HIV/AIDS PREVENTION PRACTICES IN MASSACHUSETTS SHELTERS, 1999

by

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Executive Summary

- The Life Lines HIV/AIDS Prevention Education and Harm Reduction Program for Homeless Men and Women delivers education and prevention services to shelters and day programs serving homeless persons throughout Massachusetts. In 1999, it funded a survey of these shelters and day programs, replicating in part a survey conducted in 1991.
- 126 shelters and day programs completed questionnaires, for a total response rate of 79%. The response rate in 1991 was 76%, while the percent of the shelters in the 1991 survey that were still in operation in 1999 and responded to the later survey was 75%.
- About two-thirds of the shelters provided HIV/AIDS education to guests and half provided HIV/AIDS training to staff.
- About three-quarters of the shelters distributed male condoms to guests, compared to four in ten that distributed female condoms and about one-third that made bleach kits available.
- Prevention activities for guests varied between the shelter types, with family shelters somewhat less involved in HIV/AIDS prevention and education activity. A variety of educational techniques are in use by about half of the shelters: distribution of literature and risk reduction materials, group education, and referrals for counseling and testing.
- Prevention education activities declined by 10-20 percentage points from 1991 to 1999, although the distribution of condoms and bleach kits became more common during this period.
- About one-quarter of the shelters and day programs had used the Life Lines Project for HIV/AIDS prevention education in 1999 and more than half had obtained condoms from Life Lines.
- More than half of the shelters and day programs reported providing at least basic HIV/AIDS education and universal precautions training to staff in the past 6 months. Staff training about HIV/AIDS was much less common among battered women's shelters. About half of the shelters had used non-shelter sources for staff prevention education.
- Almost all shelters had VCRs and rooms for group education, as in 1991, but there had been a decline in the use of HIV/AIDS information bulletins.
- Family shelters were much less likely to have an onsite medical clinic.
- About half of the shelters and day programs referred guests frequently for HIV/AIDS services, a slight increase since 1991; family shelters made such referrals less often.

- Guest reluctance to participate, residential transience, and substance abuse were rated as at least somewhat a hindrance to HIV/AIDS prevention education by almost three quarters of the respondents. Illiteracy and inability to speak English were rated as at least somewhat of a problem by just over half of the respondents.
- Two staff issues—insufficient knowledge about HIV and insufficient time—were rated by six in ten respondents as somewhat hindering prevention education; these had become somewhat more common in 1999, compared to 1991.
- Most respondents were satisfied with the level of support their shelter received for HIV/AIDS prevention from each of six different sources, although satisfaction with the level of support provided by Life Lines had declined since 1991.
- Almost two-thirds of the shelters and day programs were satisfied with their HIV/AIDS prevention education, but this was the lowest level of satisfaction among 13 other activities such as job training, providing food and beds, and ability to help with alcohol or drug problems.
- From 1991 to 1999, survey respondents' satisfaction with shelter HIV/AIDS prevention education activities declined by just over seven percentage points.

Lessons Learned

- Shelter providers, drop-in centers, food pantries and other homeless service providers work very hard with minimal resources to serve poor and marginalized communities.

- Shelter-based HIV prevention messages and risk reduction supplies are critical opportunities to reach a population that may otherwise not hear or receive HIV education and supplies. Homeless men and women are at increased risk for HIV due to survival behaviors associated with poverty, poor health, and nutrition, substance abuse, mental illness and exchanging sex for drugs, shelter, money or food. Because of this, shelters play a unique role in the HIV epidemic.

- In spite of the good work that providers deliver, many gaps remain in shelter-based HIV prevention services.

- Shelters should continue their good work in collaboration with outreach educators and providers in their community. *Over 70% of shelter-based services were provided by outreach workers in the community…working together works!*

- Without a cure or vaccine in sight, and without statewide access to needles exchange, free and anonymous condom and bleach kit availability is the cornerstone to HIV prevention efforts.

30% of homeless providers reported NOT making condoms available. They cited policy and philosophical restrictions for not doing so.

Almost 70% of all providers reported that they DO NOT make bleach kits available. They cited policy and philosophical restrictions for not doing so.

The epidemic in Massachusetts is being driven by high rates of injection drug use and unprotected sex. Shelters that face policy and philosophical barriers to making free and anonymous availability of condoms and bleach kits must re-evaluate these barriers. As providers, we play a key gate keeper role in the distribution process which must be addressed.

- Access to accurate information and training about HIV is paramount yet gaps remain. *About two-thirds of the shelters provided HIV/AIDS education to guests and half provided HIV/AIDS training to staff.* Anecdotal evidence suggests, in fact, that many shelters that reported having provided these services did so only infrequently or just once. Unless there is a commitment to provide regularly scheduled education groups, 'one-shot' sessions have minimal impact. Employers must also allow staff the time and resources to attend training.

Table of Contents

This report describes the results of a survey of HIV/AIDS prevention practices in Massachusetts shelters in 1999. The primary goal of the report is to describe the frequency of use of particular prevention practices and to identify the barriers to effective prevention efforts in the shelters. A secondary goal is to specify differences in prevention practices and experiences between shelters for single adults, shelters for families, battered women's shelters and day programs. In addition, the analysis reveals the extent of change in shelter-based prevention practices since 1991, when the Life Lines Project conducted a similar survey.

