

African American



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EPIDEMIOLOGIC AND SOCIOCULTURAL FACTORS IN THE TRANSMISSION OF HIV INFECTION IN BLACK GAY AND BISEXUAL MEN

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AIDS (Acquired Immunodeficiency Syndrome), first reported in 1981 (Gottlieb, Schanker, Fan, Saxon, Weisman, & Posalki, 1981), is profoundly altering the lives and communities of millions in this country. By the year 1991, the U.S. Public Health Service projects that approximately 270,000 Americans will have contracted the disease, a dramatic increase from the current 58,000 cases (Macdonald, 1986). Of these, 179,000 people will have died from AIDS. This means the disease will have struck one of every 933 Americans. In the year 1991 alone, an estimated 74,000 new cases will be diagnosed and 54,000 individuals will die.

As drastic as these statistics may seem, when they are examined by ethnic groups, the picture is particularly disconcerting for blacks (Bakeman, McCray, Lumb, Jackson, & Whitley, 1987; Centers for Disease Control, 1987; Cochran, Mays, & Roberts, 1988; Friedman, Sotheran, Abdul-Quader, Primm, Des Jarlais, Kleinman, Mauge, Goldsmith, El-Sadr, & Maslansky, 1987; Mays & Cochran, 1987). As of April 4, 1988, 58,270 cases of AIDS had been reported in the United States (CDC Weekly Surveillance Report, 4/4/88). Of these, 14,992, or approximately 26 percent, were black, although blacks represent only 12 percent of the population. It was estimated in 1987 (Mays & Cochran, 1987) that 1 to 1.4 percent of the black population was possibly infected with the virus (figures based on 1980 Census, Bureau of the Census, 1983). This was three times the estimated rate among whites. Clearly, AIDS has the potential to have a much more destructive impact on the black community than among whites.

Using the U.S. Public Health Service model for projecting AIDS incidence rates in the general population, by 1991 there will be approximately 67,000 cases in blacks, with 31,500 cumulative deaths (Mays & Cochran, 1987). Yet this may underestimate by at least 20 percent the serious morbidity and mortality attributable to AIDS (Morgan & Curran, 1986). Underreporting or underidentification of cases is a continuing problem (Cochran, 1987). In addition, racial differences in health care utilization and risk behaviors may differentially affect the accuracy of the prediction of AIDS cases in blacks, resulting in a much higher estimate than we have presented.

The epidemiologic pattern of AIDS in blacks differs dramatically from that observed in whites. As shown in Figure 1, AIDS among whites is very clearly a disease affecting homosexual and bisexual males as its principal targets. For blacks, AIDS cases are more widely distributed throughout the population. Even among individuals in a single risk category, blacks are at relatively higher risk for AIDS than whites except for infections acquired through the receipt of blood products (Centers for Disease Control, 1987).

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Support for this chapter was provided by a grant from the National Institute of Mental Health to both authors; a California State University, Northridge Foundation grant to the first author; and a USPHS Biomed grant from the University of California, Los Angeles to the second author. Work on this chapter was completed while the second author was a National Center for Health Services Research Fellow at the Rand Corporation, Santa Monica, California.

In M. Shernoff & W.A. Scott (Eds.) *The Sourcebook On Lesbian/Gay Health Care*.
Washington D.C.: National Gay and Lesbian Health Foundation, 202-211. (1988)

ADULT AIDS CASES BY RISK FACTORS AS OF APRIL 4, 1988

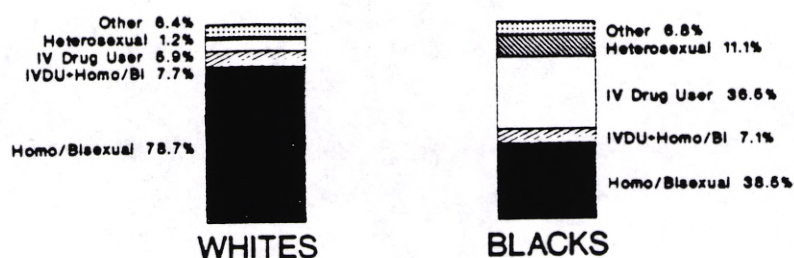


FIGURE 1

(Cochran & Mays, 1988)

EPIDEMIOLOGICAL AIDS IN HOMOSEXUAL AND BISEXUAL MALES

Of the adolescent and adult cases reported nationally (Acquired Immunodeficiency Syndrome Weekly Surveillance Report, 4/4/88), approximately 64 percent ($N = 36,603$) were homosexual and bisexual men, while an additional 7 percent ($N = 4,266$) were intravenous (IV) drug abusing homosexual or bisexual males. Of these, 5,576 were black homosexual or bisexual males and 1,030 black IV drug-abusing homosexual or bisexual males. Thirty percent of black homosexual men with AIDS (including IV drug users) live in the urban Northeast (primarily New York City and its environs); for bisexual men, the percentage is 25 percent. In contrast, for white homosexual men with AIDS, 1/3 live in the urban West, principally the urbanized regions of San Francisco and Los Angeles. White bisexual men with AIDS are most likely not to live in an urban area of more than 1 million residents (34 percent).

While the number of black homosexual and bisexual cases may seem small, it is important to gauge these numbers in proportion to the representation of blacks in the population. Thus, as seen in Figure 2, 15.2 percent of cases in homosexual/bisexual males are black, although only 10.6 percent of males over age 12 years are black. Twenty four percent of cases with the cofactors of IV drug use and homosexual/bisexual male are among blacks. In contrast, whites represent 84.6 percent of males over age 12 years and 73.9 percent of AIDS cases associated with a single risk factor of homosexual sexual transmission (62.3 percent of IV drug use and homosexual transmission cofactors cases).

AIDS CASES BY ETHNIC GROUP AS OF APRIL 4, 1988

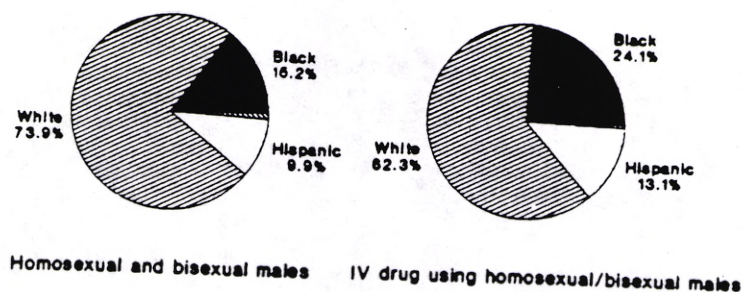


FIGURE 2

(Cochran & Mays, 1988)

If we presume an equivalent prevalence rate of male homosexual behavior across ethnic groups, even among gay and bisexual men, blacks are at higher risk for HIV infection than whites. In a recent study (Samuel & Winkelstein, 1987) of HIV seroprevalence among San Francisco gay men, 48.7 percent of whites evidenced antibodies to HIV versus 65.3 percent of blacks, despite a lack of statistically significant differences between the two groups in high risk behaviors such as needle sharing, receptive anal intercourse or number of sexual partners. The reasons for this higher prevalence rate among gay and bisexual men are still unknown. However, it may be only through achieving a greater understanding of the black gay male experience that these unexpected differences can be explicated.

SOCIOCULTURAL FACETS OF THE BLACK GAY MALE EXPERIENCE

Prior to the appearance of AIDS in this country, studies on the sexual preferences and behaviors of gay men generally ignored the specific experiences of black men (Bell, Weinberg & Hammersmith, 1981). With the press of the AIDS epidemic to develop baseline information on men's intimate behaviors, this tendency rarely to study black gay men, or to do so in the same manner as white gay men, persists. While many researchers may recognize the importance of possible cultural differences, their approach has been to assume that black gay men would be more like white gay men than black heterosexual men. Questionnaires, sampling procedures and topics of focus have been more consistent with white gay men's experiences (see Becker & Joseph, 1988 for a comprehensive review of behavior change studies). This proclivity has resulted in an emergence of comparisons between black and white men using white gay standards of behavior that may be obscuring our understanding of important psychosocial determinants of sexual behaviors in black gay men. Given the differences that have been observed in family structure and sexual patterns between black and white heterosexuals, there is no empirical basis upon which to assume that black gay men's experience of homosexuality would perfectly mimic that of whites (Bell *et al.* 1981). Indeed, very little is known empirically about the lives of black gay men (Mays & Cochran, 1987), though there are some indications, discussed below, that they are more likely to engage in activities that place them at greater risk for HIV infection.

In the absence of any data we need to proceed cautiously with assumptions that imply anything other than same sex activities of black gay men resemble those of white gay men. This caution is particularly true for AIDS studies that pur-

port to study psychosocial behavior. Studies of this type report not only on behavior but also attempt to describe motivations and circumstances that led to the behavior. In the absence of a set of questions or a framework incorporating important cultural, ethnic and economic realities of black gay men, interpretations emanating from a white gay male standard may be misleading.

DEVELOPMENT OF A BLACK GAY IDENTITY

In recent years, researchers (Spanier & Glick, 1980; Staples, 1981; Guttentag & Secord, 1983) have noted differences between whites and blacks in their intimate heterosexual relationships. Differential sociocultural factors presumably influence the development and specific structure of sexual behavior within black heterosexual relationships. These factors include the unavailability of same ethnic group partners, fewer social and financial resources, residential immobility and lack of employment opportunities. Many of these same conditions may surround the formation, maintenance and functioning of black gay male relationships.

Popular writings in past years by black gay men describe the difficulty in finding other black gay men for potential partners, the lack of a visible black gay community, an absence of role models, and the dearth of black gay male social or professional organizations (Soares, 1979; Beame, 1983). While gay bars, gay baths and public places existed where white gay men gathered, some of these were off limits to black gay men either due to actual or perceived racism within the white gay community or the danger of passing through white neighborhoods to participate in gay community activities. Thus, expectations that the experiences of black gay men are identical to those of white gay men seem unwarranted.

In examining differences between blacks and whites in the emergence of a homosexual orientation, Bell, Weinberg and Hammerstein (1981) found that, for the white males, pre-adult sexual feelings appeared to be very important. In contrast, among black males, childhood and adolescent sexual activities, rather than feelings, were stronger predictors of the development of adult homosexual orientation. Thus, blacks started to act at an earlier age on their sexual inclinations than whites did (Bell *et al.*, 1981). This would be consistent with black-white differences in the onset of heterosexual activity if socioeconomic status is not statistically controlled for (Wyatt, personal communication).

The typical conceptualization of sexual orientation is that individuals are located in terms of their sexual feelings and behaviors on a bipolar dimension where one extreme is heterosexuality, the other is homosexuality and lying somewhere in between is bisexuality (Bell & Weinberg, 1978). This definition does not include ethnicity or culture as an interactive factor influencing the expression of sexual behavior or sexual orientation. For example, Smith (1986) makes a distinction between black gays and gay blacks, complicating the demarcation between homosexuality and bisexuality. "Gay blacks are people who identify first as being gay and who usually live outside the closet in predominantly white gay communities. I would estimate that they amount to roughly 10 percent of all black homosexuals. Black gay men, on the other hand, view our racial heritage as primary and frequently live 'bisexual front lives' within black neighborhoods." These two groups are probably quite different in both social activities and sexual behaviors. The black gay man, strongly identified with Afro-American culture, will often look and behave much like the black heterosexual man except in his sexual behavior. The extent to which his same sex partners are integrated into his family and social environment may be a function of his class status (Soares, 1979). It has long been noted by blacks that there are differences, both in values and behaviors, between middle-class and working-class blacks. There is no reason to assume that, within the black gay community, such diversity would not persist. While Smith (1986) has described the black gay community in only two dimensions, we would be remiss if we stopped here. There is a growing population of black gays who have forged an identity acknowledging both statuses. As Sylvester writes in *In the Life: A Black Gay Anthology*, "At times I cried just remembering how it is to be both black and gay during these truly difficult times. But here we are, still proud and living with a culture all our own."

