioral theories guide prevention services offered in this specific program? (n=36)

	n	%
Stage of Behavior Change Model	17	47.22%
Harm Reduction	17	47.22%
Health Belief Model	12	33.33%
Social Cognition Theory	10	27.78%
Empowerment Education Theory	10	27.78%
Diffusion of Innovation	4	11.11%
Theory of Reasoned Action	3	8.33%
No specific theoretical model	2	5.56%

The majority of agencies are affiliated with the Cuyahoga County RAG (83.3%) and the Cuyahoga County Alcohol and Drug Board-HIV Prevention Providers Meeting (44.4%).

Regarding general affiliations, are you involved with any of the following planning councils? (Check all that apply) (n=36)

	n	%
Cuyahoga County RAG (Regional Advisory Group)	30	83.33%
Cuyahoga County Alcohol and Drug Board-HIV Prevention Providers Meeting	16	44.44%
Ryan White Part A Planning Council	10	27.78%
Ryan White Part B Consortium	10	27.78%
Title X/Family Planning Advisory Committee	9	25.00%
Collaborative for School Age Health	8	22.22%
Mental Health Board-Planning, Program and Oversight Committee	7	19.44%
Family and Children First Council	5	13.89%
Children and Family Health Services (CFHS) Consortia	4	11.11%
Fatherhood Council	3	8.33%
Other	3	8.33%
United Way Vision Council	0	0.00%

**Other Includes: HIV+ Adolescent Regional Ethics, Ohio Dept of Health/CDC, United Church AIDS Network*

When asked what policy changes might improve prevention services offered in the county (response categories were not provided) the majority of provider responses were in the area of programming (52.8%), with 16.7% noting that there need to be standards or credentialing for HIV educators. Funding (44.4%) was also given as a policy area that could improve prevention services.

What policy changes might improve prevention services offered in Cuyahoga County? (n=36)	**n**	**%**
Programming	**19**	**52.78%**
Standards and/or credentialing for HIV educators	6	
DEBIs alone do not work, need street-based programming	5	
HIV sensitivity training in city, county, and state programs	2	
Mentioned Once: Grassroots organizations have better community outreach; Family planning; Greater focus on case management and support groups; Offer HIV/STD education through existing state programs (i.e. WIC); Single-session education programs for non-captive audiences; Collaboration with outside agencies without violating grant terms	6	
Funding	**16**	**44.44%**
More funding overall	4	
Better coordination between funders and providers	3	
Multiple year funding for CDBG HIV prevention programs	2	
Funding for condom distribution	2	
Mentioned Once: Concentration of funds on top 4 risk groups; Funding for Safety Counts for drug users; Funding for transportation; Funding for child care; Funding for bi-sexual women with multiple partners	5	
Access & Testing	**8**	**22.22%**
Access to schools/Mandatory in schools	5	
Mentioned Once: Testing availability in medical facilities and emergency rooms; Condoms availability in jails; Mandatory HIV testing in jails	3	

Feedback offered from the providers regarding gaps and barriers to prevention services in the county shows strong support for evidence-based programming. Seventy-eight percent (77.7%) of providers do not think there is too much emphasis on evidence based-programming. In spite of the challenges DEBIs create, providers still are brought to the notion of evidence-based programming. Additionally, 100% of providers affirmed the need for evaluation plans for prevention programs.

We would like you to give us your feedback on the gaps and barriers to prevention services in Cuyahoga County (n=36)

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
We need more training opportunities for HIV and STD prevention for professionals in our community	0.0%	0.0%	36.1%	63.9%	0.0%
We need more free STD testing opportunities in our community	8.3%	13.9%	19.4%	58.3%	0.0%
Evaluation plans are important for prevention interventions	0.0%	0.0%	47.2%	52.8%	0.0%
There is a great deal of stigma in our community for persons with HIV/AIDS	2.8%	11.1%	36.1%	47.2%	2.8%
It is important to target HIV and STD prevention services to specific target populations	11.1%	5.6%	38.9%	44.4%	0.0%
Some agencies provide HIV testing and counseling with untrained staff	0.0%	16.7%	36.1%	22.2%	25.0%
We don't have the funding to do DEBIs in our agency	11.1%	44.4%	16.7%	19.4%	8.3%
There is a small enough community where the HIV and STD prevention programs all know each other	13.9%	47.2%	25.0%	11.1%	2.8%
There is too much emphasis these days on "Evidence-based" interventions	19.4%	58.3%	11.1%	8.3%	2.8%
There is political support for cutting edge/advanced prevention programs (needle/syringe exchange, Comprehensive k-12 sex education, increased youth STD screening)	2.8%	27.8%	50.0%	8.3%	11.1%
The public systems (CDPH, Ryan White, the County Board of Health, Drug Board) collaborate effectively	2.8%	19.4%	47.2%	5.6%	25.0%
Case management is too time consuming for our program to consider	19.4%	44.4%	22.2%	2.8%	11.1%
There is good communication between prevention programs, the health departments, mental health and drug treatment agencies	8.3%	50.0%	36.1%	2.8%	2.8%
There is effective public input in the planning processes	2.8%	44.4%	44.4%	2.8%	5.6%
The educational materials provided by the CDC and health departments don't work for our clients so we have to make up our own	8.3%	63.9%	27.8%	0.0%	0.0%
Funding for prevention programs is fairly distributed in our community	11.1%	38.9%	27.8%	0.0%	22.2%

Other Provider Survey

The goal of the Other Provider Survey was to explore HIV/STD prevention with other program directors of community-based agencies that do not currently provide prevention services. Fifteen (15) agencies that do not currently offer HIV/STD prevention services or programs completed the capacity (non-provider) survey. The majority of non-providers were non-profit (86.7%) or community-based (53.3%).

Of those surveyed, 86.6% report that they would like to offer HIV/STD prevention services, while 86.7% report not having the resources to add new services.

Below is a list of reasons why community-based agencies do not offer HIV/STD prevention services. For each, please tell us how much each statement applies to your agency (n=15)

	Strongly Disagree	Disagree	Agree	Strongly Agree
We would like to offer HIV/STD prevention services	0.0%	13.3%	53.3%	33.3%
HIV/STD prevention is not within the goals of this agency	40.0%	33.3%	6.7%	13.3%
It's too time consuming to provide prevention services	33.3%	66.7%	0.0%	0.0%
Clients do not want to deal with HIV/STD risk since that's not why they are here	33.3%	33.3%	33.3%	0.0%
Our agency does not have the resources to add new services like HIV/STD prevention	0.0%	6.7%	60.0%	26.7%
Our staff do not have training in HIV/STD prevention	6.7%	33.3%	46.7%	13.3%
If we talk about HIV or STDs, we will chase our clients away	60.0%	33.3%	6.7%	0.0%
Clients can access HIV/STD prevention programs from other agencies	13.3%	13.3%	60.0%	6.7%
It's harder to offer prevention services because staff time cannot be reimbursed	6.7%	33.3%	40.0%	13.3%

When asked specifically if they would like to learn more about adding prevention services to their current agency, 80% of other providers stated 'yes'.

Are you interested in learning more about the ways to incorporate HIV/STD prevention services into your current agency? (n=15)

	n	%
Yes	12	80.0%
No	3	20.0%

Of the other providers 100% would be somewhat or very interested in better collaboration among service delivery systems and 86.7% would be somewhat or very interested in staff in-service training on HIV/STD prevention and would be somewhat or very interested in obtaining a comprehensive listing of HIV/STD prevention service providers.