LIFE LINES is a statewide HIV/AIDS prevention education and harm reduction program for homeless men and women. It is a program of the Massachusetts Department of Public Health AIDS bureau. The program is committed to supporting individuals who are homeless and the providers who serve them to prevent HIV transmission; its team of outreach coordinators serves over 200 homeless service providers throughout Massachusetts. The program distributes risk reduction materials (condoms, bleach kits, literature), conducts education groups for shelter residents and training for shelter staff. LIFE LINES also builds regional capacity and coalitions by linking shelters with outreach prevention programs in their community, conducting needs assessments and raising overall HIV prevention awareness.

The program conducted a short statewide phone survey of programs in 1989, its first year of operation. This survey was followed by a lengthy mailed questionnaire survey in 1991. Services subsequently declined for some years due to programmatic and contractual changes. Life Lines' statewide services were reinitiated in 1998.

METHODOLOGY

Questionnaires were mailed to 208 organizations that were believed to be shelters or day programs serving homeless single adults and/or families. Three of these organizations were determined later to no longer be in existence and sixteen were determined to not be a shelter.

After several follow-up mailings and phone calls, 126 completed questionnaires were received, resulting in a response rate of 79 percent.

Life Lines also surveyed Massachusetts' shelters and day programs for homeless persons in 1989 and 1991. In 1989, 121 shelters and day programs were identified and 88 percent (106) responded to a brief phone interview. In 1991, 161 shelters and day programs were identified and 76 percent (123) responded to a lengthy mailed questionnaire. Of those shelters responding in 1989, 58 percent (62) were still in operation and responded to the 1991 survey. Of the total of 123 shelters responding in 1991, 69 were still in operation and 52 (75%) responded to the 1999 survey. We classified the shelters into (1) single, (2) family, (3) battered women's shelters and (4) day programs based on the information received regarding the shelter guests and program contacts by Life Lines staff.

The "Life Lines Shelter HIV/AIDS Prevention Education Survey" asked detailed questions about HIV/AIDS prevention activity at the shelters, satisfaction with this prevention activity, characteristics of the shelter and its guests, services offered at the shelter, governance and staff at the shelter, and the characteristics of the HIV/AIDS coordinator at the shelter.

Some questions replicated those appearing in the 1991 Life Lines survey, permitting identification of changes over the decade of the 1990s. Two types of comparison are made to identify those changes: (1) The 52 shelters responding to both the 1991 and 1999 surveys form a panel that can show whether shelters changed their prevention practices. (2) The total samples in both 1991 and 1992 represent the best estimates we have of prevention practices in the entire population of Massachusetts shelters in both years. Comparisons between the total samples in both years allow us to judge whether practices changed for the population of shelters as a whole. These data thus indicate the extent to which a change in prevention practices in the shelters, reflected variation within shelters or a change in the mix of shelters.

HIV/AIDS PREVENTION AND OTHER SERVICE ACTIVITIES

General Prevention Activities for Guests

Most shelters were involved in HIV/AIDS education and prevention activities (table 1). Sixty eight percent had provided some HIV/AIDS education to guests (16% had provided only part of the education they sought to) and 49% had provided HIV/AIDS education to their staff (9% only partially). 78% of the shelters distributed male condoms, 42% distributed female condoms, and only 30% made bleach kits available (for disinfecting needles and injection equipment). About 27% of shelters had had special educational programs arranged with community groups by the Life Lines project.

Table 1
HIV/AIDS Related Educational Activities

	% of Shelters
Prevention education provided to guests	66.4%(122)
Prevention education provided to staff	49.2%(121)
Male condoms distributed at shelter	78.0%(123)
Female condoms distributed at shelter	41.7%(120)
Local AIDS education arrg'd by Life Lines	27.3% (88)
Bleach kits available at shelter	30.6%(121)

Three-quarters of day programs and battered women shelters compared to about 60% of family and single shelters had provided prevention education to guests (table 2). Single shelters were more likely to have provided prevention education to staff (64%), while family shelters were least likely to have done so (32%). Day programs were more likely to distribute male condoms to guests (90%) than were the shelters (70-74%), while family shelters were less likely to distribute bleach kits than single and battered women shelters, and day programs. Similar proportions of the four types of shelters provided female condoms (about 34-48%) and Life Lines services (about 70%).

Table 2

HIV/AIDS Prevention activities by shelter type

	Shelter Type			
	Single Shelter	**Day Program**	**Family Shelter**	**Battered Women Shelter**
Prevention education-guests	64.9%	75.9%	58.3%	75.0%
Prevention education-staff	63.9%	50.0%	32.3%	47.1%
Education provided by Life Lines	72.0%	73.9%	75.0%	69.2%
Male condoms	73.0%	90.0%	74.3%	70.6%
Female condoms	42.9%	48.3%	34.3%	47.1%
Bleach kits	38.9%	33.3%	19.4%	31.3%
N	25-37	23-30	24-36	13-17

Most of the shelters that had provided HIV/AIDS prevention education to their guests had used a variety of educational techniques: about half reported having distributed literature, sponsored group discussions, distributed harm reduction materials, and made referrals for HIV testing (table 3). Just 29% had shown videos about HIV/AIDS to their guests.