We know less about the behavior of black men who identify as bisexual and least about those black men who engage in same-sex sexual behavior but identify as exclusively heterosexual. When the factor of social class is added the distinction between homosexuality and heterosexuality may become even more blurred. Among lower socioeconomic black men, those engaged in same sex sexual activities, regardless of their sexual object choices, may appear on the surface no different from black heterosexuals. If the support systems of black gay men are like those of black lesbians (Cochran & Mays, 1986), fewer economic resources result in a greater reliance on a black social network (both gay and heterosexual) for tangible and emotional support, a strong tendency to live in predominantly ethnic neighborhoods and the maintenance of emotionally and economically close family ties.

This extensive integration into the black heterosexual world may be a function of both fewer economic resources and ethnic identification. The culture of gay life, generally perceived to be white, may not be synonymous with the norms of black culture. Choices of how to dress, what language to use, where to live and who to have as friends are all affected by culture. The white gay community, while diverse, has developed norms concerning language, social behavior and other demarcations (Warren, 1974) that may not mesh well with certain subgroups of black gays. For example, in the past there has been a heavy emphasis in the gay white community (except among the middle-aged, middle class closeted gay men) on socializing in public places—bars, beaches and resorts (Warren, 1974). In contrast, the black gay community places greater emphasis on home entertainment that is private and not public, perhaps as a holdover from the days when discrimination in many public places was common. This pattern of socializing would facilitate the development of a distinct black gay culture (Soares, 1979). It is perhaps this difference in socializing that has frustrated health educators attempting to do AIDS education through the social network in gay bars. Generally, they have found that they do not reach a significant number of black men using this technique. An understanding of the black gay community makes salient that risk reduction strategies should focus on "risk behaviors" and not "risk groups." Emphasizing risk reduction strategies that rely on group membership require a social and personal identification by black men that, for many, may not be relevant.

SEXUAL BEHAVIOR

Bell and Weinberg, in a 1978 study comparing sexual activities of white and black gay men, found that blacks were more likely to report having engaged in anal sex, both passively and actively, than white gay men. In terms of our current knowledge of AIDS, this appears to be one of the highest risk factors for contracting the HIV virus (Friedland & Klein, 1987). A second aspect of black gay men's sexuality is that they may be more bisexual in their behaviors than white gay men. Evidence for this comes again from Bell and Weinberg (1978), who reported that black gay men were significantly more likely to have engaged in heterosexual coitus (22 percent) in the previous 12 months than white gay men (14 percent). This seems to be borne out nationally by the AIDS statistics. Among male homosexual/bisexual AIDS patients, black men are more likely than white men to be classified as bisexual (30 percent vs. 13 percent) rather than homosexual (70 percent vs. 87 percent). Due to the intense homophobia in the black community and the factors we discussed above, men may be more likely to remain secretive regarding their homosexual activities (Mays & Cochran, 1987). This may provide a mode of transmission of the AIDS virus outside of an already identified high risk group.

There are several other differences between black and white gay men noted in the Kinsey Institute data that have implications for contracting the HIV virus. Looking at sexual behavior both pre- and post-Stonewall, black gay men, in comparison to white gay men, were more likely to be sexually active across ethnic boundaries and less likely to report that their sexual partners were strangers (Gebhard & Johnson, 1979; Bell & Weinberg, 1978). Sexual practices post-Stonewall underwent profound change in the gay community. Black gay men were a part of that change (Gebhard &

Johnson, Bell & Weinberg, 1978). However, these differences in meeting partners or choice of partners remain. They are apparently less malleable to change than specific risk-related sexual behaviors.

While the 1978 Bell and Weinberg study was conducted on a small sample in the San Francisco area, it is suggestive of the need for further research to assess the prevalence of risk behaviors and strategies most effective for decreasing risk. Indeed, a recent report of ethnically-based differences in syphilis incidence rates (Landrum, Beck-Sague, & Kraus, 1988) suggests black gay men are less likely than white gay men to be practicing "safer sex." Sexual behavior has multiple determinants and it is important that variables such as culture, ethnic identification and class be incorporated into health education programs designed to promote sexual behavior change by black men.

INTRAVENOUS DRUG USE

IV drug use is more common in the black community (Gary & Berry, 1985) which may explain the higher than expected prevalence of blacks in the co-categories of IV drug user and homosexual/bisexual male shown in Figure 2. HIV infection is endemic among urbanized Northeast IV drug users who most likely to be black (Ginzburg, MacDonald, & Glass, 1987). Ethnic differences exist between the percentage of homosexual/bisexual men with AIDS who are also IV drug users; for white gay and bisexual men with AIDS, 9 percent have histories of IV drug use, while for blacks, the figure is 16 percent. Black gay and bisexual men who do not use IV drugs may also be at increased risk because they are more likely than whites to be sexual partners of black men who are IV drug users. In the Bell and Weinberg study (1978), 22 percent of white men had never had sex with a black man, whereas for black respondents, only 2 percent had never had sex with a white man.

ALCOHOL AS A COFACTOR

Recently, alcohol use has been implicated as a cofactor that facilitates the occurrence of high risk sexual behavior among gay men (Stall, McKusick, Wiley, Coates, & Ostrow, 1986). In predicting alcohol use among black gay and bisexual men, one might expect that normative use patterns will be influenced by what is common behavior in both the black and gay communities.

Norms for alcohol use in the black community reflect a polarization of attitudes, shaped, on the one hand, by traditional religious fundamentalism and rural southern heritage and, on the other, by a focus on socializing in environments where drinking is common, such as bars, nightclubs and home parties (Herd, 1986). This latter norm is more prevalent in urban black communities. Blacks and whites vary in small ways in their drinking patterns, although blacks are more likely to suffer negative consequences, including alcohol-related mortality and morbidity, from their drinking than are whites. Current rates of mortality due to liver cirrhosis indicate that rates are 10 times higher in black men aged 25-34 as compared to white males. While drinking is found across all socioeconomic groups of blacks, health and social problems associated with drinking have been found more often in low income urban blacks (Lex, 1987). Similarly, for this group it was found that black males 30-59 were most likely to use alcohol to face the stress of everyday life situations. This is the group most affected by HIV infection.

Within the gay male community, alcohol abuse is a serious problem (Icard & Traunstein, 1987). This may result from both the sociocultural stress of discrimination and the tendency for gay-oriented establishments to be drinking establishments as well. Thus, gay men frequently socialize in environments where alcohol consumption is normative.

Black gay and bisexual men, depending upon their relative identification with the black or gay community, would be expected to demonstrate behavior consistent with these norms. For some, this might mean a high level of abstinence apart from social drinking consistent with other black Americans; for others, alcohol consumption might more closely resemble that of white gay men with concomitantly higher rates of alcohol dependency.

CROSSING TRADITIONAL RISK GROUPS' BOUNDARIES

Early AIDS epidemiologic tracking programs conceptualized the disease as a result of the gay lifestyle (Mays, 1988). Indeed, now discarded names for different manifestations of the illness included Gay-related Immunodeficiency Disease and Gay cancer. This focus on discrete risk factors continues to the present, although the additional populations of IV drug abusers, hemophiliacs, persons born in Haiti and Central Africa and recipients of blood transfusions after 1978 have been added to the list. For whites, this approach is highly successful, describing the presumed HIV transmission vector in 94 percent of cases; for native-born blacks, the percentage of cases accurately labeled by a single risk factor (including the combination of IV drug use and male homosexual contact) drops to 88 percent (Cochran, 1987). This underscores the reality that sociocultural factors varying across ethnic groups strongly influence individuals' behavior, and by this, their risk of contracting HIV. For black gay and bisexual men, the reliance on highly specified risk groups (or factors) ignores the fundamental nature of their behavioral location in society. The multiplicity of their identities may indirectly increase their risk for HIV infection by exposing them to more diverse populations (Grob, 1983).

First, as blacks, they are behaviorally closer to two epicenters of the AIDS epidemic: IV drug use and foreign-born blacks (primarily those from Haiti and Central Africa where HIV infection is more common). Social and behavioral segregation by ethnic status is still a reality of the American experience and black gay and bisexual men suffer, like other blacks, from pervasive racism. As we noted above, if their social support systems are similar to what we know of black lesbians (Cochran & Mays, 1986), extensive integration into the black heterosexual community is common. Behaviorally, this may include both IV drug use and heterosexual activity with HIV-infected individuals. Thus, black gay and bisexual men are at increased risk for HIV infection simply by virtue of being black.

Second, as men who have sex with other men, black gay and bisexual men are often members of the broader gay community in which ethnicity probably reflects the general U.S. population (84 percent white). Black gay and bisexual men may have relatively open sexual access to white men, although racism in the community may preclude other forms of socializing (Icard, 1985). Data from the Bell and Weinberg study (1978) suggests several interesting differences, as well as similarities, between white and black gay men. Blacks reported equivalent numbers of sexual partners, both lifetime (median = 100-249 partners) and in the previous 12 months (median = 20-50), as whites. Although they were significantly less likely than white gay men to engage in anonymous sexual contacts (51 percent vs. 79 percent of partners), more than two-thirds reported that more than half their sexual partners were white men. In contrast, none of the white respondents reported that more than half their partners were black. It should be kept in mind, however, that a greater percentage of the white sample (14 percent) was recruited at bath houses than the black sample (2 percent). Nevertheless, at least sexually, Black gay men appear to be well integrated into the gay community. Therefore, black gay and bisexual men are also at higher risk for HIV infection because they are behaviorally close to another epicenter of the AIDS epidemic: the gay male community.

Third, as a social grouping unto itself, the black gay and bisexual male community may be more diverse than the white gay community (Icard, 1985). Some men identify more closely with the black community than the gay community (black gay men); others find their primary emotional affinity with the gay community and not the black community (gay black men). To the extent that this diversity of identity is reflected in behavioral diversity as well, HIV transmission may be greatly facilitated (Denning, 1987).

Thus, black gay and bisexual men are individuals often located behaviorally at the crossroads of HIV transmission. Their multiple social identities make it more likely that the practicing of high risk behavior, whether sexual or needle-sharing, will occur in the presence of HIV.

PERCEPTIONS OF RISK

There may be a reluctance among black gay and bisexual men to engage in risk reduction behaviors because of the perception by some members of the black community that AIDS is a "gay white disease," or a disease of intravenous drug users (Mays & Cochran, 1987). In addition, many risk reduction programs are located within outreach programs of primarily white gay organizations. These organizations often fail to attract extensive participation by black gay men.

Research findings suggest that the personal perception of being at risk is most often influenced by accurate knowledge of one's actual risk and personal experiences with the AIDS epidemic (McKusick, Hortsman & Coates, 1985). There may be a variety of reasons why black gay and bisexual men do not see themselves as at risk. These include the notion of relative risk and a lack of ethnically credible sources for encouraging risk perceptions (Mays & Cochran, 1988). Relative risk refers to the importance of AIDS in context with other social realities. For example, poverty, with its own attendant survival risks, may outweigh the fear of AIDS in a teenager's decision to engage in male prostitution. Economic privilege, more common in the white gay community, assists in permitting white gay men to focus their energies and concerns on the AIDS epidemic. For black gay men of lesser economic privilege other pressing realities of life may, to some extent, diffuse such concerns. Credible sources relates to the issues that we have presented here of ethnic identification. Black gay men who are emotionally and behavioral distant from the white community may tend to discount media messages from white sources.