Here is a list of capacity-building activities that might be offered. For each, please indicate your interest in the activity. (n=15)

	Not Interested	Somewhat Interested	Very Interested
Provide staff in-service training on HIV/STD prevention	13.3%	46.7%	40.0%
Providing a comprehensive directory of HIV/STD prevention services where you can refer your clients	13.3%	26.7%	60.0%
Assistance in developing grant proposals to incorporate HIV/STD prevention into your current services	20.0%	53.3%	26.7%
Training on client intervention models to motivate clients to address HIV/STD risk	26.7%	26.7%	46.7%
Better collaboration and communication between service delivery systems	0.0%	33.3%	66.7%

Secondary Data Sources & Analysis Year

The secondary data sources serve as supplements to the primary data collection (HIV health care providers, prevention provider agencies and other agencies). The research from the secondary sources broadens and confirms the need for HIV/STD prevention for various target populations within the community. With the enhanced knowledge gathered from the all data sources it is possible to extract a more comprehensive analysis of the HIV/STD needs within the City of Cleveland and Cuyahoga County.

ATLAS Program of Care Alliance Health Center: Cuyahoga County Corrections Center (June-August 2008)

Target Audience: Incarcerated Individuals

- The majority of the sample were male (88.77%), African American (62.81%), between the ages of 18-47 (83.7%), have a high school education or above (75.29%), and are heterosexuals (88.2%).
- |While most respondents report seeing a doctor within the past twelve months (78.65%), 13.89% report not being offered an HIV test. HIV and STD testing is imperative since 25.78% of the sample reported not using a condom during anal sex and 39.95% of the males report rarely or never using a condom. Respondents reported that 30.34% have had a sexually transmitted disease and 1.11% tested positive for HIV in the past. When asked about the past ten years, 16.29% report giving someone drugs or money for sex and 20.79% report receiving money or drugs in exchange for sex.

Computerized Inventory Assessment Instrument-Cleveland (CIAI)-Current Drug Users (2007-2008) from Alcohol & Drug Addiction Services Board of Cuyahoga County

Target Audience: Drug users

- Of the 13,041 drug users screened, the majority were heterosexual (80.9%), followed by bisexual (1.8%), and homosexual (1.4%). The remaining 15.9% did not answer the question pertaining to their sexual orientation
- When questioned about condom usage, 73% of the heterosexual respondents report sometimes or never using a condom, followed by 69.3% of bisexual respondents and 63.9% of homosexual respondents reporting only sometimes or never using a condom.
- Of the individuals reporting never being tested for HIV, 72.6% report only sometimes or never using a condom.
- Of the individuals reporting having sex with someone who might have HIV or AIDS, 76.6% report only sometimes or never using a condom.
- 17.1% of individuals reporting not ever being tested for HIV/AIDS, also report partaking in risky sexual behavior.
- Of the individuals reporting sharing a needle or works, 80.9% report only sometimes or never using a condom.
- When asked about engaging in risky sexual behavior, 45.0% of bisexuals, 36.0% of homosexuals, and 22.3% of heterosexuals report partaking in such behaviors.
- Of the individuals reporting having sex with someone who might have HIV or AIDS, 31.4% did not consider themselves to be partaking in risky sexual behavior.
- Of the respondents reporting that they never use a condom, 16.5% report risky sexual behavior.

Community Development Block Grant HIV Program Evaluation Summary (CDBG) (2007-2009)

The Cleveland Department of Public Health in partnership with the AIDS Funding Collaborative instituted a two-year evaluation for all HIV Prevention programs receiving Community Development Block Grant (CDBG) dollars (n=8) beginning with the 2007-2008 grant year. During the first year of the evaluation a profile of risk and knowledge was created to measure the risk behaviors and knowledge of the clientele serviced by the eight programs. A survey of risk behaviors and knowledge was completed by 2,106 clients. Of the sample, 64.5% had a high knowledge of HIV risk while the remaining 35.5% had low knowledge. CDBG is continuing their evaluation with data available for the first six months of year two (n=1512). The full report can be obtained from www.clevelandhealth.org.

Year 1	n	%
Lower Risk-Low Knowledge	422	20.0
High Risk-Low Knowledge	327	15.5
Lower Risk-High Knowledge	1021	48.5
High Risk-High Knowledge	336	16.0
Total	**2106**	**100.0%**

First Six Months Year 2	n	%
Low Risk- Low Knowledge	25	1.7
Low Risk- High Knowledge	27	1.8
Moderate Risk-Low Knowledge	201	13.3
Moderate Risk-High Knowledge	412	27.2
High Risk-Low Knowledge	287	19.0
High Risk-High Knowledge	560	37.0
Total	**1512**	**100.0%**

The Cleveland Teenagers, Sexuality, and Religion Project, Report on HIV/AIDS (2006-2009); Christian Community, Inc.

Target Audience: Youth affiliated with religious congregations

Youth Survey

- The sample was comprised of 1,305 teenagers (grades 9-12) who were active in religious congregations in the greater Cleveland area.
- 23% of teens of faith are having sexual intercourse. This is below the state average of 39% of all youth.
- High rates of other sexual behaviors were reported with 37% of 11th/12th grade boys and 32% of 11th/12th grade girls saying they have had oral sex. There is the belief that they cannot contract HIV or STDs from oral sex.
- 15% of sexually active females reported experiencing a pregnancy.
- 2.1% of those reporting sexual activity (intercourse or oral sex) report having HIV/AIDS.
- 13.9% of those reporting sexual activity (intercourse or oral sex) report having had another STD.

Clergy Survey

- N=344 clergy in the greater Cleveland area.
- 66% felt teenagers should be taught both sexuality education and abstinence.
- 16.7% of congregations, in the past five years, had at least one person with HIV.
- 27% of congregations, in the past five years, had at least one instance of a person having an STD.
- 50% of congregations, in the past five years, had at least one teenager coming out as gay, lesbian or bisexual.

Cleveland Youth RARE Project & Social Marketing Campaign (2006)

Target Audience: African American Youth and Parents

Youth Sample

- The sample was comprised of 128 youth age 13-20+, African American (85.2%), and heterosexual (91.4%).
- When questioned about routes of transmitting HIV, 98.4% knew it was from unprotected sex; however, 16% of males and 21% of females reported not using a condom. It is important to note that access was not the limitation for condom usage, with 97% of males and 100% of females reporting having access to condoms.
- Family doctors, parents or guardians, and the Internet are the three most popular venues for obtaining information regarding HIV, STDs, and teen pregnancy.

Parent Sample

- The sample was comprised of 39 parents age 20-50s, most were mothers (97.4%), and African American (84.6%).
- Parents were asked about their ability to talk with their teens about HIV, STDs and teen pregnancy. They were asked to rank their ability as excellent, above average, average, below average, and extremely poor. In terms of HIV, 13.5% reported having an average to below average ability. When talking about STDs 16.2% report only an average or below average ability. In relation to teen pregnancy, 24.3% report being average or below in their ability to talk with their teens.