Comparison of shelter prevention education practices in 1999 to those reported in the 1991 survey reveals a decrease in prevention and changes in methods of prevention education (table 3). In 1991, almost nine in ten of the shelters reported that "HIV prevention education [had] been provided to GUESTS at the shelter during the past 6 months." By 1999, fewer than 70% of shelters reported that they provided HIV/AIDS prevention education to guests. Both for the population of shelters and for the 52 shelters in the panel, the percentage of shelters providing prevention education declined by between 20 and 30 percentage points. Among those shelters that reported delivering any prevention education to guests, videos, group discussions and HIV/AIDS literature had become less popular, declining by about 10-20 percentage points from 1991 to 1999 (although there was no decline for shelters in the panel in terms of group education or distribution of HIV/AIDS literature). However, the distribution of condoms became more widespread between 1991 and 1999 and more shelters distributed bleach kits in 1999 than in 1991 (although within the panel of shelters the likelihood of distributing bleach kits had not changed).

Table 3
Prevention Education in 1991 and 1999

	1991 Total sample	**1999 Total sample**	**1999: Match with 1991**	**1991: Match with 1999**
Prevention education-guests	89% (62)	68.5%(124)	59.6% (52)	90.4%(52)
Prevention education-staff	71% (121)	50.4%(121)	52 %(50)	74.5%(51)
Videos on HIV/AIDS*	56% (64)	29.4%(85)	38.7%(31)	56 %(25)
Group education/ discussion*	92% (87)	75.9%(87)	90.3%(31)	91.9%(37)
HIV/AIDS Literature*	100% (87)	81.6%(87)	77.4%(31)	100%(27)
Condoms distributed	62% (120)	78 %(123)	78.4%(51)	66 %(50)
Bleach kits available	16% (121)	30.6%(121)	22 %(50)	17.6%(51)

*Percentages based only on those shelters providing any education services.

The four types of shelter were similar in the likelihood of having used most HIV/AIDS prevention and education tools (table 4). However, distribution of educational literature and harm reduction materials, as well as HIV/AIDS videos and referrals about HIV/AIDS were a bit more common in day programs than in the other shelter types. Family shelters were somewhat less likely to distribute harm reduction materials, make HIV referrals, run HIV support groups, or maintain HIV bulletin boards than the other shelter types.

Table 4

HIV/AIDS Prevention Education Provided to guests on site by shelter type

	Shelter Type			
	Single Shelter	**Day Program**	**Family Shelter**	**Battered Women Shelter**
Group education	48.6%	50.0%	55.6%	64.7%
HIV ed. literature	54.1%	63.3%	55.6%	58.8%
Videos on HIV	18.9%	23.3%	22.2%	17.6%
Harm reduct'n matl	54.1%	63.3%	44.4%	47.1%
Referrals to HIV	54.1%	60.0%	41.7%	47.1%
HIV support group	27.0%	23.3%	8.3%	17.6%
HIV posters	5.4%	10.0%	13.9%	5.9%
HIV counseling	43.2%	40.0%	36.1%	35.3%
HIV bulletin boards	21.6%	20.0%	11.1%	17.6%
N	37	30	36	17

Specific Prevention Sources and Barriers with Guests

A variety of sources were used to provide prevention education to guests, but shelter staff were the most common source—more than half of the shelters that had provided prevention education to their guests had used shelter staff to do so (table 5). Health Care for the Homeless and community-based outreach groups were used by about one third of the shelters. The Life Lines Project and "other" sources had each been used

for HIV/AIDS prevention education to guests by about one-quarter of the shelters. Other possible sources of prevention education--local hospitals, American Red Cross and the AIDS Action Committee were used less often.

Table 5

Who provides education for guests*

	Pct. of Cases
Shelter staff	58.6%
Health care for homeless	31
Community based outreach	36.8
Local hospital	13.8
Life Lines	27.6
American Red Cross	6.9
AIDS Action Committee	13.8
Other	25.3

N=87

*% of shelters providing HIV/AIDS guest education.

Additional information was requested from the respondents about their experiences with distributing condoms and bleach kits. Those respondents who reported that their shelter did not distribute condoms were asked why this was the case. About six in ten reported that their shelter has no barriers to condom distribution (table 6). In about seven percent of the cases, policy restrictions and/or program philosophy were reported as a barrier to condom distribution. An equal proportion (5%) mentioned discomfort of either staff or volunteers as a reason for not distributing condoms. About one-quarter of the cases said that they lacked a supply of condoms to distribute.

Table 6

Barriers to distribution of condoms

	Pct. of cases
Policy restrictions	7.2%
Against program philosophy	6.3
Discomfort of staff	5.4
Discomfort of visitors	5.4
Inadequate supply	23.4
No barriers	67.6

N=111

About four in ten shelters distributed condoms through shelter staff, while almost 70% left condoms in open containers for guests to pick up themselves—the procedure recommended by the Life Lines Project to make condoms more easily accessible and available on an anonymous basis (table 7). Staff from other agencies distributed condoms in 15% of the shelters.

Table 7
How condoms distributed

	Pct. of cases
By shelter staff	41.3%
By outside staff	14.3
Left in open container	68.1
No condoms distributed	20.2

N=119

The Life Lines Project was by far the most common source of condoms distributed by the shelters—about six in ten shelters used condoms from Life Lines. Just over one-quarter of the shelters used condoms distributed by Mass Department of Public Health, and about one quarter of shelters used condoms distributed from community based outreach programs; smaller proportions of the shelters paid for their condoms from their own budget or relied on Health Care for the Homeless, the Visiting Nurse Association, or donations for condoms.