TRACKING CHANGES AMONG THESE MEN

We know very little about the response of black gay and bisexual men to the threat of AIDS. Recent research attempts to identify psychosocial and lifestyle factors predictive of risk reduction behaviors among gay men have utilized almost exclusively caucasian informants. Generally, few participants in the major federally funded studies of gay men have been black gay men (Becker & Joseph, 1988). The reasons for this low participation rate have not been empirically documented, but probably have multiple origins. Researchers, in designing their studies, may utilize questions that lack cultural relevance or rely on recruitment strategies emphasizing white gay community and friendship networks. Additionally, there may be resistance by the black community to allow access to participants. This may stem both from past experiences with white researchers who conducted their research with insensitivity to black individuals and the community itself, and from the general distrust many blacks have of whites as a whole. Apart from these issues, the generally greater religious conservatism in the black community encourages a level of homophobia that may lead black men who are sexually active with other men to be more difficult to locate in the first place.

It is within this context that we have designed a national study of AIDS risk reduction in black gay and bisexual men. Our goals are to gather data that are culturally accurate: 1) in documenting the HIV-related knowledge, attitudes, perception of risks and sexual activities of black men who engage in same sex activities; 2) in assessing to whom these men feel they can turn for support and information to cope with everyday stresses and hassles as well as HIV-related concerns; and 3) to determine what barriers prevent or hinder these black men from seeking out health and AIDS related information.

Our goal is to reach at least 1,000 black gay and black men who participate in same sex activities with other men throughout the United States. We are striving to reach a very diverse group. Black men living in rural or urban areas, men who identify as gay, bisexual or heterosexual (if they engage in same sex activities), men whose occupations range from never employed to professionals and the full spectrum of the age range from 18 years and up. The success of our reaching this diverse group depends on the participation of members of the community.

As the study is totally anonymous, we depend on others to help us reach black men. Questionnaires are distributed through social and professional organizations such as the National Coalition of Black Lesbians and Gays and by mem-

bers of the gay heterosexual community. If white gay men and lesbians wish to assist the project, they should request copies of the questionnaires to disseminate to friends or acquaintances that are black and sexually involved with other men. Individuals may also request copies of the questionnaire or the information flyers describing the study to place in bars, bookstores, gyms or distribute at houseparties that will be attended by large numbers of black men. Each individual who helps, no matter how small the effort, is important to the attempt to accurately reflect the diversity of the black men's community. If you are interested in either participating in the study or disseminating questionnaires, you can call or write Dr. Vickie M. Mays, c/o Black Community AIDS Research and Education (Black C.A.R.E.) Project, 1283 Franz Hall, Los Angeles, CA 90024-1563 (213) 825-9858.

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**A REPORT ON
THE FIRST TRACKING SURVEY OF
AIDS KNOWLEDGE, ATTITUDES, AND BEHAVIORS
IN
SAN FRANCISCO'S BLACK COMMUNITIES**

1988-1989

Volume I

**Conducted for the
AIDS Surveillance Office
San Francisco Department of Public Health**

**By
Polaris Research and Development**

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EXECUTIVE SUMMARY

This survey is the second in a series designed to document the AIDS-related knowledge, attitudes, beliefs, and behaviors in San Francisco's Black communities and to measure changes in those conditions over time. The first survey was conducted in the spring of 1987 and established baseline measures. It consisted of 400 face-to-face interviews with a population-based sample of Black adult residents of San Francisco.

This survey was conducted in the fall and winter of 1988-89. Face-to-face interviews were conducted with 350 Black adult San Franciscans. Respondents were selected using a random block-random household sampling procedure in those census tracts that had Black populations of 50% or more in 1980.

Awareness of the Threat of AIDS

The proportion of respondents who had heard about AIDS was over 95% in both 1987 and 1988. However, the proportion of those knowing a PWA increased significantly from 1987 when 20.9% knew a PWA to 35.8% in 1988.

While 81% of the respondents agreed that "AIDS is a serious problem for Black people," it was not clear that the respondents all felt it was equally serious. Although the proportion of respondents identifying AIDS/ARC as the most serious health problem confronting the Black community increased significantly over the 1987 baseline, still less than 50% of survey respondents felt it was the most serious health threat faced by the Black community.

In terms of personal concern, 84% of the respondents said that they considered their own risk of AIDS "to be very low." On a scale of 1 to 10 where respondents were asked to indicate their personal level of concern about AIDS, the mean score in 1988 was an extremely moderate 5.9--a score not significantly different from the mean (7.2) in 1987.

Those more likely to view AIDS as a threat to the Black community and to be personally concerned about AIDS were generally younger, likely to report that they had changed behavior due to AIDS, likely to have engaged in various risky sexual or drug behaviors, and more likely to know a PWA, and to be single or live with a lover.

Knowledge about AIDS

In 1987 respondents were very knowledgeable about how HIV is and is not transmitted. However, knowledge levels increased significantly in 1988 in five of 11 instances where the same questions were asked on both the baseline and tracking surveys.

In general, respondents have firmly grasped that HIV is transmitted through sexual contact, needle-sharing, and from mother to child. Nevertheless, although it decreased between 1987 and 1988, there is still substantial confusion about casual transmission. Respondent confusion appears to have some logical consistencies, though.

The percentage of respondents who said they believed that various forms of casual contact were risky increased as the closeness and intimacy of contact--and, in accordance with classic germ theory, potential for exposure to germs--increased. About thirty percent (30.7%) said they believed HIV could be transmitted by kissing; 25.0% by drinking from the same glass; 19.1% from being exposed to a cough or sneeze, 17.3% from eating food handled by an HIV+ person, down to shaking hands at 6.1%.

Another area of confusion was related to the medical use of needles. Respondents now have a good understanding that needle-sharing by intravenous drug users is an efficient route of HIV transmission. This perception of risk seems to have been generalized to other forms of needle use--including those used to draw blood for lab tests, in donating blood, and in giving blood transfusions. The confusion about mosquitos may also be related to concern about transmission through needle use since most people are aware that mosquitos draw blood.

Knowledge about which sexual practices are safe and which are risky also increased significantly between 1987 and 1988, although there is still a great deal of uncertainty about the safety of anal intercourse with a condom (48% believed it was unsafe, 41% believed it was safe, and 11% were not sure), about oral sex, and about touching a partner's sex organ. Only 60% of the respondents were aware that five or more years could pass between infection with HIV and the development of symptoms, and intravenous drug users (IVDUs) in particular, were less likely to know that female to male transmission was possible.

The respondents who were likely to have higher levels of knowledge about AIDS transmission routes than the sample as a whole included individuals age 30 to 39 and 18 to

29; those who had engaged in risky sexual behaviors or injected drugs, those who know a person with AIDS (PWA), people who were single or lived with a lover; those with children; and those with more education and higher incomes. The likelihood of being more knowledgeable about the comparative risk of various sexual practices was associated with knowing a PWA and with reported attempts to change behaviors due to the AIDS epidemic.

Risk Levels and Risk Factors

In 1987, 35.7% of the respondents were assumed to be at risk of exposure to HIV as a result of their sexual or drug-using behavior. In 1988, based on a formula used in a companion survey conducted in San Francisco's Latino community, a total of 30.6% of the respondents were found to be at risk. The difference, however, was not statistically significant.

Since 1987 the mean number of sexual partners during the year prior to the survey declined from 3.67 to 2.55. That decline was statistically significant. Those respondents who reported that they had a higher than average number of sexual partners during the year were younger, more likely to have risky partners or to participate in unprotected sexual intercourse, and more likely to be bisexual than either heterosexual or homosexual.

The percentage of respondents reporting that they had homosexual or bisexual partners also declined from 7.0% in 1987 to 2.6% and the percentage with partners who abused non-intravenous drugs or alcohol declined from 20.1% to 13.9%. Non-significant declines also occurred in the percentage of respondents who had sexual partners who injected drugs and shared needles, who exchanged sex for money, or who had unknown sexual histories.

However, the percentage of respondents who had partners who had sexually transmitted diseases increased between 1987 and 1988 as did the percentage of those who had partners with AIDS or ARC--from 0.5% in 1987 to 1.8% in 1988. And another 1.2% had partners who were HIV+, but were not yet symptomatic.

With the exception of a statistically significant decline in the percentage of respondents who reported that they engaged in oral sex that involved the swallowing of semen, there were no differences in the incidence of other sexual behaviors respondents engaged in during the month before the survey in 1987 and 1988. Analysis also showed that

many of those reporting that they'd engaged in protected vaginal or anal intercourse also engaged in unprotected intercourse and did so with greater frequency.

Respondents reported a high degree of substance abuse. Forty-four percent said that they had used marijuana at least once during the year, 29% had used cocaine, and 17% had used "crack." Just over seven percent (7.4%) had injected drugs during the year prior to the survey--a percentage virtually identical to the 7.3% of the sample who were intravenous drug users in 1987--and another 4% admitted to having injected drugs more than a year before the survey. About 40% of those reporting intravenous drug use within the past year had also shared needles.

About a third of those who had ever shared needles said that they'd shared needles with gay IVDUs and with people who had later developed AIDS or tested positive for HIV. Needle sharing was also correlated with unprotected anal and vaginal sex.

A sizeable minority of the sample reported that they'd been high on non-intravenous drugs when they'd had sex. Almost forty percent (38%) said they had been high on alcohol, 23 % on marijuana, 13% had used cocaine, and 8% had used crack during sex. Drug use during sex correlated highly with having unprotected vaginal and anal sex and with having partners who were HIV+, had an STD, or were intravenous drug users.

In looking across all of the demographic and attitudinal variables used to discriminate between various segments of the sample, it became clear that the 30.6% of the Black population who were at some heightened risk of exposure to HIV as a result of their sexual and/or drug using behaviors shared several statistically significant characteristics.

They were more likely to be men. They were more likely to be young--under forty in general and between 18 and 29 years of age in particular. They were more likely to know a PWA. They were more likely to be bisexual. They were more likely to be either single or to live with a lover. They were more likely to have at least a high school education. They were more likely to have been in jail at some point for more than three days and they were less likely to attend church. They were more knowledgeable about how HIV is and is not transmitted. They were also more likely to feel personally vulnerable to AIDS and to report that they had made some change in their behaviors due to AIDS.

Antibody Testing

Almost ninety percent (87%) of the respondents said that they'd heard of the antibody test. Nevertheless, only about fifty of the respondents had taken the test and only about 1 in 5 said that they were "very likely" or "somewhat likely" to take the test in the future. Strikingly, none of the IVDUs said that they were likely to take the test.

Risk Reduction

Almost half (47%) of the respondents said that they had made changes in their behaviors due to AIDS. However, they have not made the kinds of changes in behavior that are most likely to be effective in reducing risk. Although over eighty percent of them said that they believed that condoms can reduce the spread of AIDS, only 27% reported that they used condoms more often. Others used less effective strategies for reducing transmission of the virus--40% indicated that they'd been more careful in choosing partners and 25% said that they'd had fewer partners.

Respondent's attitudes about condom use were highly varied. Although there were broad agreement that they were easily available and a majority of the respondents felt that they knew how to use them correctly, opinions about comfort and sensation were more divergent, and a substantial proportion of the respondents said that they were not sure that condoms were needed in monogamous relationships or with partners who had good hygiene.

The majority of the respondents also reported that they were comfortable asking their partners about their sexual histories--except that they indicated that they would feel least comfortable asking about STDs and HIV status. Those respondents with less than a high school education also indicated that they felt much more uncomfortable in asking partners about their sex and drug using history.

Intravenous drug users also indicated that they were attempting to reduce their risks as well. They said they were using bleach more frequently to clean needles. Female IVDUs, in particular, were more likely to clean their needles than men and more like to have decreased needle sharing behavior.

Effectiveness of Prevention Education

Almost ninety percent (88%) of the respondents reported that they had received or seen AIDS educational materials in the prior year and between 24% and 83% said they recalled specific messages. The messages that respondents recalled most seemed to be associated with various demographic characteristics of the population--a fact which suggests both that highly targeted educational programming that emphasizes the effects of the epidemic on Black people should be employed in the Black community and that particular at-risk segments of the Black population--such as women, parents, IVDUs, bisexuals, etc.--can be targeted effectively.