Youth Provider Sample

- Focus groups were conducted with 20 youth providers. The providers were age 20-50s, mostly female (95%), African American (65%), and worked with social services, a non-profit organization, or an educational institution (70%).
- Of the 20 providers, most reported being excellent or above average in their ability to talk with teens about HIV (60%), STDs (80%) and teen pregnancy (75%). While, 2 (10%) report being extremely poor at talking with teens about HIV, STDs and teen pregnancy.
- Youth providers report obtaining most of their information about HIV, STDs and teen pregnancy from the internet, medical agencies, and social service agencies.

Recommendations

- Comprehensive sex education that contains skill building
- Usage of peer educators
- Youth involvement with prevention planning
- Increased family involvement

*Full report can be obtained from www.clevelandhealth.org

'In Care' Needs Assessment of Persons Living with HIV/AIDS in Cleveland TGA, Cuyahoga Regional HIV Health Services Planning Council, Ryan White Part A (2008)

Target Audience: Persons Living with HIV/AIDS

- As of December 2005, there were 1,870 people in Cleveland living with HIV, 2,205 living with AIDS, and 155 newly diagnosed cases. Of the newly diagnosed, most were males (76%), African American (59%), ages 25-44 (69%), living within Cuyahoga County (86%), and were MSM (41%).
- 210 respondents completed the 2008 'In Care' survey. Of them, 43.7% were MSM, 39.5% persons living with HIV/AIDS, 21.1% drug users, 14.9% women of childbearing age, 12.3% African American females, 7.7% Hispanic females, 6.2% incarcerated, 5.6% bisexuals, and 3.1% transgender.
- Of those with HIV/AIDS, 52.1% were diagnosed since 2000.
- HIV/AIDS top sources of acquirement were: MSM (45%), heterosexual sex (33.7%), and sex with a drug user (10.9%).
- Most individuals were tested for HIV because they were ill or entered the hospital (46.9%), followed by partner told them (18.4%), risky sexual practice (16.8%), tested as part of a physical (16.8%), official notification (7.8%), and used injection drugs (5.0%).

- When asked how long after they found out they were HIV positive it took them to enter medical care, 17.4% responded over one year. When questioned what could have helped them get medical care earlier, 42.3% said if they had received counseling about HIV when they were first diagnosed, 27% if they would have been educated about the problems associated with not getting care, and 23.4% if they were in contact with someone with HIV that could help them.
- When asked about substance usage, 19.9% currently used. The primary drugs of choice were: marijuana (63.0%), alcohol (52.2%), cocaine (17.4%), crystal (4.3%) and other (4.3%). Of the total sample, 12% had injected drugs in the past.
- Of those reporting injection drug use, 24.5% had shared a needle and 30.4% reported not cleaning their needles.
- 26.1% report having sex with two or more people in the past six months.
- When asked about their condom usage in the past six months, 8% reported never using a condom during vaginal sex and 6.4% report never using a condom during anal sex. Since diagnosis, 47.7% only sometimes use a condom and 35.8% report never using a condom.
- When asked why they continue to have unprotected sex, 52.5% report 'it feels good', 34.4% state their partner will not let them, 14.8% feel like they are not at risk, and 11.5% report not having time.
- In relation to casual sex, 18.8% report having casual sex partners, with 56.3% of these having same sex casual partners and 14.1% having casual partners of both sexes.
- When asked if they felt at-risk for catching a disease 64.8% reported 'no'. The two main reasons for this feeling were: same partner (72.4%) and age (22.4%).
- The top five service needs cited are: Primary medical care, medications, medical case management, housing services, and oral health care.

Northern Ohio Recovery Association, Inc. (2008)

Target Audience: Youth

Face-to-face interviews were conducted with key stakeholders and leaders in Cleveland, Ohio. Major themes that emerged from preliminary data analysis are:

- Education: Youth are lacking sex education or it is simply coming too late (teen years). Sexual education programs need to target children earlier while remaining age appropriate and being culturally sensitive.
- Peer pressure: Sexual behavior is seen as a "rite of passage" within social groups and sexual activities are often part of a dare.
- High risk sexual behaviors are on the rise: Oral and anal intercourse among teens is increasing, which increases the risk for HIV as well as other sexually transmitted diseases. Older teens often prey on younger teens' ignorance in such situations. Clinics can be the key to reducing such behaviors by providing information and handouts.
- Financial and material incentives for sexual activity: Boys are bartering with girls for sexual favors. Most girls inform their mothers of such relationships, but the mothers fail to condemn them.
- Other daughters keeping relationships secret from mothers: Girls are ashamed, fearful or anticipate competition with their mothers so they do not inform their mothers of their sexual relationships. This was linked to a lack of father-involvement with teen girls that lead them to seek relationships with other males to fill the void.

- Refusal skills: There is the myth among teens that once you are sexually active you cannot stop being sexual active.
- Open parenting: Parents and other relatives are key in promoting abstinence and to education youth about sex. Teens are most willing to listen to parents who are open and willing to listen in a non-judgmental way.

Ohio Substance Abuse Monitoring (OSAM) Focus Groups-Current Drug Users (2009)

Target Audience: Drug Users

- Information regarding HIV/AIDS and STDs were obtained from: Needle exchange, other programs, hospitals, jail/prison, books/pamphlets, online, shelter and from people living with HIV.
- HIV and STD testing was done at: Needle exchange, hospital, shelter, other programs, and jail.
- Programs in the community they knew of that provide HIV/STD prevention were: Needle exchange, Project Safe, The Free Clinic, prison, hospitals, detox, and Treatment Alternatives to Street Crime (TASC).
- Why people are still getting infected with HIV and STDs: Drug usage, feel that they cannot get it (too old, not gay), lack of education, refuse to listen to facts, and having unprotected sex.

Service Gaps

The HIV/STD prevention gap assessment was conducted to provide a comprehensive listing of the current populations being served by prevention services in Cuyahoga County as well as to identify service gaps and prioritize HIV/STD prevention needs within the county. Based on estimates of target populations served by prevention providers, a service gap assessment was conducted. For each target population, estimates from national and local sources were utilized to determine the size of each population within Cuyahoga County. This provided an estimate of the percent of the Cuyahoga County population served by the surveyed prevention providers. It is important to note that this gap assessment includes estimates only provided by the HIV/AIDS funded prevention providers and that prevention may be provided by other organizations (for example, schools, hospitals, private providers or treatment center). Priority ranking was then based on percent of population served: First highest priority = 10%; second highest priority = 11-25%; third highest priority = 26% or greater.

Population Served in Cuyahoga County

	Number Served Annually (HIV Prevention Providers)	Cuyahoga County Census Data (n=1,295,958)	% of Population Served	Rank*
Sexual Orientation				
Bisexual Persons	3,124	30,066[1]	10 %	1
Lesbian Women	1,202	8,761[1]	14%	2
Gay Men	3,108	14,307[1]	22%	2
Transgender Persons	242	518[1]	47%	3
Drug Users	10,869	194,394[2]	6%	1
Age				
Older Adults (55+)	3,134	338,977	1%	1
Youth (13-24)	17,299	167,475[3]	10%	1
Race				
African America/Biracial Women	17,629	200,338	9%	1
African American/Biracial Men	16,890	179,378	9%	1
Latinos	1,200	53,134	2%	1
HIV/AIDS				
Persons with HIV/AIDS	2,368	3,845[4]	62%	3

Notes:

1 Estimates based on National Center of Health Statistics: Male Bisexuals=1.8%, Gay Men=2.3%, Lesbian Females=1.3%, Female Bisexuals=2.8% and Transgender=.0004%

2 Estimates based 15% of U.S. population are drug users, estimate provided by U.S. Dept of Justice Bureau of Justice Statistics

3 Based on census data for ages 15-24. Data not available for ages 13-14

4 Data provided from Cleveland Department of Public Health, Cleveland Area HIV/AIDS Exposure Report

*Rankings based on % of population served: 1=1-10%; 2=11-25%; 3=26% or greater.