Table 8
Source of condoms

	Pct. of cases
Shelter budget	4.4%
Life Lines	57.0
Health care	15.8
Community-based outreach program	22.8
Visiting nurse	4.4
Donations	15.8
Mass Dept of Public Health	28.1
No condoms distributed	14
	N=114

Policy restrictions and/or program philosophy were the major barriers to distribution of bleach kits in shelters. Among shelters that distributed condoms, five in every ten respondents in particular cited policy restrictions as a reason for not distributing bleach kits. One quarter of shelters mentioned lack of bleach vial supply, while only one in ten cited the discomfort of staff, visitors or volunteers.

Table 9

Reasons bleach not available*

	Pct. of cases
Policy restrictions	51.6%
Against program philosophy	43.8
Discomfort of staff	7.8
Discomfort of visitors	4.7
Inadequate supply	25
	N=64

*% of shelters not providing bleach.

Half of shelters that reported distribution of bleach kits used shelter staff to do so. About three in ten shelters mentioned distribution of bleach kits by staff from other agencies; while 45 percent reported leaving the kits in open containers—the procedure that makes kits most accessible.

General Prevention Activities for Staff

About 40% of the shelters reported providing basic HIV/AIDS education, universal precautions training and occupational risk training to staff during the past six months (table 10). About one-quarter to one-third of the shelters provided staff training in confidentiality policy, shelter HIV/AIDS policies, and new treatments. Training in other areas was much less common.

Table 10
HIV/AIDS Prevention Education provided to staff in last 6 months

	% Shelters
Basic HIV/AIDS education	45.2%
New treatment	27.8%
Legal issues	11.9%
HIV/AIDS meds storage	11.1%
HIV/AIDS treatment adherence	13.5%
Rights of clients	17.5%
Shelter HIV/AIDS policy	24.6%
Shelter confidentiality policy	34.1%
Occupational risk	38.1%
Universal precautions	42.9%
N of cases	*126*

The family and battered women's shelters were less likely to have provided most types of prevention education to staff (table 11). Shelters for singles were most likely to have provided basic HIV/AIDS education to staff (60%), training about confidentiality 46%), occupational risks (51%) and universal precautions (57%) in the last six months, while family and battered women's shelters tended to have been least likely to have done so. Only a few family and battered women's shelters had provided any staff training about HIV medication storage, treatment adherence, and clients' rights issues.

Table 11
HIV/AIDS Prevention Education Provided to Staff by Shelter Type

	Shelter Type			
	Single Shelter	**Day Program**	**Family Shelter**	**Battered Women**
Basic HIV education	59.5%	46.7%	36.1%	29.4%
New treatments	37.8%	33.3%	19.4%	11.8%
Legal issues	16.2%	10.0%	11.1%	5.9%
HIV medication storage	16.2%	16.7%	2.8%	5.9%
HIV treatment adherence	21.6%	16.7%	5.6%	5.9%
Rights of clients	24.3%	23.3%	8.3%	5.9%
Shelter HIV policy	32.4%	20.0%	19.4%	29.4%
Shelter confid'lity policy	45.9%	30.0%	30.6%	23.5%
Occupational risk of HIV	51.4%	36.7%	27.8%	35.3%
Universal precautions	56.8%	43.3%	30.6%	41.2%
N	37	30	36	17

Prevention Sources for Staff

Staff, community based outreach workers, "other sources" and Health Care for the Homeless were the most common sources of prevention education for other staff--about five in every ten shelters had used staff for this purpose and half of the one-third had used community outreach workers (table 12). About two in ten shelters had used Health Care for the Homeless and "other sources." In total, about half of the shelters had used external sources for staff prevention education.

Table 12

Who provides education for staff*

	Pct. of cases
Shelter staff	51.7%
Health care for homeless	21.7
Community based outreach	35
Local hospital	15
Life Lines	8.3
American Red Cross	6.7
AIDS Action Committee	6.7
Other	23.3

N=60

*% of shelters that have provided any staff education.

Educational Supplies

Most shelters had some supplies useful for HIV/AIDS education. Almost nine in ten had access to a VCR, and space for group education, and five in ten had access to a Web site (table 13). There had been no changes in VCR access or space of group education from 1991 to 1999, but the use of HIV/AIDS information bulletins had decreased within the shelter population by almost 20 percentage points.

Table 13

HIV/AIDS educational supply in 1991 and 1999

	% of shelters in 1999	**% of shelters in 1991**	**1999 Pct of cases that match the 1991 survey**	**1991 Pct of cases that match the 1999 survey**
VCR	89 %(118)	88% (122)	91.8%(49)	90.2%(51)
Room for group education	91.5%(118)	92.2%(77)	89.8%(49)	94.3%(35)
HIV/AIDS info bulletin	39 %(118)	56% (107)	38.8%(49)	*

*****data not available

Medical services for HIV/AIDS may be provided either on or off site, and by either in house or visiting staff. There was no clear favorite among these options (see table 14).

Table 14

Medical clinic and staff

	Designated on site medical clinic	**No designated on site medical clinic**
With visiting medical staff	24.6%(118)	27.1%(118)
With in house medical staff	16.9%(118)	19.5%(118)

A comparable question about shelter access to a VCR was asked in the surveys in 1991. Responses indicate a slight increase in access to a VCR among shelters responding to both surveys, from 84 to 89 %.

About 90% of each type of shelter had access to a VCR for educational purposes (table 15). Web access was more common in single and battered women's shelters than in day program or family shelters. However, day programs and battered women shelters were more likely to have space for group education than the other two types of shelter.