Conclusion

There is little reason for optimism--but pessimism is not justified either. Although those at highest risk have not substantially reduced their risks despite their high levels of knowledge about AIDS, their acquaintance with PWAs, and their sense of personal vulnerability, these factors provide a basis for developing effective risk reduction strategies.

To do so, however, prevention efforts need to be more carefully targeted on various "market segments." The population that is not at risk has to be supported in maintaining safe behaviors and the general message that AIDS is having a disproportionate effect on Blacks has to continue to be emphasized. Those segments of the population that seem as a result of educational deficits to not have gotten the basic information about AIDS need continuing information efforts aimed at them as well. For those most at risk however, efforts need to move beyond the provision of general information about AIDS transmission to a focus on personalized risk assessment, emphasis on the de-coupling of sex and drugs, increased clarity about the effectiveness of various risk reduction strategies, skill building in risk reduction, and the development of new community norms around issues such as condom use and needle cleaning.

The media through which prevention messages are delivered also needs careful consideration. The messages that were recalled most frequently by respondents were not those that were broadcast on television and radio for the most part. The major CDC sponsored "America Responds to AIDS" message was recalled by only 57% of the respondents and even the spot that the campaign specifically targeted Blacks, "Why did my Daddy die of AIDS?" only had a recall level of 36%. In contrast, the most highly recalled messages, "Black People Get AIDS Too," "AIDS kill women and babies," and

**CALIFORNIA STATEWIDE HIV/AIDS NETWORKS CONFERENCE
AMERICAN RED CROSS
MAY 3, 1991**

AGENDA

TIME

Luncheon

12:00 - 1:30 p.m.

Introduction/Welcome : Ms. Margo Malarkey,
Director H & S
introduces, Ms. Sue
Richter, VP/GM of WOH

Patrick Baker, Chair of
California SWN

Rafael Oyala, National
Project Leader for SWN.

Jesse S. Valencia,
HIV Specialist at WOH

SWN Conference meeting:
* Laurel Room

1:30 - 3:00 p.m.

SWN's Show n' Tell Sessions:

Mary Petersen, Chair
Colorado, SWN

Patty Parsons, Chair
Oregon, SWN

Kay Fisher, Chair
Washington SWN

Jo Hill, Chair
New Mexico SWN

Marylin Shigetani, Chair
Hawaii SWN

Presentations of accomplishments of SWN's, chaired by Patrick
Baker.

Break

3:00 - 3:15 p.m.

National SWN's overview/update
Rafael Oyala

3:15 - 3:45 p.m.

California SWN update
Patrick Baker

3:45 - 4:00 p.m.

National/CDC update
Jesse S. Valencia

4:00 - 4:30 p.m.

Dinner

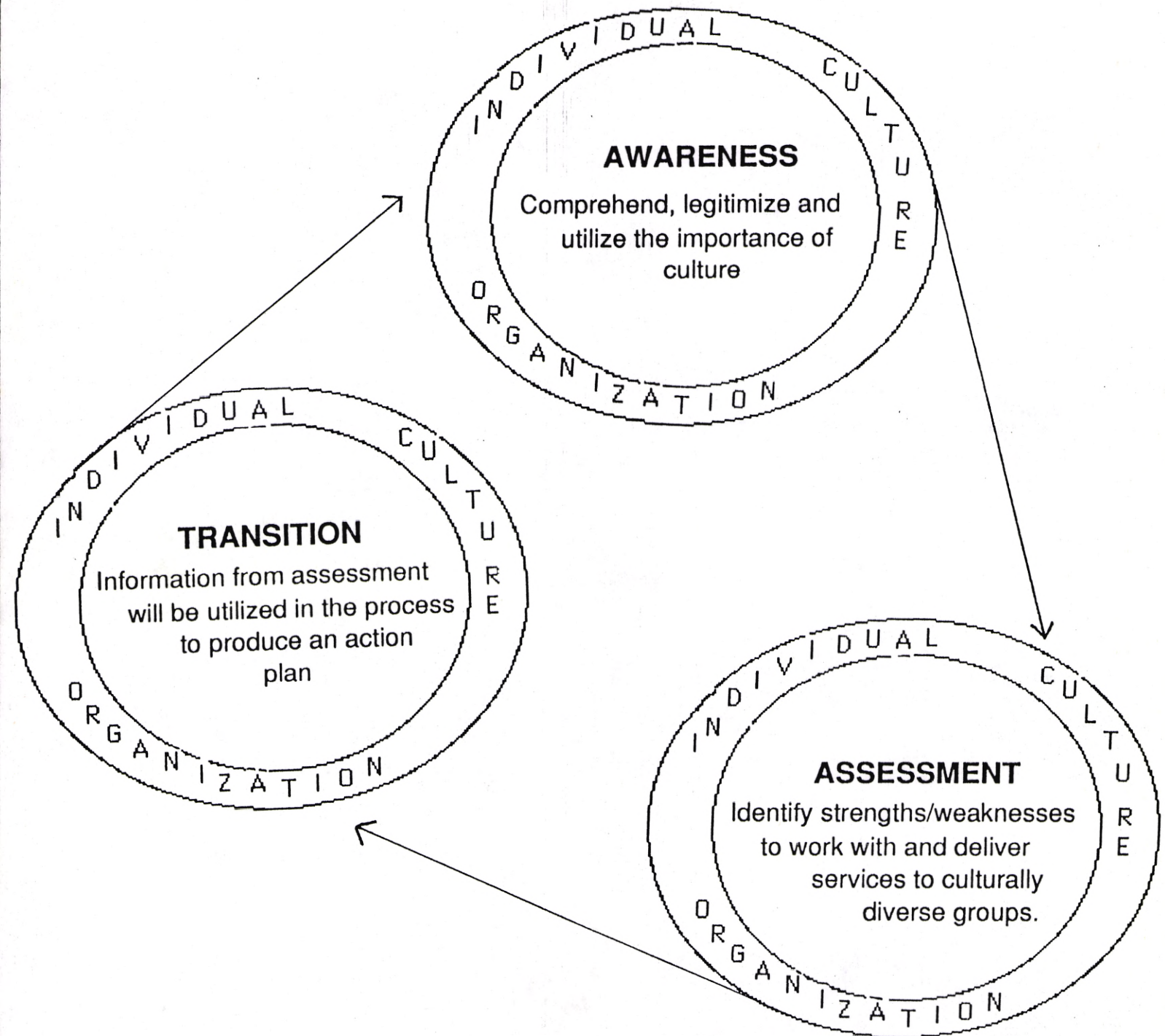
6:30

MULTICULTURAL SYMPOSIUM MAY 4, 1991

AMERICAN RED CROSS

AGENDA	Time
Introduction/Presentation Introduction to Multiculturalism Philosophy and Chronology The impact of Multiculturalism on Service Delivery	9am-10:15
Break	10:15-10:30am
Cultural Specific Focus Groups Development of Cultural Awareness Participants will attend 2 of the 4 groups. Each group will run twice for 45 minutes. Four focus groups: African American Asian/Pacific Islander Native American Hispanic/Latino	10:30am-12pm
Lunch	12pm-1:pm
Presentation: Multicultural Process	1:15pm-1:30pm
Four Multicultural Focus Groups Representative of 4 groups held in morning session. Groups will discuss: Cultural specific sessions Cross Cultural/ Multicultural process.	1:40pm-2:10pm
Break	2:15pm-2:30pm
Presentation: Multicultural System Change Model	2:30pm-3:pm
Same Four Multicultural Focus Groups Groups will discuss: The Next step. How to incorporate what participants have learned Role of Individual and Organization in the change process.	3:10pm-3:50pm
Report Back from Focus Groups	4:pm-4:30pm
Summary/Evaluation	4:30pm-5:pm

MULTICULTURAL SYSTEMS CHANGE MODEL



In any successful organization change process, to address the issues of cultural diversity the entire system needs to participate, i.e. the individual representing the population, the culture representing the collective of individuals, and the organization representing the structure and environment in which they function.

AMERICAN RED CROSS
WESTERN OPERATIONS HEADQUARTERS
HEALTH & SAFETY SERVICES
&
CALIFORNIA STATEWIDE HIV/AIDS NETWORK

MULTI-CULTURALISM SYMPOSIUM
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**AMERICAN RED CROSS
STATEWIDE HIV/AIDS NETWORK**

GOAL AND OBJECTIVES

Goal

In an effort to control the spread of HIV infection and to maximize resources, a statewide system of collaboration will be created in which information is disseminated, collected, and exchanged; specific training needs are addressed; funding resources are identified and utilized; and a structure is developed tailored to meet the needs of the state.

Objectives

1. Strengthen chapter resources through collaboration with other Red Cross units and community based organizations (CBOs).
2. Increase coordination and communication between Red Cross units, state and local public health agencies and other HIV/AIDS serving organizations.
3. Increase coordination and communication between and among chapters, stations, field service territories, and blood regions.
4. Heighten Red Cross identity throughout the state as a leader in HIV/AIDS education.
5. Standardize and Solidify multi-jurisdictional training contracts.
6. Establish and increase the training sites within the state for specific HIV/AIDS education programs.
7. Increase communications between state legislators and Red Cross units regarding pending or new legislation related to HIV/AIDS.
8. Develop a unified approach to Department of Health and Board of Education and funding resources.
9. Provide mechanism for quality control of programs and individuals within the state.
10. Assist in timely identification of problems.
11. Develop volunteer leadership.
12. Standardize training and roll out of new products.
13. Increase funding potential.

Chapter XI

Collaborative Agreements

Section 1

Collaboration: How and Why?

Collaboration is the result of joint efforts of different groups working toward a common goal. Collaboration can happen within organizations, but more commonly, it is an effort involving two or more independent organizations. Collaboration between HIV/AIDS-oriented groups and groups outside the AIDS effort which possess special expertise—in advertising, for example, or legal aid—can be particularly fruitful. No matter what type of organization is involved, the same factors that enhance collaboration can also undermine it.

How Do Organizations Collaborate?

A collaborative relationship takes many forms. The variety of ways in which organizations collaborate reflects the different levels of involvement partners can choose. Some examples of involvement include:

- Referral (Directing people to appropriate services.)
- Information sharing and technical assistance (Sharing surveillance data, expertise on program planning)
- Providing or receiving resources (Grant money, office space, or materials.)
- Participation in community policy making and planning (Involvement can range from minimal to intense, from being present at meetings to joining forces for greater lobbying power.)
- Joint development and implementation of materials or activities (Health fairs, pamphlets, a speakers' bureau, or a counseling center.)

Why Collaborate?

Messages are most effective when they come from multiple sources. When people at risk for HIV infection hear the same risk reduction message on television, from an outreach worker with whom they identify, in a pamphlet from the library, and at a local cultural festival, they may change their behavior. Collaboration can ensure multiple sources for risk reduction messages.

Organizations have different areas of expertise and influence depending on their focus, constituency, or length of service in the community. The expertise includes knowledge of attitudes, knowledge, beliefs, and practices. It could also include skills in knowing

what techniques will work and how to carry them out.

Influence or rapport is equally important to effective risk reduction education efforts. Most people seek information from someone with whom they identify, communicate easily with, and trust. Some organizations have rapport or influence with political decision-makers, the media, the community-at-large, funding sources, or people with HIV infection and AIDS. The combinations, possibilities, and needs for collaboration are limitless.

Section 2

Barriers to Collaboration

Collaboration is not always easy. First of all, certain barriers to collaboration are specific to working in HIV/AIDS. Even after more than five years of general publicity about the disease, someone with whom you would like to collaborate may react with fear or hostility when you mention involvement with AIDS. Even if you do not encounter this reaction, you may discover that a collaboration partner lacks knowledge or has erroneous beliefs about HIV/AIDS.