Prevention Priorities

The table below presents the consolidated prevention priorities for Cuyahoga County based on all data service.

We would like you to give us your feedback on the gaps and barriers to prevention services in Cuyahoga County (n=36)

	HIV Case Rank	STD Case Rank	Health Care Providers: Overall Priorities (67 surveys)	Prevention Providers: Overall Priorities (36 surveys)	Prevention Service: Gaps number (# served Cuyahoga County)	Average Priority Score	Priority Rank (Score)
Bisexual Persons	Very High	NR	Very High	Very High	Very High	1.0	1
African American/ Biracial Men (especially Youth, Young Adults)	Very High	Very High	Very High	High	Very High	1.2	2
African American/ Biracial Women (especially Youth, Young Adults)	Very High	Very High	Very High	High	Very High	1.2	2
MSM	Very High	NR	Very High	Very High	High	1.25	3
Youth	High	Very High	High	Very High	Very High	1.4	4
Transgender Persons	NR	NR	Very High	Very High	Moderately High	1.67	5
Latinos	Moderately High	High	Moderately High	Very High	Very High	2.0	6
Drug Users	Moderately High	NR	High	High	Very High	2.0	6
Older Persons	High	NR	Moderately High	High	Very High	2.0	6
Persons Living With HIV/AIDS	Very High	NR	Moderately High	Moderately High	Moderately High	2.5	7

There were 10 categories of persons with highest priorities for HIV and STD prevention. The HIV and STD Case Ranks are taken from the City of Cleveland Department of Public Health case data; categories marked "NR" were not rated within the HIV or STD case data. The health care provider ranking is taken from 67 surveys completed by physicians, nurses, social workers and other health care professionals treating persons living with HIV/AIDS in clinics, private practices and hospitals. The prevention service gap ranking is taken from actual number of individuals who received publicly funded HIV or STD prevention services divided by the estimated population for each in Cuyahoga County. Prevention provider rankings were taken from 36 surveys completed by providers who listed those "not adequately reached" or "not reached at all" under current prevention services. Overall, the data represents a "comprehensive" ranking taking into consideration local HIV and STD case data, the opinions of health care providers, the opinion of prevention providers and service gaps.

Please note these categories are not mutually exclusive. In developing the prioritization process, the Needs Assessment Committee recognized that individuals frequently fall into more than one category (e.g. African American bisexual men, Latino drug users, and MSM youth) and that the combination of risk factors elevates risk level. The committee also noted that although these populations are prioritized, they are all at high risk and in need of HIV/STD prevention programming.

Group Specific DEBIs & Other Best-Evidence Interventions

The Diffusion of Effective Behavioral Interventions (DEBI) project was designed to bring science-based, community, group and individual-level interventions to community-based providers. The goal of the DEBI project is to enhance the capacity of communities to implement effective HIV and STD prevention programs. With funding from the Centers for Disease Control and Prevention, the Center on AIDS and Community Health (COACH) provides information on training on effective interventions.

Based on the results of this HIV and STD community prevention needs assessment, the following DEBIs have been identified as particularly relevant to the needs of the target populations in Cuyahoga County. Prevention providers are urged to consider the adoption of the DEBIs listed below.

Group	Approved DEBIs	Other Best-Evidence Interventions
All Groups	• PROMISE • RESPECT • Safe in the City	• "light" • Project FIO (the Future Is Ours) (8-session) (women) • RESPECT Brief Counseling + Booster
African American/Biracial Men	• d-UP! Defend Yourself! • Many Men, Many Voices • Video Opportunities for Innovative Condom Education & Safer Sex (VOICES)	• Connect • Focus on the Future
African American/Biracial Women	• Real AIDS Prevention Project (RAPP) • Sisters Informing Sisters on Topics about AIDS (SISTA) • Video Opportunities for Innovative Condom Education & Safer Sex (VOICES)	• CHOICES • Communal Effectance-AIDS Prevention • Connect • Project S.A.F.E. (Standard Version) • Sisters Saving Sisters: One-on-one & Group Skills-building
LGBT	• d-UP! Defend Yourself! • Many Men, Many Voices • MPowerment • Popular Opinion Leader (POL)	• Brief Group Counseling • Seropositive Urban Men's Intervention Trial (SUMIT) Enhanced Peer-led

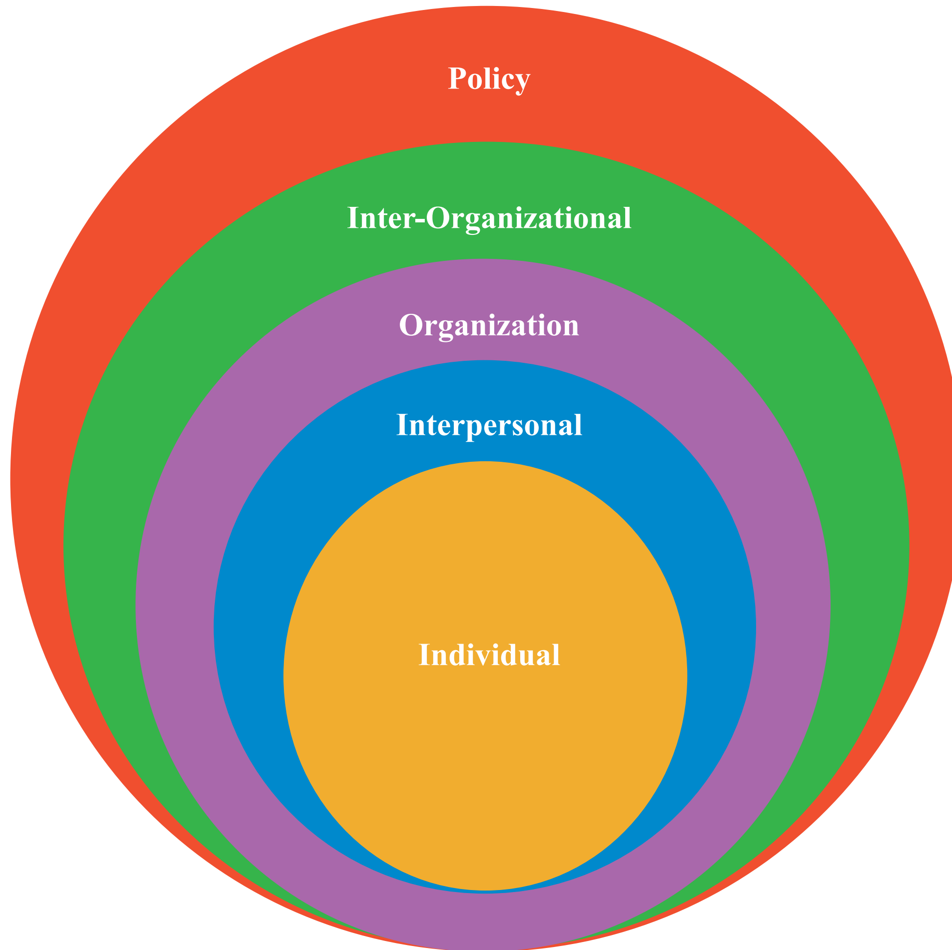
Group	Approved DEBIs	Other Best-Evidence Interventions
Drug Users	• CLEAR: Choosing Life: MPowerment! Action! Results! • Community POWER • Drug Users Intervention Trial (DUIT) • Holistic Health Recovery Program • Psycho-Medical Intervention Model (MIP) • Safety Counts • Study to Reduce Intravenous Exposures (STRIVE)	• Female- & Culturally-Specific Negotiation • Modelo de Intervencion Psicomedica • Self-Help in Eliminating Life-Threatening Diseases (SHIELD) • Study to Reduce Intravenous Exposures (STRIVE) • Women's Co-Op (women)
Latinos	• Real AIDS Prevention Project (RAPP) • Video Opportunities for Innovative Condom Education & Safer Sex (VOICES)	• Connect • Cuidate (Take Care of Yourself) • Project S.A.F.E. (Standard Version) (women) • Women's Health Promotion (WHP) (women)
MSM	• Community POWER • d-UP! Defend Yourself! • Many Men, Many Voices • MPowerment • Popular Opinion Leader (POL)	• Brief Group Counseling • EXPLORE • Personalized Cognitive Risk-Reduction Counseling • Seropositive Urban Men's Intervention Trial (SUMIT) Enhanced Peer-led
Persons Living with HIV/AIDS	• CLEAR: Choosing Life: Empowerment! Action! Results! • Healthy Living Project (HLP) • Healthy Relationships • Holistic Health Recovery Program • Living in the Face of Trauma (LIFT) • Opinions/Opciones Project • Partnership for Health (PfH) • Positive Choice: Interactive Video Doctor • Together Learning Choices (TLC)	• Seropositive Urban Men's Intervention Trial (SUMIT) Enhanced Peer-led • Women Involved in Life Learning from Other Women (WILLOW) (women)
Youth	• Community POWER • CLEAR: Choosing Life: Empowerment! Action! Results! • Focus on Youth with Informed Parents and Children Together • MPowerment • Reasonable, Empowered, Aware, Living Men (REAL Men) • Street Smart • Teen Health Project • Together Learning Choices (TLC)	• Becoming a Responsible Teen (BART) • Be Proud! Be Responsible • Cuidate (Take Care of Yourself) • Focus on Youth (FOY) + ImPACT • Sistering, Informing, Healing, Living, and Empowering • Sisters Saving Sisters (girls)