Table 15

HIV/AIDS Educational supplies by shelter type

	Shelter Type			
	Single Shelter	**Day Program**	**Family Shelter**	**Battered Women Shelter**
VCR	85.7%	85.7%	88.9%	100.0%
WEB	65.7%	42.9%	38.9%	56.3%
Room for group education	91.4%	100.0%	80.6%	100.0%
HIV/AIDS info bulletin	62.9%	50.0%	75.0%	37.5%
N	35	28	36	16

Single shelters were more likely to have a designated on-site medical clinic with in-house medical staff(26%) than were battered women (19%) or family shelters (11%) (table 16).

Table 16

Medical clinic and staff by shelter type

	Shelter Type			
	Single Shelter	**Day program**	**Family Shelter**	**Battered Women Shelter**
Designated on site medical clinic with in house medical staff	25.7%	14.3%	11.1%	18.8%
Designated on site medical clinic w with visiting medical staff	25.7%	32.1%	19.4%	18.8%
No designated on site medical clinic with in house medical staff	11.4%	17.9%	33.3%	12.5%
No designated on site medical clinic with visiting medical staff	20.0%	25.0%	36.1%	25.0%

Referral Practices for HIV-Related and Other Services

Shelters referred their guests to a variety of other agencies for needed services. Almost eight in ten shelters reported referring their guests frequently to housing agencies in the past month. Almost seven in ten shelters had referred their guests frequently for

financial benefits and about half frequently referred guests for job training. Referrals were common for needs such as, substance abuse, mental health, family support services, and education; about half of the shelters referred guests frequently for these problems. Referrals to other agencies were least frequent for HIV testing and counseling, HIV support services, and treatment of other sexually transmitted diseases (STDs). About half of the shelters reported no referrals for these needs within the past month. About one-sixth of the shelters referred guests frequently for these problems and another one third made at least a few referrals for these needs.

Table 17

Referrals to other agencies

	No referral	**A few referral**	**Freq. referral**	**N**
STDs	59.6%	32.5	7.9	114
HIV testing	47.8%	33.9	18.3	115
Other HIV supporting services	45 %	42.3	12.6	111
HIV med treatment	51.8%	31.3	17	112
Substance abuse treatment	17.9%	28.6	53.6	112
Mental health treatment	7 %	34.2	58.8	114
Medical treatment	4.5%	37.8	57.7	111
Family support services	21.2%	44.2	34.5	113
Housing search	8.8%	13.2	78.1	114
Job training	17 %	35.7	47.3	112
Job training related to welfare to work	27.1%	30.8	42.1	107
Benefits	2.7%	29.5	67.9	112
Education	17.1%	44.1	38.7	111

The longitudinal comparison provided little indication of change in referral practices during the 1990s (table 18).

Table 18

Referrals to other agencies in 1991 and 1999

	Any referral 1991	**Any referral 1999**	**Any referral 1999 for shelters that match 1991**	**Any referral 1991 for shelters that match 1999**
STDs	36%	40.4	40.4	27.1
HIV testing	43%	52.2	43.7	
Other HIV supporting services	37%	55	45.7	41.7
HIV med treatment		48.2	37	
Substance abuse treatment	86%	82.1	80.4	85.4
Mental health treatment	81%	93	95.7	87.2
Medical treatment	90%	95.5	93.3	89.4
Family support services	81%	78.8	83	82.2
Housing search	95%	91.2	93.6	95.8
Job training	82%	83	89.1	83.3
Job training related to welfare to work		72.9	88.6	
Benefits	93%	97.3	70.2	93.7
education	90%	82.9	87.2	91.7

The frequency of referrals for both HIV/AIDS services and other STD treatment decreased with the proportion of families among the shelter's guests: shelters used only by single adults referred guests most often for HIV/AIDS and other STD services, while family shelters did so much less often.

There were other, less marked, differences in referral practices between the shelters. Shelters for singles were less likely to refer guests for family support services and education and welfare-to-work job training than family shelters, but more likely to refer guests for substance abuse services, mental treatment and mental health treatment. The four types of shelter were similar in the frequency of referring guests for financial benefits, housing, and mental and physical health services.

Table 19
Some(frequent and few) referrals to other agencies by shelter type

	Shelter Type			
	Single Shelter	**Day Program**	**Family Shelter**	**Battered Women Shelter**
STDs	44.1%	37%	26.5%	68.7%
HIV testing	70.6	53.6	29.4	56.2
Other HIV supporting services	75.8	53.8	38.2	50
HIV med treatment	73.5	57.7	23.5	31.2
Substance abuse treatment	97	76.9	71.4	81.2
Mental health treatment	100	88.5	91.4	87.5
Medical treatment	100	96.2	97.1	87.5
Family support services	57.6	80.8	94.3	87.5
Housing search	97.1	88.5	91.4	87.5
Job training	88.2	88	88.2	50
Job training related to welfare to work	72.4	60	85.3	62.5
Benefits	100	91.7	100	93.7
education	77.4	73.1	97.1	75
N	31	26	35	16

EVALUATION OF PREVENTION AND OTHER SERVICE ACTIVITIES

Barriers to Prevention Education

Respondents were asked to rate the extent to which several characteristics of guests and of services hindered HIV/AIDS prevention education efforts. None of the guest characteristics were viewed as hindering prevention education "very much" or "extremely" by more than one in five staff respondents (see table 20). However, at least half of the respondents rated many characteristics as at least somewhat a hindrance to prevention education.