The same barriers—fear and hostility, lack of knowledge—can occur if your organization serves a population that mainstream America has traditionally assigned, legally or culturally, to “the outside.” These people include IV drug users, prostitutes, prisoners, undocumented immigrants, and in some areas, bisexuals and homosexuals. Judgmental or phobic attitudes about these people can make collaboration extremely difficult.

Community politics can be barriers to collaboration. Some community leaders or organizations, for example, may decide it is politically unwise to collaborate with your organization because of its association with HIV/AIDS, its constituency, its policies or methods. The political atmosphere of a community may encourage competition between local tradition of antagonism between certain organizations is so entrenched it prevents collaboration.

The most common barriers to collaboration transcend the area of HIV/AIDS: it takes time to collaborate. We are busy and pressured. Often it seems easier to do a task ourselves rather than getting others involved.

Our capacity for loyalty, when applied to organizations or individuals we are trying to reach, sometimes causes us to approach collaboration with other organizations with mistrust rather than with openness. And, being sensitive to what is fair, we are bothered if a collaborative relationship seems one-sided—all “give” with little “take”—or if there is no evidence of commitment or genuine interest from our partner.

Poor communication creates many barriers to collaboration. The problem can be as simple as not being able to get through to a collaborator on the phone or not having calls returned. Often, however, poor communication goes deeper. For example, two organizations may enthusiastically agree to work together on a project without knowing much about each other. They may not know if their goals, resources, constituents, and meth-

ods are common or complementary. They may not clearly define which of them will do what when. This leaves the project to operate on assumptions, which can turn out to be disastrously wrong.

Assumptions and unspoken, unconfirmed expectations also lead easily to mistrust, accusation, and the resurfacing of old negative beliefs. (Example: Under stress, a large, established organization may accuse a small, grass-roots group of being hostile and uncooperative; the small group retaliates by charging the larger group with bureaucratic indifference.)

Finally, poor communication occurs when partners are not honest or open with each other. It is hard to regain trust if one collaboration partner finds out that the other held back information or if one perceives that the other is not taking the other organization seriously. It can be hard to give and to receive criticism, and it is difficult to compromise.

Section 3

Factors That Enhance Collaboration

Most factors that enhance collaboration are grounded in common sense. A partner's knowledge about and sensitivity to HIV/AIDS issues, or to cultural or ethnic differences, can make collaboration easier. If a partner is not knowledgeable, then a genuine openness to becoming knowledgeable and sensitive is essential. If none of these characteristics describe a potential collaborator, then patience, persistence, and a willingness to educate your partner are essential.

In dealing with community politics, gaining influential allies in the community can strengthen collaboration. A local celebrity or public figure may openly support your efforts or work quietly behind the scenes on behalf of a collaboration. When there is a history of competition or antagonism between organizations, an infusion of new staff unencumbered by old issues can make a new start.

Evidence of commitment to the collaboration and its value is important in building a relationship. Evidence might simply be an organization's consistent willingness to "go the extra mile"; or it might be a concrete gesture such as a tour of partner's facility, attendance at a national conference to learn more about a relevant topic, or the printing of collaborators' names on a brochure or program.

Effective communication is a cornerstone of a productive working relationship. This means spending the time, effort, and honesty to clarify goals, objectives, roles, and strategies when making plans. This also means giving and receiving feedback—positive and negative—striving always to be constructive. Being willing to support your opinions and suggestions with clear rationale is part of honest communication; so is really listening to what your partner has to say. honest communication can require uncomfortable feelings and situations such as confrontation or, conversely, admitting blame. There is nothing that builds stronger bridges than good communication.

Also at the heart of successful collaboration are patience, persistence, and openness. A

willingness to give a partner a chance—and another chance—and a third. Finally, it is important to “keep your eyes on the prize”: to affirm and reaffirm your goals in collaborating. Discussing and agreeing on a goal or objective with your collaborator gives you a mutual rallying point, something you both have in common. Goals keep competitiveness, jealousies, and other roadblocks to collaboration at a minimum. Thinking in terms of ultimate rather than immediate outcomes can help when it feels as if collaboration is taking too much time. Collaboration comes easily to some people; they seem to have been born with the skill to achieve it. You can learn about collaborations that have worked by talking with other organizations in your community or finding out about programs similar to yours in the Clearinghouse and contacting people in those programs. You can contact the National AIDS Information Clearinghouse by calling (301) 762-5111.

Section 4

Steps to Collaboration

The ideas about collaboration we have discussed are presented below in chronological order. Use this list as a guide for effective collaboration.

1. Identify an organization with whom collaboration is necessary or beneficial, as well as contact persons within the organization. If you do not already know whom to contact, ask around. You should be able to get their names from other organization and your own:
2. Find out as much as possible about the organization and its HIV/AIDS prevention activities. Consider these questions about the other organization and your own?
 - What are your respective HIV/AIDS prevention goals? Are they the same? Complementary? How?
 - What roles do you foresee in the collaboration?
 - What can you offer the organization?
What do you want from them?
 - What are your present limitations?
3. Gain support within your organization for the proposed collaboration. Show how you expect it to benefit all involved.
4. Make an appointment with the key individuals you identified from the organization. Think in advance of possible factors that could enhance or hinder collaboration that you might encounter. Envision what you might do to overcome barriers.
5. Meet with potential collaborators. Talk honestly and convincingly. More important, listen. Realize that a trusting and productive

American Nurses Association

American Red Cross leadership and American Nurses Association (ANA) leadership representatives have met to explore ways the two organizations can work together to increase nurse involvement in Red Cross activities.

The ANA has endorsed Red Cross HIV/AIDS educational materials and alerted state nurses associations about the availability of these materials.

These meetings grew out of a resolution adopted by the ANA House of Delegates in 1986 calling for more appropriate involvement of registered nurses in the work of the American Red Cross, specifically related to HIV/AIDS education.

A. Philip Randolph Institute

The A. Philip Randolph Institute with its 187 chapters in 37 states will cooperate with the American Red Cross in increasing the participation of Blacks in service and involvement in the programs of the American Red Cross.

This Statement of Understanding establishes a working relationship between the A. Philip Randolph Institute and the American Red Cross. It provides the broad framework for cooperation between these organization at the national, state, and local levels. Both the American Red Cross and the A. Philip Randolph Institute recognize the potential benefits to be realized by both organizations and the Black community through collaboration.

Black Shriners

On August 16, 1986, the American Red Cross signed a Statement of Understanding with the Ancient Egyptian Arabic Order Nobles of the Mystic Shrine, North and South America, Inc., and its Auxiliary, Imperial Court, Daughters of Isis.

The Imperial Court, Daughters of Isis, and Auxiliary recognize the importance of health promotion and disease prevention and can lend leadership in working with the Black community as well as the general population.

Food and Drug Administration

The American Red Cross Blood Services announced a voluntary agreement with the Food and Drug Administration (FDA) on September 14, 1988 to further ensure a safer blood supply. The agreement followed the completion of internal reviews of blood services regions by the Red Cross and the FDA.

relationship is not instant, but takes time, perseverance, and proof of commitment. Be ready to compromise. Be flexible.

6. Sketch out a plan. Decide who will do what, how, and when.
7. Talk as often as necessary. Be accessible.
8. Give equally. Do not ask without giving in return.
9. From time to time, compare notes on how well the collaboration is working. Do this during both the ups and downs of the relationship.
- 10 Celebrate when collaboration is successful. Share your secrets of success with others.

Conclusion

Two factors make collaborating to prevent AIDS a real challenge. The first is that we are human. The second is that AIDS is inhuman; fighting it in our communities requires inordinate amounts of time, money, and dedication. Few resources are left over with which to nurse a problematic collaborative relationship. Yet we must collaborate in order to bring together the most powerful and effective forces against this problem.

Section 5

Red Cross Collaborative Agreements

The American Red Cross has formed partnerships with the American Council of Life Insurance and the Health Insurance Association of America, as well as with the U.S. Public Health Service and the Centers for Disease Control in the development and dissemination of materials. The Red Cross has many statements of understanding and collaborative agreements with a variety of organizations at the national level.

The American Red Cross has a number of collaborative agreements with organizations. Some are written agreements or formal contracts. Others are unwritten communication between executives.

The following are organizations that we have collaborative agreements with and a summary of that agreement:

American Federation of Teachers

A Statement of Understanding was signed in July, 1988 between the American Red Cross and the American Federation of Teachers. This Statement of Understanding was signed so that young people of America can receive better educational services and assistance through the American Red Cross.

Head Start

A Statement of Understanding was signed between the American Red Cross and Project Head Start on December 12, 1984. This partnership is to promote coordination at the national, regional, and community levels between the American Red Cross and the Head Start Bureau, Administration for Children, Youth, and Families, Office of Human Development Services, U.S. Department of Health and Human Services, and to promote outreach to low-income families by making available to these families Red Cross programs in health, parent education, and nutrition and by referring eligible parents to the programs and services of Head Start.

Red Cross units are encouraged to contact local Head Start programs to share information about courses and programs, such as nutrition, parenting, first aid, and other health-promotion and disease-prevention programs, available to Head Start parents, staff, and children, and to plan methods of implementation with the Head Start director.

Indian Health Services

The American Red Cross announced a collaboration with the Indian Health Services, the Bureau of Indian Affairs, and the Administration for Native Americans in August, 1988. This established a partnership at the national level that will result in the development and implementation of health initiatives directed to Indian people.

Junior League

Leaders of the American Red Cross met with officers of the Association of Junior Leagues on July 22, 1987, and agreed the two organizations should work together in the fight against HIV/AIDS.

Red Cross President Richard Schubert and Junior League President Virginia Austin agreed that local Red Cross and Junior League units should contact each other and determine which service groups in their area are disseminating HIV/AIDS information.

National Association of Community Health Centers, Inc.

A Statement of Understanding was signed January 30, 1984. This relationship between the National Association of Community Health Centers, Inc. (NACHC) and the American Red Cross will enable cooperation and collaboration between the two organizations to advance health-promotion and disease-prevention programs among underserved populations in urban and rural settings.

NACHC facilitates a community health center's ability to provide quality health services to the community it serves.

National Urban League

The American Red Cross and the National Urban League joined in a collaborative HIV/AIDS education effort in June, 1987 in order to reach urban areas with reliable information and education.

Together, the two national organizations seek to distribute information through the Urban League affiliates and Red Cross chapters. The two organizations will communicate on a local level to determine what approach best suits community needs and then work together to complete the project.

SOME POINTS TO REMEMBER ABOUT CROSS-CULTURAL RELATIONSHIPS

1. What seems to be logical, sensible, important and reasonable to a person in one culture may seem stupid, irrational and unimportant to an outsider.
2. Feelings of apprehension, loneliness, lack of confidence are common when visiting another culture.
3. When people talk about other cultures, they tend to describe the differences and not the similarities.
4. Differences between cultures are generally seen as threatening and described in negative terms.
5. Personal observations and reports of other cultures should be regarded with a great deal of skepticism.
6. One should make up one's own mind about another culture and not rely on the reports and experiences of others.
7. It requires experience as well as study to understand the many subtleties of another culture.
8. Understanding another culture is a continuous and not a discrete process.
9. Stereotyping is probably inevitable in the absence of frequent contact or study.
10. The feelings which people have for their own language are not often evident until they encounter another language.
11. People often feel that their own language is far superior to other languages.
12. It is probably necessary to know the language of a foreign culture to understand the culture in depth.

DO'S AND DON'TS FOR BETTER HUMAN RELATIONS
AMONG ETHNIC GROUPS

1. Be aware of words, images and situations that suggest that all or most members of a racial or ethnic group are the same.