Descriptions of the specific DEBI interventions can be obtained from http://www.effectiveinterventions.org/. Descriptions of the specific Best Evidence Interventions can be obtained from http://www.cdc.gov/hiv/topics/research/prs/best-evidence-intervention.htm.

Part IV: Strategies and Recommendations

Strategies

Addressing the HIV and STD risk of target populations in Cuyahoga County will require multiple components working at several levels.



Whereas the majority of intervention efforts have been focused on the individual risk level, it will also be important for a comprehensive plan to be developed at other levels. If, for example, a provider conceives of the personal risk behavior of a single individual (e.g. "Terry"), prevention efforts might also focus on Terry's interpersonal network (friends-peers). This interpersonal network comes into contact with an organization on a daily basis (school). The school has the primary goal of education; however, it has accepted the challenge to provide HIV/STD prevention programs. The school as an organization is not alone in the prevention efforts, but must collaborate inter-organizationally in order to both afford and deliver effective prevention (for example, the public health department). These organizations exist in a policy environment that must allocate Federal, State and local funds to an overall prevention effort.

Realistically, this leads to some global concepts regarding how to plan for HIV and STD prevention in Cuyahoga County:

- Effective interventions understand and address individual risk behaviors
- Effective interventions understand the context in which the risk behaviors occur
- Effective interventions involve and grow out of the community
- Effective interventions involve multiple partners and multiple components at multiple levels

Recommendations

HIV/STD prevention recommendations based on data from the community needs assessment and aimed at all five levels of action--individual, interpersonal, organizational, inter-organizational, and policy--are presented below. Specific objectives related to each recommendation, along with identified stakeholders, timelines, and potential activities, provide a foundation for implementing the recommendations.

Individual Level

1. Increase the capacity to deliver individualized interventions that are culturally and developmentally appropriate for targeted high-risk populations.

Objective	Stakeholders	Time-Frame	Examples of Activities
Make funding decisions in response to the identified "Prevention Priorities" (page 53)	CDPH, HIV/STD/ Local Funders	Short term	• Weight priority populations in funding decisions
Align prevention programs with priority populations and agency expertise and capacity	Local prevention agencies	Short term	• Implement programming to address the unmet prevention needs • Secure formal training/technical assistance for appropriate interventions • Cultural competence trainings about prevention priority populations

Needs Assessment Data Supporting Recommendation 1

- 94.4% of HIV prevention providers feel that specific target populations are not being reached at all with current HIV/STD prevention services (p. 24).
- 16.7% of HIV prevention providers report their primary challenge being the provision of prevention services to special populations (p. 28).
- According to the ATLAS program HIV and STD testing is imperative since 25.78% of the sampled Cuyahoga County Corrections Center inmates reported not using a condom during anal sex and 39.95% of the males reported rarely or never using a condom (p.36).
- According to the Cuyahoga County Alcohol and Drug Addictions Services Board CIAI-C assessment, drug users are not using safe sex practices. Of the individuals reporting never being tested for HIV/AIDS, 72.6% report only sometimes or never using a condom. Of the individuals reporting having sex with someone who might have HIV or AIDS, 76.6% report only sometimes or never using a condom (p. 37).
- The Year 1 CDBG evaluation indicated that 48.5% of clients were lower risk-high knowledge (p.38).

2. Increase sustained and reinforced prevention (in practice current efforts largely result in one time outreach).

Objective	Stakeholders	Time-Frame	Examples of Activities
Establish funding levels that support models for sustained client engagement and retention	Local Funders	Short term	• Prioritize funding for multi-session interventions or brief interventions with follow-up • Elongate funding cycles from 1 year to multi-year cycles
Identify and implement effective models of client recruitment and retention	Local Agencies; Community Planning Bodies	Short term	• Assess the effectiveness of client participation incentives • Develop realistic expectations for client recruitment and retention

Needs Assessment Data Supporting Recommendation 2

- 33.3% of HIV prevention providers note that programming logistics issues are a primary concern in providing prevention services. Community recruitment, program retention, data documentation, and willing participants are all significant barriers (p. 28).
- 44.4% of HIV prevention providers recommended expanding access to testing and 38.9% recommended modification to current programming as ways to increase HIV counseling and testing (p. 27).
- According to Ohio Substance Abuse Monitoring (OSAM), current drug users are aware of where to obtain HIV/STD prevention materials and testing (p. 41).
- Based on Year 1 and Year 2 CDBG Evaluation findings, the majority of the evaluation data collected was from one-time community based events that lacked opportunity for any client follow-up (p. 37).