Respondents rated several guest characteristics as important hindrances to HIV/AIDS prevention education. Guest reluctance to participate, and residential transience were the most commonly identified hindrance to HIV/AIDS prevention education; they were rated as at least somewhat a hindrance by almost three quarters of the respondents. About three quarters rated substance abuse as a hindrance to prevention education. Illiteracy and inability to speak English were rated as at least somewhat of a problem by just over half of the respondents.

Table 20

Guest Characteristics that Hinder AIDS Prevention education

Hinder Prevention Education…

Guest characteristics	**Not at all**	**Somewhat**	**Very Much**	**Extremely**	**Total**
Guest illiteracy	45 %	48.6%	5.4%	.9%	100%(103)
Non speaking English guests	36.9	50.5	10.8	1.8	100%(103)
Guests reluctance to participate	27.8	53.7	15.7	2.8	100%(100)
Guests residential transience	27.7	43.6	23.8	5	100%(94)
Mental illness	34.9	45	16.5	3.7	100%(101)
Substance abuse	37	38.9	16.7	7.4	100%(100)

The prevalence of several guest characteristics that hindered HIV/AIDS prevention education had changed from 1991 to 1999 (table 21). Illiteracy among guests seemed to have declined by 5-10 percentage points as a hindrance to prevention education during this period. Mental illness and substance abuse had become somewhat more common as hindrances to prevention education.

Table 21

Guest characteristics that hinder AIDS Prevention education in 1991 and 1999

Guest characteristics	**% of shelters 1999**	**% of shelters 1991**	**1999 % Shelters that match 1991 survey**	**1991 % Shelters that match 1999 survey**
Guest illiteracy	55 %	61	46.8	63.8
Non speaking English guests	63.1%	55	59.6	65.2
Guests reluctance to participate	72.2%	62	71.7	69.6
Guests residential transience	72.3%	55	69	63.8
Mental illness	65.1%	39	65.2	46.7
Substance abuse	63 %	49	60.9	56.5

All of the guest characteristics, except for ability to speak English were less likely be judged as hindering HIV/AIDS prevention education in shelters with families and battered women shelters (table 22).

Table 22
Guest characteristics that hinder HIV/AIDS Prevention education by shelter type

	Shelter Type			
Guest characteristics	**Single Shelter**	**Day Program**	**Family Shelter**	**Battered Women Shelter**
Guest illiteracy	53.3%	69%	51.5%	37.5%
Non speaking English guests	65.5	65.5	70.6	37.5
Guests reluctance to participate	80.6	70.4	75	46.7
Guests residential transience	80	76	58.6	73.3
Mental illness	76.7	71.4	53.1	56.3
Substance abuse	41.4	78.6	46.9	43.7
N	29-31	25-28	29-34	15/16

Two staff issues—insufficient knowledge about HIV and insufficient time—were rated by six in ten respondents as somewhat hindering prevention education (table 23). Between one-quarter and one-third rated insufficient staff interest, inadequate space, and staff fear of HIV as hindering prevention education at least somewhat. Inadequate staffing levels and inadequate resources were viewed as hindering AIDS prevention education at least somewhat by about half the respondents. Policy restrictions were rated as at least somewhat a problem by just over one in ten respondents.

Table 23
Service characteristics that hinder AIDS prevention education

	Hinder Prevention Education…				
Staff & services	**Not at all**	**Somewhat**	**Very Much**	**Extremely**	**Total**
Insuff. HIV knowl	41.9%	40%	14.3%	3.8%	100%(105)
Insufficient time	34.9	39.4	17.4	8.3	100%(109)
Insuff. interest	70.1	26.2	3.7	0	100%(107)
Staff fear of HIV	75.7	22.4	3.7	0	100%(107)
Policy restriction	86.9	10.3	2.8	0	100%(107)
Inadeq. resources	51.4	34.9	11.9	1.8	100%(109)
Inadeq. space	67.3	22.7	8.2	1.8	100%(110)
Insuffic. staff	55	25.7	14.7	4.6	100%(109)

Insufficient staff knowledge and time had become somewhat more common hindrances to prevention education from 1991 to 1999 (table 24). There had been no change in the other service characteristics named.

Table 24

Service characteristics that hinder AIDS prevention education in 1991 and 1999

Guest characteristics	**% of shelters 1999**	**% of shelters 1991**	**1999 % Shelters that match 1991 survey**	**1991 % Shelters that match 1999 survey**
Insufficient staff knowledge about HIV	58.1%	50	63.6	45.8
Insufficient staff time	65.1%	56	65.2	51.1
Insufficient staff interest	29.9%	27	28.3	32.6
Staff fear of HIV	24.3%	32	25	27.7
Policy restriction	13.1%	13	17.8	12.5
Inadequate resources	48.6%	53	47.8	53.1
Inadequate shelter space	32.7%	36	38.7	38.3
Inadequate staff	45 %		43.5	

Although respondents believed that characteristics of shelter staff and shelter facilities hindered HIV/AIDS prevention education, these beliefs did not vary much by shelter type (table 25). Respondents in battered women shelters were less likely to cite inadequate resources as hindering HIV/AIDS prevention.