2. Avoid using qualifiers that reinforce racial and ethnic stereotypes.

Does this sentence.....contain this hidden stereotype

The articulate Black professor. Blacks lack intelligence, verbal skills.

3. Avoid racial identification except when it is essential to communication.

NO

YES

Judy, an outgoing Black woman....

Judy, an outgoing woman....

4. Avoid using ethnic cliches.

5. Be aware of the possible negative implications of color symbolic terms. Choose language and usage that do not offend people or reinforce bias.

Example - black market
 black magic

6. Be aware of language that, to some, has questionable racial or ethnic connotations.

Example - culturally deprived
 culturally disadvantaged

7. Avoid patronizing tokenism with regard to any racial or ethnic group.

HOW TO DECREASE CROSS-CULTURAL BARRIERS

Listed below are some ways that may help you decrease cross-cultural communication barriers.

1. LANGUAGE

- a. Learn the language.
- b. Find someone who can speak the language.
- c. Ask for clarification if you are not sure what the person said.

2. NON-VERBAL COMMUNICATION

- a. Do not assume you understand any non-verbal communication unless you are familiar with the culture.
- b. If the non-verbal communication is insulting in your culture, do not take it personally.
- c. Develop an awareness of your own non-verbal communication which might be insulting in certain cultures.

3. PRECONCEPTIONS AND STEREOTYPES

- a. Make every effort to increase awareness of your own preconceptions and stereotypes of cultures you encounter.
- b. With this awareness, reinterpret their behavior from their cultural perspective.
- c. Be willing to test, adapt, and change your own stereotypes to fit your new experiences.

4. EVALUATION

- a. Maintain objectivity.
- b. Recognize that you cannot change a person's culture overnight.
- c. Do not judge someone from another culture by your own cultural values until you have come to know them and their cultural values first.

5. STRESS

Cross-cultural situations are often ambiguous and result in stress because you are not sure what others expect of us or what you can expect of them. As cross-cultural barriers are reduced, you can expect the level of stress to diminish.

NATIONAL AIDS HOTLINE

1-800-342-AIDS

(1-800-342-2437)

**INFORMATION • EDUCATION • REFERRALS
24 HOURS/DAY • 365 DAYS/YEAR**

The National AIDS Hotline Services

The National AIDS Hotline is a toll-free service of the U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control (CDC). The Hotline provides callers with confidential information and referrals and can arrange for the mailing of free, written materials. Callers to the National AIDS Hotline number, **1-800-342-AIDS (342-2437)**, are able to speak with Information Specialists who can answer their questions about HIV infection and AIDS, and provide appropriate referrals to meet their individual needs.

Information Specialists at the National AIDS Hotline receive specialized training on HIV/AIDS information, communication skills, and identification of appropriate local or national resources. Information Specialists use a computerized system to access the referral database of approximately **10,000** local and national organizations.

All services of the National AIDS Hotline are **free and confidential**. Callers who want general information about HIV infection or AIDS, or who may have very sensitive or personal questions are able to speak with specially trained staff who will listen to their concerns, and provide information and referral services which meet their individual needs.

Spanish Service: 1-800-344-SIDA

Spanish-speaking callers may call **1-800-344-SIDA (344-7432)** between the hours of 8am and 2am Eastern Time to speak with native Spanish-speaking Information Specialists. This service is available 7 days a week. A recorded message, in Spanish, with basic information about HIV infection and prevention is available between 2am and 8am Eastern Time.

TTY/TDD Access: 1-800-AIDS-TTY

Deaf callers who have access to a TTY (teletypewriter) machine may dial **1-800-AIDS-TTY (243-7889)** to reach Information Specialists who are skilled in English and American Sign Language (ASL). The TTY/TDD lines are staffed between 10am and 10pm Eastern Time, Monday through Friday. During the weekend, and between the hours of 10pm and 10am weekdays, callers receive a pre-recorded message informing them about HIV infection, AIDS, and methods to reduce the risk of transmission.

**FREE PUBLICATIONS,
BROCHURES AND POSTERS
AVAILABLE**

THE NATIONAL AIDS HOTLINE: YOUR RESOURCE

The National AIDS Hotline:

- is the world's largest health-related information hotline
- received over 1,000,000 calls in 1989, gave 400,000 referrals and took orders for over 1,000,000 publications
- offers HIV/AIDS information for the public 24 hours a day, 7 days a week
- offers a contact point that can be used as a referral for local hotlines during hours when they are not in operation (holidays, overnight, etc.).
- offers Spanish language services through SIDA lines 1-800-344-SIDA (344-7432). These information specialists are not only bilingual but bicultural and thus understand the special needs of the Hispanic population.
- offers teletypewriter (TTY) 1-800-AIDS-TTY (243-7889) services for the Deaf. TTY information specialists are fluent in both English and American Sign Language (ASL) and understand the cultural differences existent within the Deaf Community.
- can supply local Health Departments, health educators, clinics and others with a readily available resource for their clients. Cards and flyers about the National AIDS Hotline are also available for distribution to clients. The Hotline can be used to provide reinforcement and clarification of HIV/AIDS information.

The National AIDS Hotline (NAH) is a toll-free service of the U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control (CDC). NAH communicates with all levels of the American public. As the primary contact point, NAH provides trained information specialists, who, when appropriate utilize a large referral database to give callers local reference points for a variety of HIV/AIDS services. By providing written information as well, NAH brings to a close the circle of integrated communication, each segment playing a vital role.

1-800-342-AIDS

Conference attendees

May 3, 1991

Jesse S. Valencia

WOH support & HIV/AIDS
informational update.

The HIV/AIDS unit of Western Operations Health and Safety department is here to support your efforts in the area of HIV/AIDS services, programs and activities. To this extent, this brief overview will provide you with the parameters of our support.

- Consultation: We can provide assistance in the area of programmatic consultation in any area as it relates to HIV/AIDS.
- Rollouts/implementation/training/s: Upon your request, we can provide support and assistance with any training in your jurisdiction, provide faculty, assist with recruitment, logistics and implementation.
- Informational resource: We can provide you with the most current information regarding our National HIV/AIDS programs and products.
- Multicultural inclusiveness: We are prepared to assist with information and resources that will enhance your efforts to be pro-active in the areas of multicultural inclusiveness as it relates to HIV/AIDS.
- Program design/evaluation: We can assist and support your efforts in program design and in the development of an evaluation tool that will reflect the goals and objectives of your program design.
- Field support: Upon request, we can assist with exhibits, conferences, workshops and the planning of same.
- Marketing: Upon request, we can assist with the marketing of specific programs ie. (Latino and African American AIDS prevention programs).
- Resource Library: Available at your request, is the HIV/AIDS resource (lending) library. We have information through videos, slides, audio tapes, transparencies, books and guides, directories, reports, subscriptions and duplicated materials. All materials have as their focus HIV/AIDS.

Page 2

To: Conference attendees

Date: May 3, 1991

Subject: WOH support & HIV/AIDS informational update.

The following represents an overview of the current status of our national HIV/AIDS programs.

- Hispanic HIV/AIDS prevention program for youth and families: Currently, the rollouts/implementation and trainings of Instructors for this specialization course are underway in all jurisdiction (WOH, MOH & EOH). It is expected that the rollouts will be completed by mid-May of this fiscal year, and we will have impacted over 1,000 persons with this new and vital much need program.
- African American HIV/AIDS prevention program for youth and families: The undertaking of the rollout implementation and training associated with this program are currently underway in each of the Operations jurisdictions. Completion of the preliminary rollouts are expected by mid-May of this fiscal year. This program will have impacted over 1,000 persons, with this culturally specific information.
- Workplace HIV/AIDS program: Under review and revision, is our national "Workplace program". Currently, the Instructor's Manual is under revision and review, as is the new support video "Working America: Living with AIDS" which will replace, Working Beyond Fear. Included in the new Workplace program will be support materials ie. Instructor Training Guide, Instructor Training video, Marketing video, Guide, Kit and Brochure.
- Chapter Grants: Notification to the field will be forthcoming regarding the second (2nd.) Request For Proposals (RFP) for our Chapter Grants. The grant process will include funding in the following areas, mini-grants, culturally specific and creative/innovative outreach.
- Statewide HIV/AIDS Networks (SWN).: SWN's are a nationally supported project through funding from the Centers for Disease Control. Within WOH jurisdiction Hawaii, California, Washington, New Mexico, Utah, Colorado and Oregon currently have SWN's groups and advisory committees. The SWN's afford training opportunities, informational updates, networking, outreach and support to participating field units within the state. Community based organizations, local health departments and the State Office of AIDS are also part of the constituency of the SWN's.

Page 3.

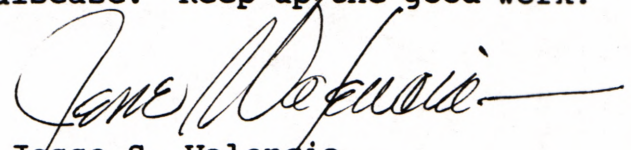
To: Conference attendees

Date: May 3, 1991

Subject: WOH support & HIV/AIDS informational update.

The information provide in this document is for your use and that of your field units as an informational update. We at WOH are here to serve you upon request. Please feel free to call me at any time with your request for assistance or information. I can be contacted at (415) 375-7280, remember, we are here to enhance your efforts in the area of HIV/AIDS.

Give us a call, if we can be of service, and please continue with your efforts to impact this deadly disease. Keep up the good work!

A handwritten signature in dark ink, appearing to read "Jesse Valencia", with a long horizontal flourish extending to the right.

Jesse S. Valencia
HIV Specialist
Western Operations



AIDS Information Exchange

Geographical Index to Foundations Funding AIDS

NATIONAL

AT&T Foundation
C.S. Fund
Chicago Resource Center
Clark (The Edna McConnell) Foundation
Commonwealth Fund, The
Design and Interior Furnishing Foundation for AIDS
Ford Foundation, The
Gannett Foundation, Inc.
Hearst Foundation, Inc.
Itleson Foundation, Inc.
Johnson (The Robert Wood) Foundation
Kaiser (The Henry J.) Family Foundation
Kresge Foundation, The
Levi Strauss Foundation
Mac Arthur (J. Roderick) Foundation
Mac Arthur (John D. and Catherine T.) Foundation
Maurice Falk Medical Fund
McKnight Foundation, The
Mertz-Gilmore (Joyce) Foundation
Metropolitan Life Foundation
New York Life Foundation
New York Life Insurance Co.
Petrus Crowe Fund
Pew Memorial Trust
Primerica Foundation
Public Welfare Foundation, Inc.
Rockefeller Brothers Fund
Sloan (Alfred P.) Foundation
Spencer Foundation, The
Starr Foundation, The
Warwick (Dionne) Foundation, The

EASTERN U.S.

Dana (The Charles A.) Foundation
Phillips (Ellis L.) Foundation
Van Ameringen Foundation, Inc.