Interpersonal Level

3. Engage peer networks, families and other social networks in prevention efforts.

Objective	Stakeholders	Time-Frame	Examples of Activities
Develop and implement a strategy for online and technology-driven prevention efforts	Local Agencies	Short and Longer Term	• Establish outreach profiles on social networking sites targeting populations such as MSM, Heterosexual, Bisexuals and other target populations • Research promising practices for technology based prevention
Develop and implement a strategy for prevention activities in alternative venues that reach at-risk individuals as well as their family and networks	Local Agencies, Funding Bodies	Short term	• Research local and national promising practices that provide prevention in venues such as barber shops, beauty salons, spas, churches, senior centers, sex clubs/parties

Needs Assessment Data Supporting Recommendation 3

- 71.6% of HIV health care providers report that education is the most critical HIV/STD prevention need within the community. Specifically there is a need for additional community education in prevention efforts (p. 16).
- HIV prevention providers note the need for additional community-based educational programs, with 38.9% stating that modification to current programming is needed to increase HIV counseling and testing (p. 27).
- According to the Community Development Block Grant year 2 data, 32.3% of individuals at moderate- to high-risk of contracting HIV have low prevention knowledge (p. 38).
- Increased youth and family involvement were recommended by the Cleveland Youth RARE Project & Social Marketing Campaign as key avenues toward increasing community level HIV/STD prevention (p. 38).

4. Increase assistance to People Living with HIV/AIDS (PLWHA) for HIV disclosure.

Objective	Stakeholders	Time-Frame	Examples of Activities
Identify and implement effective practices that empower PLWHA for HIV disclosure	People living with HIV/AIDS; HIV Care System; Prevention Providers; Testing Sites	Short and Longer Term	• Facilitate Comprehensive Risk Counseling Service providers participation in CAP/CAB to support referral • Assess existing disclosure content of existing support groups and peer education community activities • Coordinate disclosure activities with stigma reducing activities
Develop and implement standardized guidelines for HIV care and prevention providers for supporting clients with HIV disclosure	People living with HIV/AIDS, DIS,IHIV Care and Prevention Funders and Providers	Longer Term	• Assess current clinical and program practices that support disclosure • Research best practices on disclosure in varied settings • Train care and prevention providers with disclosure best practices

Needs Assessment Data Supporting Recommendation 4

- HIV health care and prevention providers report a need for additional client education around issues of disclosure and partner notification (p. 15, 29).
- 29.9% of HIV health care providers did not report that assist patients with disclosure communication (p. 15).

Organizational Level

5. Foster access to training programs for prevention staff to increase capacity to implement evidence-based effective prevention, which includes the CDC's recognized Evidence Based Interventions (EBIs), harm reduction, and other proven strategies.

Objective	Stakeholders	Time-Frame	Examples of Activities
HIV funders provide adequate levels of funding for staff to have formal accredited training for the interventions their program is providing	HIV/STD Funders	Short Term	• RFP instructions should include training requirements and the budget should reflect training costs
Align prevention programs with agency expertise and capacity	Local prevention agencies	Short term	• Secure formal training/technical assistance for appropriate interventions

Needs Assessment Data Supporting Recommendation 5

- 27.8% of HIV prevention providers surveyed report that their program does not offer any DEBI programs (p. 30).
- 77.7% of HIV prevention providers affirm the importance of evidence-based interventions, indicating the disagree or strongly disagree that there is too much emphasis these days on evidence-based interventions (p. 34).

6. Develop and implement a protocol for HIV and STD prevention in clinical settings where medical providers see clients on an ongoing basis.

Objective	Stakeholders	Time-Frame	Examples of Activities
Identify and implement as needed best practice protocols for integrated HIV/STD prevention with people living with HIV/AIDS	HIV/STD Funders and Clinical Providers; People living with HIV/AIDS	Longer Term	• Assess and determine if current clinical and program practices are in place that support prevention with positives • Research and identify appropriate best practice on prevention with positives for various clinical settings • Provide appropriate training to providers
Identify and implement as needed a best practice protocol for integrated HIV/STD prevention with all patients	HIV/STD Funders; Clinical Providers; Patients; Professional Medical Associations; Medical and Nursing Schools	Longer Term	• Assess and determine if current clinical and program practices that support universal HIV/STD prevention and testing • Research and identify appropriate best practices on HIV/STD prevention and testing in various clinical settings • Provide appropriate training to providers

Needs Assessment Data Supporting Recommendation 6

- 49.3% of HIV health care providers state that the most helpful way to improve HIV/STD prevention efforts in the community is to provide more trainings about the most effective prevention strategies for positive patients in a clinical setting (p. 16).
- 77.6% of HIV health care providers report not following a specific protocol or standardized checklist (p. 16).
- According to the Cleveland Youth RARE Project & Social Marketing Campaign, family doctors are a main venue for teens to obtain information regarding HIV, STDs, and pregnancy (p. 38).
- 46.9% of the respondents in "In Care" survey discovered they were HIV positive due to becoming ill or entering a hospital further supporting the need for HIV and STD prevention protocols in clinical settings (p. 39).

7. Increase organization capacity to effectively develop and submit grant proposals for expansions and continuation funding.

Objective	Stakeholders	Time-Frame	Examples of Activities
Increase knowledge and awareness of free, local and national grant development resources	HIV/STD Funders; Local HIV/STD Agencies; The Foundation Center; National funders	Short Term	• Attend free Foundation Center and other local and state trainings • Agencies will join available HIV/STD funding networks email listings • Agencies will access available technical assistance
Develop mechanisms for funders to provide feedback to applicants regarding their proposals	HIV/STD Funders	Short Term	• Initiate a Letter of Intent component in RFP process as appropriate • Feedback request will be included in Request for Proposals(RFP) process for applicants • Local funders provide site visits/specific technical assistance during the grant development process

Needs Assessment Data Supporting Recommendation 7

- 56.7% of HIV health care providers and 69.4% of HIV prevention providers note the need for additional funding and access to prevention services (p. 16, 28).

Inter-Organizational Level

8. Develop and publish a comprehensive HIV/STD prevention, treatment, and care service directory to increase access to services.

Objective	Stakeholders	Time-Frame	Examples of Activities
Extract directory data from the needs assessment surveys and compile an HIV/STD prevention service directory	CDPH, RAG Needs Assessment Committee	Short Term	• Electronically distribute an service directory
Integrate resources from the Ryan White service area listed in the Statewide HIV prevention resource directory into local resource directory	Columbus AIDS Taskforce (Statewide provider); CDPH, RAG Needs Assessment	Short term	• Reference Statewide resources or contact information in the local directory
Integrate HIV/STD prevention service directory with the Ryan White Part A Community Resource Directory	RAG Needs Assessment Committee, Ryan White A Service and Awareness Committee; Ryan White Part B Consortia	Longer Term	• Regularly update the integrated service directory

Needs Assessment Data Supporting Recommendation 8

- Of the other providers surveyed, 86.7% would be interested in receiving a comprehensive directory of HIV/STD prevention services to whom they can refer their clients (p. 36).

9. Establish mechanisms to improve coordination among agencies engaged in HIV prevention efforts as well as HIV care.

Objective	Stakeholders	Time-Frame	Examples of Activities
Improve relationships and communication between leadership of stakeholder organizations	All Care and Prevention Providers and Funders	Short and Longer Term	• Semi-annual prevention and care providers' executive director meetings
Improve relationships and communication between front-line program staff of stakeholder organizations	All Care and Prevention Providers and Funders	Short and Longer Term	• Semi-annual prevention and care providers' front line meetings
Move towards maximum integration of RAG and Ryan White planning bodies	HIV Prevention and Care Funders and Planning Body Membership	Short and Longer Term	• Ongoing integrated RAG and Planning Council meetings • Assess state and national models of planning council integration • Evaluate the success and challenges of integrated meetings

Needs Assessment Data Supporting Recommendation 9

- 61.1% of HIV prevention providers disagreed with the statement that "the community is small enough that HIV and STD prevention programs all know each other". (p. 34) Community planning opportunities, such as RAG and Ryan White Part A Planning Council, are not drawing in new partner and unfunded agencies as well as effectively raising awareness of the service network that exists.