Table 25

Staff characteristics that hinder HIV/AIDS prevention education by shelter type

	Shelter Type			
Staff characteristics	**Single Shelter**	**Day Program**	**Family Shelter**	**Battered Women**

				Shelter
Insufficient staff knowledge about HIV	53.6%	60%	58.1%	62.5%
Insufficient staff time	65.5	62.1	65.6	68.7
Insufficient staff interest	23.3	33.3	31.3	40
Staff fear of HIV	31	17.9	**96.9**	20
Policy restriction	19.4	14.3	12.9	100
Inadequate resources	45.2	66.7	46.9	31.3
Inadequate shelter space	35.5	32.1	40.6	18.8
Inadequate staff	32.3	50	43.7	66.7
N	31	28	31/32	15

Satisfaction with Prevention and Other Services

Most respondents were satisfied with the level of support their shelter received for HIV/AIDS prevention from each of six different sources. Support received from Life Lines, the shelter, and community organizations or health service providers for HIV/AIDS prevention activities elicited a rating of very or somewhat satisfied from more than three-quarters of the respondents. Seven in ten respondents were very or somewhat satisfied with shelter staff members' attitudes and efforts for HIV/AIDS, and with the support received from local and state agencies. Respondents were less satisfied, overall, with the shelter guests' responsiveness to HIV/AIDS prevention activities.

Table 26

Satisfaction with Support Provided to Shelter HIV/AIDS Prevention Efforts

Level of Satisfaction

	Very sat.	**Somewhat sat.**	**Neither sat/dis**	**Somewhat dissat**	**Very dissat.**	**Total**
By staff	33.6%	38.3%	14%	13.1%	.9%	100%(107)
By shelter	52.6	27.8	15.5	4.1	0	100%(97)
Life Lines	53.3	23.3	21.1	2.2	0	100%(90)
Local/state agencies	37.8	27.9	23.4	5.4	5.4	100%(111)
Guest responsiveness	16.7	39.8	24.1	16.7	2.8	100%(108)
Community & health care provider	38.7	41.4	12.6	5.4	1.8	100%(111)

Survey respondents reported a decline in satisfaction with the level of support staff provide to prevention education efforts and with the level of support provided by Life Lines from 1991 and 1999 (table 27). About two-thirds of the respondents believed that additional help from Life Lines with HIV/AIDS prevention activities would be very useful (table not shown).

Table 27

Satisfaction with Support Provided to HIV/AIDS Prevention Efforts, 1991 & 1999

	% of shelters 1999	**% of shelters 1991**	**1999 % Shelters that match 1991 survey**	**1991 % Shelters that match 1999 survey**
By staff	71.9%	77	59.6	82.7
By shelter	80.4%	64	74.4	76.6
Life Lines	76.6%	59	82	61.2
Local/state agencies	65.7%	56	60.9	56
Guest responsiveness	56.5%	58	52.2	64.6
Community organizations/health care providers	80.1%		81.4	

Satisfaction with the support given to the shelter for HIV/AIDS prevention efforts tended to be high in each type of shelter and for each source of support (table 28). Respondents in day programs were most satisfied with support given by the shelter to HIV/AIDS prevention and least satisfied with guest responsiveness. Singles shelters were more satisfied with the support given to the shelter by staff, government agencies, and community organizations, while family shelters were more satisfied with the support received from Life Lines.

Table 28

At Least "Some" Satisfaction with Support to Shelter for HIV/AIDS Prevention

Shelter Type

	Single Shelter	**Day Program**	**Family Shelter**	**Battered Women Shelter**
By staff	85.3	80	60.3	53.3
By shelter	80	92	72.4	72.8
Life Lines	80	77.7	80.7	57.1
By local/State gov	77.1	65.4	60.6	53.3
Guest responsiveness	57.6	51.8	59.4	50
Comm org/hlth care providers	94.1	76.9	73.5	68.8
N	30-35	18-26	26-34	14-16

Levels of satisfaction with the shelter's ability to help guests varied between different guest problems (table 29). Satisfaction was very high with the shelter's ability to provide food and beds and help with benefits more than 95% were very or somewhat satisfied. Satisfaction was somewhat lower with the shelter's ability to help with crisis intervention, housing search, and family problems. Satisfaction was lowest with HIV/AIDS prevention education, only 62% were very or somewhat satisfied.

Table 29
Satisfaction with Shelters Ability to Help ...
Level of Satisfaction

	Very sat.	**Some sat.**	**Neither sat./dissat**	**Somewhat dissatisfied**	**Very dissat.**	**N**
Job training	28%	48%	18%	6%	1%	107
Providing food, beds	82	16	1	1	1	114
Alcoholism	37	41	15	7		112
Drug problems	39	37	15	9		113
Crisis intervention	53	36	9	3		115
Benefits	65	31	3	1		113
Mental health problems	39	47	9	4	1	116
Physical health probs	50	41	8	1		112
Family problems	45	31	19	5		105
Child care	37	24	29	8	2	95
Housing search	56	33	3	3	3	114
HIV/AIDS Prev. educ.	25	37	27	10	2	112
Health insurance	38	41	17	3	1	109

From 1991 to 1999, survey respondents' satisfaction with shelter HIV/AIDS prevention education activities declined by just over seven percentage points (table 30).