ARIZONA

Mountain Bell Foundation

ARKANSAS

Levi Strauss Foundation

CALIFORNIA

Ahmanson Foundation, The (Southern CA)
Atkinson Foundation (San Mateo County)
California Community Foundation
Dayton Hudson Foundation
Flintridge Foundation
Gerbode (Wallace Alexander) Foundation
Goldman (Richard and Rhoda) Foundation (San Francisco Bay)
Irvine (The James) Foundation
Kaiser (The Henry J.) Family Foundation (San Francisco Bay)
Levi Strauss Foundation
Marin Community Foundation (Marin County)
Pacific Mutual Foundation (Orange County)
Parker Foundation, The (San Diego County)
San Francisco Foundation, The
Sierra Foundation, The (El Dorado and Nevada Counties)
Skaggs (L.J.) and Mary C. Skaggs Foundation
Times Mirror Foundation, The
Van Lobel Sels (Ernst D.)-Eleanor Slate Van Lobel
Sels Charitable Foundation (Northern CA)
Zellerbach Family Fund, The (San Francisco Bay Area)

COLORADO

Colorado Trust, The
Denver Foundation, The (Denver)
Mountain Bell Foundation

CONNECTICUT

Connecticut Mutual Life Foundation, Inc. (Hartford)
Five Town Foundation (Darien, Norwalk, Wilton, Weston, Westport)
Hartford Foundation For Public Giving
New Haven Foundation, The (South Central CT)

DISTRICT OF COLUMBIA

Meyer (Eugene and Agnes E.) Foundation
Van Ameringen Foundation, Inc.
Washington, Inc., Community Foundation of Greater

FLORIDA

Dade Foundation (Dade County)

GEORGIA

Atlanta Community Foundation, Inc. Metropolitan
Levi Strauss Foundation

HAWAII

Gerbode (Wallace Alexander) Foundation

IDAHO

Mountain Bell Foundation

ILLINOIS

Borg-Warner Foundation, Inc. (Chicago, IL area)

Chicago Community Trust (Cook County, IL)

McCormick (Robert R. Charitable Trust (Chicago)

KANSAS

Oppenstein Brothers Foundation

MARYLAND

Goldseker (Morris) Foundation of Maryland, Inc. (Baltimore)

Meyer (Eugene and Agnes E.) Foundation

MASSACHUSETTS

Dayton Hudson Foundation

Hyams (Godfrey M.) Trust (Boston Metropolitan Area)

Van Ameringen Foundation, Inc.

MICHIGAN

Dayton Hudson Foundation

MINNESOTA

Bremmer (Otto) Foundation

Dayton Hudson Foundation

Gamble the (B.B.) and P.W. Skogmo Foundation (Minneapolis-St. Paul)

Minneapolis Foundation, The (Minneapolis-St. Paul seven county area)

St. Paul Foundation (St. Paul-Minneapolis metropolitan area)

MISSOURI

Oppenstein Brothers Foundation

MONTANA

Mountain Bell Foundation

NEVADA

Bremmer (Otto) Foundation

Levi Strauss Foundation

Pacific Telesis Foundation

NEW MEXICO

Levi Strauss Foundation

Mountain Bell Foundation

NEW YORK

Booth Ferris Foundation (New York Metropolitan area)

Buffalo Foundation, The (Erie County)

Calder (The Louis) Foundation (New York)

Central New York Community Foundation, Inc. (Onondaga, Madison Counties)

Diamond (The Aaron) Foundation (New York)

Emerson (Fred L.) Foundation, Inc. (Central New York area)

Fund for the City of New York, Inc. (New York City)

Hoyt (Stewart W. and Wilma C.) Foundation (Broome County))

New York Community Trust (New York City)

New York Foundation (New York City metropolitan area)

Revson (Charles H.) Foundation (New York City)

Rochester Area Foundation

Rubinstein (Helena) Foundation (New York City)

Scherman Foundation, Inc., The (New York City)

United Hospital Fund (New York City)

Utica Foundation, Inc. (Utica, Oneida, and Herkimer counties)

Van Ameringen Foundation, Inc.

Wein (Lawrence A.) Foundation, Inc. (NYC)

NORTH CAROLINA

Reynolds (Z. Smith) Foundation

OHIO

Cleveland Foundation (Cleveland area)

OREGON

Flintridge Foundation

PENNSYLVANIA

Dolfinger-McMahon Foundation (Philadelphia area)

Foerderer (Percival E. and Ethel Brown) Foundation (Philadelphia)

Harrisburg Foundation, The Greater

Philadelphia Foundation, The

(Philadelphia, Bucks, Chester, Delaware, Montgomery Counties)

Pittsburgh Foundation (Pittsburgh and Allegheny counties)

Van Ameringen Foundation, Inc.

RHODE ISLAND

Rhode Island Foundation

TEXAS

Dayton Hudson Foundation

El Paso Community Foundation (El Paso area)

Haas (Paul and Mary) Foundation (Corpus Christi)

Meadows Foundation

Moody Foundation

Smith (W.W.) Charitable Trust

UTAH

Mountain Bell Foundation

VIRGINIA

Levi Strauss Foundation

Meyer (Eugene and Agnes E.) Foundation

WASHINGTON

Flintridge Foundation

Seattle Foundation, The (Seattle area)

WISCONSIN

Bremmer (Otto) Foundation

La Crosse Foundation (La Crosse County)

Milwaukee Foundation, WI

WYOMING

Mountain Bell Foundation

Prepared by Sara M. Wilson



AIDS Information Exchange

Volume 5, Number 5

August 1988

Funding Sources for AIDS Activities

*Prepared for the 2nd National Conference on the Prevention of
HIV Infection Among Racial and Ethnic Minorities in the U.S.*

August 15-17, 1988, Washington, DC

Private foundation support for AIDS-related activities—including services, education and research—represents an important resource for organizations seeking to initiate and expand their efforts. This issue of *AIDS Information Exchange* provides a catalog of foundation support for AIDS programs and is designed to assist groups in seeking funding sources.

Foundations are listed alphabetically and include: address, telephone, cumulative dollar value of AIDS grants to date, contact person, limitations of awards (e.g., geographic, dollar amounts), and application information.

A major source of information for this listing was a comprehensive report prepared by The Foundation Center entitled *AIDS: A Status Report on Foundation Funding* (October 1987) (available for \$20 plus \$2 postage; contact the Center at (212) 620-4230). The Foundation Center is in the process of completing an updated report, which will be available in the fall.

Additional resources included *AIDS Related Special Project Fund Grants*, a listing of projects supported by The United Hospital Fund; and the *National AIDS Network Monitor* (Volume 2, Number 3, Spring 1988), "Foundations Increase Grants for AIDS." In addition, a number of foundations provided referrals on additional foundations providing grant support for AIDS-related programs.

AT & T FOUNDATION

550 Madison Ave.
New York, NY 10022-3297
(212) 605-6734

NO: 5 AMNT: \$67,500

CONTACT: Sheila A. Connolly, Secy.

LIM: No regional limitations.

APPLICATION INFO:

Initial approach: Letter or proposal

Copies of proposal: 1

Deadline(s): None

AHMANSON FOUNDATION, THE

9215 Wilshire Blvd.
Beverly Hills, CA 90210
(213) 278-0770

NO.: 1 AMNT.: \$150,000

CONTACT: Lee Walcott, V.P.

LIMITATIONS: Limited primarily to southern CA, with an emphasis on Los Angeles, CA.

APPLICATION INFO.:

Initial approach: Proposal or letter

Copies of proposal: 1

Deadline(s): None

ATKINSON FOUNDATION

Ten West Orange Ave.
So. San Francisco, CA 94080
(415) 876-1559

NO: 5 AMNT: \$14,547

CONTACT: Norma Arlen, Admin.

LIMITATIONS: Giving support primarily in San Mateo County, CA.

APPLICATION INFO:

Initial approach: Telephone, proposal or letter

Copies of proposal: 1

Deadline(s): None

—continued, page 2—

USCM AIDS Education Grants

Since 1985, The U.S. Conference of Mayors, in cooperation with the Centers for Disease Control, has provided grant support for community-based AIDS education programs. To date, \$1.63 million has been distributed to over 65 organizations through six funding cycles. Grants are provided in amounts of up to \$42,000 for one year projects. The next funding cycle deadline is Oct. 12, 1988. For further information, contact Matthew Murguia or Debra DeHaney of the Conference of Mayors, (202) 293-7330.

CHICAGO RESOURCE CENTER

209 W Jackson Blvd.
Chicago, IL 60606
(312) 461-9333

NO: 46 AMNT: \$404,518

CONTACT: Mary Anne Snyder, Dir.

LIMITATIONS: No regional restrictions.

APPLICATION INFO:

Initial approach: Proposal.

Copies of proposal: 1

Deadline(s): Dec. 19, Mar. 31, June 30, and Sept 30.

CLARK (THE EDNA MC CONNELL) FOUNDATION

250 Park Ave., Rm. 90
New York, NY 10017
(212) 986-7050

NO: 1 AMNT: \$19,000

CONTACT: Peter D. Bell, Pres.

LIMITATIONS: No regional restrictions.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 1

Deadline(s): None.

CLEVELAND FOUNDATION

1400 Hanna Bldg.
Cleveland, OH 44115
(216) 861-3810

NO: 4 AMNT: \$97,935

CONTACT: Steven A. Minter, Dir.

LIMITATIONS: Giving limited to the greater Cleveland area,
with a primary emphasis on Cleveland and Cuyahoga
County, OH.

APPLICATION INFO:

Initial approach: Letter, proposal, or telephone

Copies of proposal: 2

Deadline(s): Mar. 31, June 15, Aug. 31, and Dec. 15

COLORADO TRUST, THE

One Civic Center Plaza
1560 Broadway, Suite 875
Denver, CO 80202-9697
(303) 837-1200

NO: 1 AMNT: \$31,045

CONTACT: Brian Keplinger, Assoc. Dir., Prog.

LIMITATIONS: Giving Primarily in Colorado.

APPLICATION INFO:

Initial approach: Letter and proposal

Copies of proposal: 3

Deadline(s): None

COMMONWEALTH FUND, THE

One East 75th St.
New York, NY 10021-2692
(212) 535-0400

NO: 1 AMNT: \$5,000

CONTACT: Cynthia H. Woodcock, Asst. V.P.

LIMITATIONS: No regional limitations.

APPLICATION INFO:

Initial approach: Letter or proposal

Copies of proposals: 3

Deadline(s): None

CONNECTICUT MUTUAL LIFE FOUNDATION, INC.

140 Garden St.
Hartford, CT 06154
(203) 727-6621

NO: 1 AMNT: \$25,000

CONTACT: Astinda R. Olds, Asst. V.P.

LIMITATIONS: Given Primarily in the Hartford, CT area.

APPLICATION INFO:

Initial approach: Letter or proposal

Copies of proposal: 1

Deadline(s): None

DADE FOUNDATION

200 So. Biscayne Blvd., Suite 3480
Miami, FL 33131-2343
(305) 371-2711

NO: 1 AMNT: \$4,913

CONTACT: Ruth Shack, Exec. Dir.

LIMITATIONS: Limited to Dade County, FL.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 1

Deadline(s): Submit proposal preferably in Nov.;
deadline Dec. 1

DANA (THE CHARLES A.) FOUNDATION

150 E. 52nd ST., 23rd Fl.
New York, NY 10022
(212) 223-4040

NO: 1 AMNT: \$20,000

CONTACT: Robert N. Kreidler, Pres.

LIMITATIONS: Giving primarily in the eastern U.S.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 1

Deadline(s): None

DAYTON HUDSON FOUNDATION

777 Nicolet Mall
Minneapolis, MN 55402
(612) 370-6553

NO: 1 AMNT: \$20,000

CONTACT: Vivian K. Struck, Admin. Officer

LIM: Giving primarily in areas of company
operations including MN, MI, MA, CA, and TX.