10. Implement coordinated prevention and service delivery with non-HIV funded social service systems and organizations serving specific target audiences.

Objective	Stakeholders	Time-Frame	Examples of Activities
Open and sustain communication with the larger social service systems to expand the reach of HIV/STD prevention activities to target audiences	Local Prevention Providers and Funders, Family and Children First Council; Homeless Services Advisory Councils; ADAMHS Board; Cuyahoga County MR/DD Board; Family Planning Advisory Council; Healthy Fathering Collaborative; Juvenile Justice System; Probation and Parole Systems; Employment and Family Services; Veterans Administration; Domestic Violence Center; Community Health Center Board	Short and Longer Term	• Active participation at the FCFC • Presentations by named stakeholders at RAG • RAG membership participation at the other systems' planning bodies • Distribution of the prevention service directory to the other systems' provider organizations
Facilitate HIV/STD prevention organizations' awareness of and client referrals to other social services systems	See above Stakeholders	Short and Longer Term	• Distribution of other services directories • Active use of 211/First Call for Help • Train prevention staff on referral procedures for each system
Build partnerships between the larger social service systems and the HIV/STD prevention organizations to expand the reach of HIV/STD prevention activities to target audiences	See above Stakeholders	Longer Term	• Partnership activities will be determined together with partners as relationships develop

Needs Assessment Data Supporting Recommendation 10

- 58.3% of HIV prevention providers disagree or strongly disagree that the communication between prevention programs, health departments, mental health and drug treatment agencies is good (p. 34).
- 100% of the other providers are interested in better collaboration and communication between service delivery systems (p. 36).

Policy Level

11. Standardize credentialing for HIV testing, HIV and STD prevention service providers, HIV educators, and HIV community advocates.

Objective	Stakeholders	Time-Frame	Examples of Activities
Assess the HIV/STD professional knowledge and staff development needs of the prevention providers and volunteer educators/testers	RAG Needs Assessment Committee; CDPH; All Prevention Staff and Funders	Short Term	• Research existing staff knowledge and professional development tools • Develop HIV/STD staff knowledge survey tools
Implement a standardized HIV/STD prevention training program for primary and continuing education	RAG Needs Assessment Committee; CDPH; All Prevention Staff and Funders	Short and Longer Term	• Research integrated HIV/STD prevention training and staff development models • Require staff training as a contractual condition
Coordinate and market HIV/STD speakers' bureau to maximize coverage	HIV/STD Local Agencies; Community Advocates; Community Partners (schools, churches, etc.)	Short Term	• Provide standardized and ongoing training to speakers' bureau participants • Target all services providers with ongoing presentations
Create quality control mechanisms that ensure the accuracy of prevention messaging and programs	RAG Needs Assessment Committee; CDPH; All Prevention Staff and Funders	Short and Longer Term	• Peer to peer presentations and feedback • Site visits and technical assistance • Funder observations

Needs Assessment Data Supporting Recommendation 11

- The HIV prevention providers report the need for standards and/or credentialing for HIV educators. Across the programs surveyed, 40.8% of the full-time employees had not completed post secondary education (p. 20, 35).
- 58.3% of HIV prevention providers 'agree' or 'strongly agree' that some agencies are providing HIV testing and counseling with untrained staff (p. 34).

12. Implement stigma-reduction programs to make HIV and STD testing and care more acceptable to target audiences.

Objective	Stakeholders	Time-Frame	Examples of Activities
Implement a targeted HIV/STD social marketing campaign on a consistent basis	HIV/STD Funders	Short Term	• CDPH prioritize annual funding of social marketing • Coordinate campaigns with online prevention activities • Access national, technical assistance for social marketing materials
Implement a stigma reduction training program for all HIV/STD prevention and care staff	HIV/STD Funders and Local Agencies	Short and Longer Term	• Identify stigma reduction training protocols and tool kits • Identify stigma reduction as a year long theme for community planning groups

Needs Assessment Data Supporting Recommendation 12

- Stigma and stereotypes were the top barriers reported by HIV prevention providers for both HIV (41.7%) and STD (38.9%) prevention (p. 29).
- Providers report that stigma is among the greatest challenges facing clients they serve (p. 25).
- 27.8% of prevention providers agree or strongly agree that there is a great deal of stigma in our community for persons with HIV/AIDS (p. 34).

13. Coordinate and increase streams of prevention funding (and reimbursement) to service gaps (page 51) across target audiences.

Objective	Stakeholders	Time-Frame	Examples of Activities
Maximize the role of the AIDS Funding Collaborative in coordinating prevention funders	AFC funding members	Short Term	• Ensure that funders are aware of the funding decisions of other funding bodies
Create a standardized funding proposal format for use by the major prevention funders	AFC, CDPH, ADAMHS	Short Term	• Research national models for proposal formatting
Facilitate and produce a community response to state and national funding opportunities	CDPH, AFC, Community Agencies	Longer Term	• With community partners, outline priority programs or initiatives that can be developed into full proposals • Develop a system for monitoring state and national RFPs

Needs Assessment Data Supporting Recommendation 13

- 69.4% of HIV prevention providers note the need for additional funding and access to prevention services (p. 28, 30)

14. Improve integration of HIV care and prevention systems, including the relevant community planning processes.

Objective	Stakeholders	Time-Frame	Examples of Activities
Facilitate ongoing communication and coordination of programming between the administrators of systems	Care and Prevention Funders, AFC	Short and Longer Term	• Reciprocated participation in planning activities and funding processes
Move towards maximum integration of RAG and Ryan White planning bodies	HIV Prevention and Care Funders and Planning Body Membership	Short and Longer Term	• Ongoing integrated RAG and Planning Council meetings • Assess state and national models of planning council integration • Evaluate the success and challenges of integrated meetings
Increase community dialogue between prevention and care providers about the intersection of treatment in prevention	People living with HIV/AIDS, Local Funders, Care and Prevention Agencies, and Community Advocates	Short and Longer Term	• Community Presentations about: Test and Treat models of care, Prevention with Positives, Treatment Adherence, Community Viral Loads

Needs Assessment Data Supporting Recommendation 14

- 49.3% HIV health care providers felt more training about the most effective prevention with positives strategies in a clinical setting would be helpful to improving HIV/STD prevention efforts in the community. (p. 16).

15. Support evidence-based, comprehensive K-12th grade sexual health education programming to be included in all local schools' health curriculum. Comprehensive sexuality education includes age-appropriate medically accurate information about a broad range of topics such as relationships, abstinence, contraception, disease prevention, and decision-making.