Table 30

Satisfaction with Shelters Ability to Help ...in 1991 and 1999

	% of shelters 1999	**% of shelters 1991**	**1999 % Shelters that match 1991 survey**	**1991 % Shelters that match 1999 survey**
Job training	76%	46	80	34.7
Providing food, beds	98%	96	100	94
Alcoholism	78%	70	76.6	66.7
Drug problems	76%	69	74.5	65.9
Crisis intervention	89%	94	89.3	93.8
Benefits	96%	80	95.9	77.1
Mental health problems	86%	70	81.3	70.2
Physical health problems	91%	81	85.1	75
Family problems	76%	75	72.7	74.5
Child care	61%	61	65	59.5
Housing search	89%	80	89.6	79.2
HIV/AIDS Prevention education	62%	69	56.5	64.6
Health insurance	79%		78.7	

RESPONDENT CHARACTERISTICS

The educational level of the survey respondents was high (table 31). About forty percent had completed college; another quarter had completed a graduate degree. A quarter had finished some college.

Table 31

Level of Education

	% Shelters
completed graduate degree	27.0%
completed college	39.6
some college	24.3
completed high school/GED	4.5
vocational degree	.9
RN or LPN	3.6
Total	100%

About one quarter of respondents spent less than one hour per week on HIV/AIDS issues, while six in ten spent between one and twenty hours per week (table 32). About one fifth spent 20 or more hours per week on HIV/AIDS issues.

Table 32

Time devoted to HIV/AIDS per week

	% of Shelters
more than 30 hrs/wk	12.6%
20-30 hrs/wk	7
1-20 hrs	60.7
less than 1 hour	22.5
Total	100% (71)

About nine in ten respondents thought that it was at least somewhat important that they receive additional AIDS training (table 33). One-quarter thought that additional HIV/AIDS training was extremely important, and another one-third thought it was very important.

Table 33

Importance of additional HIV/AIDS training

	% shelters in 1999	**% shelters in 1991**
extremely important	25%	33
very important	33.3	24
somewhat important	38	34
not at all important	3.7	9

CONCLUSIONS

HIV Prevention activities in shelters and day programs throughout Massachusetts exist but gaps remain. Most shelters provide some educational services to guests and staff and a substantial proportion distribute condoms to guests; basic training in HIV/AIDS issues was also provided to staff in about half the shelters. Distribution of bleach kits was much less common.

A decline in Life Lines activity for several years coincided with reduced HIV/AIDS prevention and education efforts statewide. Prevention and education activities declined by 10-20 percentage points between the 1991 and 1999 surveys, satisfaction with the level of support provided by Life Lines declined, as did satisfaction with shelter HIV/AIDS prevention education activities overall. Nonetheless, shelter-based distribution of both condoms and bleach kits increased during this period.

There were many differences in education and prevention activities between the different shelter and program types examined. In general, shelters for single adults reported the most education and prevention activities; family shelters the least.

Most shelters and day programs surveyed were satisfied with their HIV/AIDS prevention activities, but this was the lowest level of satisfaction among 13 different shelter activities and programs. Delivery of HIV/AIDS prevention and education activities was hindered most by guest reluctance to participate and their residential transience and substance abuse, staff efforts were also hampered by insufficient knowledge about HIV and insufficient time for HIV/AIDS education and prevention activities.

All these conclusions from the survey data must be interpreted in light of the measurement strategies used. Since it was not possible to measure in detail the amount or quality of staff training and guest education, the percentage of shelters indicating that training and education has been provided may be much larger than the percentage of shelters in which training and education has been effective. Anecdotal evidence suggests, in fact, that many shelters that reported having provided these services did so only infrequently.

In spite of such limitations, the survey results suggest the value of several strategies for increasing the effectiveness of HIV/AIDS education and prevention activities in Massachusetts shelters and day programs. Full exposure of staff to basic HIV/AIDS education and universal precautions training will require substantial additional efforts; staff in battered women's shelters may require targeted efforts due to the need for tailored prevention messages and restrictions on visitors for security reasons. The availability of VCRs and conference rooms suggests that outreach educators and LIFE LINES training efforts will be able to draw on adequate resources. Providing staff with some release time for training and ensuring knowledgeable presentations about HIV/AIDS would lessen the two most common barriers to effective staff efforts.

Efforts directed to shelter and day program guests should focus on the factors that decrease their participation in HIV/AIDS education and prevention. Group discussions designed to lower guest reluctance to participate and vigorous efforts to engage addicts in substance abuse treatment would both help to increase interest in the Life Lines program. Literacy lessons could directly incorporate information about HIV/AIDS prevention.

Special attention should be given to family shelters, which have been somewhat less involved in HIV/AIDS prevention education. Women in family shelters should be particularly targeted in light of state surveillance data that show 30% of all infections are among women whose primary risk factor was injection drug use (not their partners). Women who are pregnant can now take advantage of recent medical advances to reduce vertical transmission with treatment during pregnancy, labor and delivery. Yet, discussion of HIV/AIDS risk behavior between women in family shelter with staff poses potential loss of family shelter privileges for the family or worse. This dilemma may ultimately discourage family shelters from addressing HIV/AIDS. However, prevention activities in these shelters lag those in shelters open only to adults.

Efforts to increase shelter-based HIV/AIDS prevention education cannot rely only on outreach educators from other cities or regions of the state. The LIFE LINES experience suggests that it is not realistic for shelter staff to provide training or group education themselves. Linking local outreach educators with community shelters and day programs makes sense. Outreach educators and community agencies must work in conjunction with shelters in their neighborhoods in order to overcome their all-too-common resource deficits as well as the isolation of shelters from other service agencies. Most persons who become homeless remain so for only a short time, or cycle between being housed and being homeless. Reducing the risk of HIV transmission is a community-wide problem that requires a community-wide solution.