Objective	Stakeholders	Time-Frame	Examples of Activities
Sustain the existing Cleveland Metropolitan School District K-12 Grade Responsible Sexual Behavior Program (a.k.a. the Cleveland Model)	Collaborative for School Age Health, CMSD, CDPH, Public and Private Funders (Current and Future)	Short and Longer Term	• Ensure full funding for all aspects of the program • Ensure the staff are implementing the curriculum with fidelity • Support the institutionalization of the Model and evaluation activities (including ongoing teacher training, materials distribution, administration support)
Share program and evaluation data from the CMSD K-12 program with other, local communities	Collaborative for School Age Health, CMSD, CDPH, CCBOH, AFC	Short and Longer Term	• Participate in national working groups • Present community briefings
Increase the number and diversity of prevention providers participating in advocacy efforts for comprehensive sexual health education	Collaborative for School Age Health, CMSD, CDPH, Local Agencies, Family and Children First Committee	Longer Term	• Form partnerships with youth-serving systems (FCFC, MyCom, Tapestry, etc)
Engage the Ohio Department of Education to support policy development and creation of curriculum standards	Collaborative for School Age Health, CMSD, CDPH, ODE, ODH, National Partners	Longer Term	• Collaborate with OCPG and ODH to advocate for policy development • Participate in the Collaborative's efforts to draft position papers and standards • Support ODE Wellness Program's process to develop and create standards

Needs Assessment Data Supporting Recommendation 15

- HIV health care providers when asked about HIV/STD prevention needs in the community largely reported the need for education, specifically the need for high school sex education rather than abstinence only (p. 18).
- When asked which target groups are not being reached at all in Cuyahoga County with current HIV or STD prevention services, 27.8% of HIV prevention providers reported the need for services in charter schools, private schools, parochial schools and the outer suburban rings of Cuyahoga County (p. 24).
- According to the Cleveland Teenagers, Sexuality, and Religion Project, Report on HIV/AIDS, 66% of the clergy in the Cleveland area support teenagers being taught both sexuality education and abstinence education (p. 38).

- The Northern Ohio Recovery Association, Inc found that youth in the area either are lacking sexual education training or it is coming too late. Sexual education programs that target children earlier while remaining age appropriate and culturally sensitive are recommended (p. 40).

Areas of Additional Assessment

This needs assessment process, while expansive, had limitations in terms of the scope of what was examined. Further exploration and assessment of some additional areas related to HIV prevention is warranted. Specifically, the Needs Assessment Committee recommends:

- Assessment of the HIV testing services that are provided in the area.
- Assessment of HIV prevention providers' knowledge of, access to, and linkage with the other major social service networks/systems (homeless services, Alcohol and Drug Addiction and Mental Health Services [ADAMHS] Board, veterans services, etc).

Glossary & Acronyms

AIDS: A disease of the immune system characterized by increased susceptibility to opportunistic infections, as pneumocystis carinii pneumonia and candidiasis, to certain cancers, as Kaposi's sarcoma, and to neurological disorders: caused by a retrovirus and transmitted chiefly through blood or blood products that enter the body's bloodstream, esp. by sexual contact or contaminated hypodermic needles.

ATOD: Alcohol, Tobacco and Other Drugs

CDC: Centers for Disease Control and Prevention

Chlamydia: A widespread, often asymptomatic sexually transmitted disease caused by Chlamydia trachomatis, a major cause of nongonococcal urethritis in men and pelvic inflammatory disease and ectopic pregnancy in women.

DIS: Disease intervention specialists

Gonorrhea: A sexually transmitted disease caused by gonococcal bacteria that affects the mucous membrane chiefly of the genital and urinary tracts and is characterized by an acute purulent discharge and painful or difficult urination, though women often have no symptoms.

HIV: Human Immunodeficiency Virus. A retrovirus that causes AIDS by infecting helper T cells of the immune system.

Incidence: The number of new diagnoses occurring over a specified period of time. Incidence rates are the number of new diagnoses in a specific population (e.g. per 100,000) over a specified period of time. Annual incidence rates are routinely reported as the, HIV (non-AIDS) diagnoses per 100,000 population per year, or HIV-with-AIDS (or "doorstep" AIDS) diagnoses per 100,000 population per year. With this definition, the AIDS diagnosis occurred within 12 months of the initial HIV diagnosis.

ODH: Ohio Department of Health

Prevalence: The number of persons living with HIV/AIDS at a point in time. This number may be standardized and reported per 100,000 persons in a population, or per 100 persons as a percent in a population at a single point in time. US Census Bureau is the source for the population count. Standardized prevalence is useful since it allows one to compare the prevalence across different groups or geographic areas.

RAG: The Cuyahoga County HIV Prevention Regional Advisory Group.

STD: Sexually Transmitted Disease. Any of various diseases, including chancroid, Chlamydia, gonorrhea, and syphilis, that are usually contracted through sexual intercourse or other intimate sexual contact.

Syndemic: The concentration of two or more diseases or other health conditions in a population in which there is some level of biological interaction among the diseases and health conditions that magnifies the negative health effects of one or more of the co-present diseases or health conditions.

Syphilis: A chronic infectious disease, caused by a spirochete, Treponema pallidum, usually venereal in origin but often congenital, and affecting almost any organ or tissue in the body, esp. the genitals, skin, mucous membranes, aorta, brain, liver, bones, and nerves.

Appendix

All zip codes serviced by the prevention programs are within the City of Cleveland.

Primary Zip Codes Served (n=36)

	n	**%**
44113	12	33.33%
44115	12	33.33%
44102	11	30.56%
44105	9	25.00%
44108	9	25.00%
44103	8	22.22%
44106	8	22.22%
44109	8	22.22%
44110	7	19.44%
44112	7	19.44%
44114	6	16.67%
44104	5	13.89%
44107	4	11.11%
44118	3	8.33%
44122	3	8.33%
44128	3	8.33%
44117	1	2.78%
44119	1	2.78%
44135	1	2.78%
44144	1	2.78%

Zip Codes (ZCTA) and Statistical Planning Areas of Cleveland and Municipal Boundaries for Cuyahoga County

Cleveland Department of Public Health
01/13/2009 - Biostatistics

44123
44119
44132
North Collinwood
Euclid
44117
44110
South Collinwood
Bratenahl
Euclid-Green
44143
44108
Forest Hills
Glenville
44112
East Cleveland
St. Clair-Superior
44121
South Euclid
44103
Goodrich-Kirtland Park
Hough
44106
University
Cleveland Heights
44114
Downtown
44118
44113
44115
Central
Fairfax
University Heights
Bay Village
Lakewood
44107
Edgewater
Ohio City
44104
Buckeye-Shaker
Woodland Hills
Detroit-Shoreway
44113
Industrial Valley
Cleveland
Rocky River
44102
Kinsman
44127
44116
Cudell
Tremont
North Broadway
44120
Shaker Heights
44122
Westlake
Clark-Fulton
Mt. Pleasant
44111
West Boulevard
Stockyards
Jefferson
Kamms Corners
Brooklyn Centre
Union-Miles
Highland Hills
South Broadway
Newburgh Heights
Fairview Park
Corlett
44105
Linndale
44109
44126
Lee-Miles
44144
Warrensville Heights
Brooklyn
Cuyahoga Heights
Old Brooklyn
44128
North Randall
Puritas-Longmead
North Olmsted
44135
Garfield Heights
Riverside
Brooklyn Heights
44125
Bedford Heights
Maple Heights
44137
Brook Park
44129
Parma
44134
44131
44130
44142
Seven Hills
Independence
Parma Heights
Valley View
CDPH
Cleveland Department of Public Health
44017
Olmsted
Berea
Middleburg Heights
Walton Hills
Walton Hills