APPLICATION INFO:

Initial approach: Letter with proposal

Copies of proposal: 1

Deadline(s): None

DENVER FOUNDATION, THE

455 Sherman St., Suite 220
Denver, CO 80203
(303) 778-7587

NO: 1 AMNT: \$20,000

CONTACT: Patricia J. Harrington

LIM: Giving limited to within a 40-mile
radius of Denver, CO.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 1

Deadline(s): Dec. 31, Mar. 31, June 30, and Aug 31

**DESIGN AND INTERIOR FURNISHING
FOUNDATION FOR AIDS**

Box 5176
New York, NY 10150
(212) 371-8299
NO: Over 100 AMNT: Over \$1,000,000
CONTACT: Ellen Sokoloff
LIM: No regional limitations
APPLICATION INFO:
Initial approach: Letter
Copies of proposal: 1
Deadline(s): None

DIAMOND (THE AARON) FOUNDATION

1270 Ave. of the Americas, Suite 2624
New York, NY 10020
(212) 757-7680
NO: 9 AMNT: \$2,336,905
CONTACT: Vincent McGee, Exec. Dir.
LIM: Giving primarily in New York, NY.
APPLICATION INFO:
Initial approach: Letter and proposal
Copies of proposal: 1
Deadline(s): None

DOLFINGER-MCMAHON FOUNDATION

One Franklin Plaza, 15th Fl.
Philadelphia, PA 19102
(215) 854-6318
NO: 1 AMNT: \$5,000
CONTACT: Joyce E. Robbins, Exec. Secy.
LIM: Giving limited to the greater Philadelphia, PA area
APPLICATION INFO:
Initial approach: Proposal
Copies of proposal: 2
Deadline(s): Submit proposal preferably in
Mar. or Sept.; deadline Apr. 1 and Oct.

EL PASO COMMUNITY FOUNDATION

Texas Commerce Bank Building, Suite 1616
El Paso, TX 79901
(915) 533-4020
NO: 5 AMNT: \$38,600
CONTACT: Janice W. Windle, Exec. Dir.
LIM: Giving limited to the El Paso, TX area.
APPLICATION INFO:
Initial approach: Proposal with 16 summary sheets
Copies of proposal: 7
Deadline(s): Feb. 5

EMERSON (FRED L.) FOUNDATION, INC.

63 Genesee St.; P.O. Box 276
Auburn, N.Y. 13021
(315) 253-9621
NO: 1 AMNT: \$10,000
CONTACT: Ronald D. West, Exec. Dir. and Secy.
LIM: Giving primarily in the central N.Y. area.
APPLICATION INFO:
Initial approach: Letter, telephone, or proposal
Copies of proposal: 1
Deadline(s): 2 months prior to June and
December board meetings

FIVE TOWN FOUNDATION

4 Maple St.
Norwalk, CT 06850
(203) 582-0815
NO: 1 AMNT: \$1,000
CONTACT: D. W. Norman, Exec. Dir.
LIM: Giving limited to Darien, Norwalk, Wilton,
Weston, and Westport, CT.
APPLICATION INFO:
Initial approach: Telephone
Copies of proposal: 8
Deadline(s): None

FLINTRIDGE FOUNDATION

1100 El Centro St., Suite 103
South Pasadena, CA 91030
(818) 799-4178
NO: 2 AMNT: \$100,000
CONTACT: Jaylene L. Moseley, Managing Dir.
LIM: Giving primarily in CA, OR, and WA.
APPLICATION INFO:
Initial approach: Letter
Deadline(s): None.

**FOERDERER (PERCIVAL E. AND ETHEL
BROWN) FOUNDATION**

P.O. Box 7734
Philadelphia, PA 19101-7734
(215) 828-8145
NO: 1 AMNT: \$5,000
CONTACT: Thomas L. Higgenson, Secy.
LIM: Giving primarily in the Philadelphia, PA area
APPLICATION INFO: No new proposals are being
considered at this time

FORD FOUNDATION, THE

c/o Manufacturers Hanover Trust Co.
600 Fifth Ave.
New York, NY 10020
(212) 957-1595
MAILING ADDRESS:
20 Nassau St., Suite 514
Princeton, NJ 08542
NO: 1 AMNT: \$50,000
CONTACT: Philip W. Havens, Exec. Dir.
LIM: Giving limited to within the U.S.
APPLICATION INFO:
Initial approach: Letter
Copies of proposal: 10
Deadline(s): Submit proposals during months prior to stated
deadlines; Feb 1, Apr. 1, and Sept. 15

FUND FOR THE CITY OF NEW YORK, INC.

419 Park Ave. South, 16th Fl.
New York, NY 10016
(212) 689-1240
NO: 2 AMNT: \$20,000
CONTACT: Anita Nager, Grants Admin.
LIM: Giving limited to NYC.
APPLICATION INFO:
Initial approach: Proposal
Copies of proposal: 1
Deadline(s): None

GAMBLE (THE B.B.) AND P.W. SKOGMO FOUNDATION

821 Marquette Ave., 500 Foshay Tower
Minneapolis, MN 55402
(612) 339-7343

NO: 1 AMNT: \$10,000

CONTACT: Marion G. Etzweiler, Secy. Treas.

LIM: Giving limited to the Minneapolis-St. Paul, MN, metropolitan area.

APPLICATION INFO:

Initial approach: Proposal of five pages or fewer

Copies of proposal: 10

Deadline(s): Apr. 1, and Oct. 1

GANNETT FOUNDATIONS, INC

Lincoln Tower-26th Fl.
Rochester, NY 14604
(716) 262-3315

NO: 11 AMNT: \$450,000

CONTACT: Eugene C. Dorsey, Pres.

LIM: Giving primarily in areas of company operations within the U.S. and Canada.

APPLICATION INFO:

Initial approach: Letter or Proposal

Copies of proposal: 1

Deadline(s): None

GERBODE (WALLACE ALEXANDER) FOUNDATION

470 Columbus Ave., Suite 209
San Francisco, CA 94133
(415) 391-0911

NO: 2 AMNT: \$57,500

CONTACT: Thomas C. Layton, Exec. Dir.

LIM: Giving primarily in programs directly affecting residents of Alameda, Contra Costa, Marin, San Francisco, and San Mateo counties in CA and HI. As a second priority, grants will be made in other northern CA communities.

APPLICATION INFO:

Initial approach: Letter

Deadline(s): None

GOLDMAN (RICHARD AND RHODA) FUND

1090 Sansome St.
San Francisco, CA 94111
(415) 956-4954

NO: 1 AMNT: \$40,000

CONTACT: Duane Silverstein, Exec. Dir.

LIM: Giving primarily in the San Francisco Bay Area, CA.

APPLICATION INFO:

Initial approach: Letter or telephone

Deadline(s): None

GOLDSEKER (MORRIS) FOUNDATION OF MARYLAND, INC.

330 North Charles St.
Baltimore, MD 21201
(301) 837-5100

NO: 1 AMNT: \$8,000

CONTACT: Timothy D. Armbrust

LIM: Giving limited to the Baltimore, MD area

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 1

Deadline(s): Apr. 1, Aug. 1, and Dec. 1

HAAS (PAUL AND MARY) FOUNDATION

P.O. Box 2928
Corpus Christi, TX 78403

NO: 1 AMNT: \$1,000

CONTACT: Paul R. Haas, Trustee

LIM: Giving primarily in the Corpus Christi, TX

APPLICATION INFO:

Initial approach: Proposal

Copies of proposal: 1

Deadline(s): None

HARRISBURG FOUNDATION, THE GREATER

127 Pine St.
Harrisburg, PA 17101
(717) 236-5040

NO: 1 AMNT: \$2,400

CONTACT: Dianne L. Swatskopf

LIM: Giving primarily in PA with an emphasis on Dauphin, Cumberland, Franklin and Perry counties.

APPLICATION INFO:

Initial approach: Letter or proposal

Deadline(s): Apr. 15 for spring round; Sept. 1 for fall round

HARTFORD FOUNDATION FOR PUBLIC GIVING, THE

85 Gillette St.
Hartford, CT 06105
(203) 548-1888

NO: 2 AMNT: Several 100,000

CONTACT: Susan Campbell

LIM: Giving limited to CT non-profit agencies.

APPLICATION INFO:

Initial approach: Letter of intent

Deadline(s): First cycle deadline; Dec. 1

HEARST FOUNDATION, INC.

889 7th Ave.
New York, NY 10106
(212) 586-5404

NO: 2 AMNT: \$60,000

CONTACT: Robert M. Frehse, jr., Exec. Dir.

LIM: Giving limited to the U.S. and its territories.

APPLICATION INFO:

Initial approach: letter or proposal

Copies of proposal: 1

Deadline(s): None

HOYT (STEWART W. & WILMA C.) FOUNDATION

1000 Security Mutual Bldg.
80 Exchange St.
Binghamton, NY 13901
(607) 722-6706

NO: 1 AMNT: \$2,500

CONTACT: Judith C. Peckham, Exec. Dir.

LIM: Giving limited to Broome County, NY.

APPLICATION INFO:

Initial approach: Telephone or letter

Deadline(s): The 1st of months prior to board meetings

Board Meetings: Bimonthly, beginning in Jan.; no grants awarded in Jan.

HYAMS (GODFREY M.) TRUST

One Boston Place, 32nd Fl.
Boston, MA 02108
(617) 725-1520

NO: 1 AMNT: \$20,000

CONTACT: Joan M. Diver

LIM: Giving limited to the Boston, MA, metropolitan area.

APPLICATION INFO:

Initial approach: Proposal

Copies of proposal: 6

Deadline(s): Submit proposal preferably
in fall or winter; no set deadlines

IRVINE (THE JAMES) FOUNDATION

One Market Plaza
Steuart St. Tower, Suite 2305
San Francisco, CA 94105
(415) 777-2244

NO: 1 AMNT: \$100,000

CONTACT: Luz A. Vega, Dir., of Grants Prog.

LIM: Giving limited to CA.

APPLICATION INFO:

Initial approach: Letter

Deadline(s): None

ITTELSON FOUNDATION, INC.

645 Madison Ave., 16th Fl.
New York, NY 10022
(212) 838-6010

NO: 1 AMNT: \$50,000

CONTACT: William T. Beatty II, Exec. Dir.

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 1

Deadline(s): None

JOHNSON (THE ROBERT WOOD) FOUNDATION

P.O. Box 2316
Princeton, NJ 08543-2316
(609) 452-8701

NO: 14 AMNT: \$10,729,005

CONTACT: Edward H. Robbins, Proposal Mgr.

LIM: Giving limited to the U.S.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 1

Deadline(s): None

KAISER (THE HENRY J.) FAMILY FOUNDATION

525 Middlefield Rd., Suite 200
Menlo Park, CA 94025
(415) 329-1000

NO: 6 AMNT: \$75,240

CONTACT: Barbara H. Kehrner, V.P.

LIM: Giving limited to the San Francisco Bay Area, CA for the
Community Grants Program only; other grants nationwide.

APPLICATION INFO:

Initial approach: Letter or telephone

Copies of proposal: 3

Deadline(s): None

KRESGE FOUNDATION, THE

P.O. Box 3151
3215 West Big Beaver Rd.
Troy, MI 48007-3151
(313) 643-9630

NO: 1 AMNT: \$200,000

CONTACT: Alfred H. Taylor, Jr., Pres.

LIM: No regional limitations.

APPLICATION INFO:

Initial approach: Letter or telephone

Deadline(s): None

LA CROSSE FOUNDATION

P.O. Box 489
La Crosse, WI 54602-0489
(608) 782-1148

NO: 1 AMNT: \$1,000

CONTACT: Carol B. Popelka, Prog. Dir.

LIM: Giving limited to La Crosse county, WI.

APPLICATION INFO:

Initial approach: Letter

Deadline(s): Submit proposal preferably 1 month before
committee meetings

Board Meeting Date(s): Apr., June, Sept., and Dec.

LEVI STRAUSS FOUNDATION

1155 Battery St.
P.O. Box 7215
San Francisco, CA 94106
(415) 544-6577

NO: 4 AMNT: \$81,500

CONTACT: Martha Montag Brown

LIM: Giving primarily in areas of company operations in AR, CA,
GA, NV, NM, TX, and VA, and abroad. Some national giving.

APPLICATION INFO:

Initial approach: Letter or proposal

Copies of proposal: 1

Deadline(s): None

MAC ARTHUR (J. RODERICK) FOUNDATION

9333 North Milwaukee Ave.
Niles, IL 60648
(312) 966-0143

NO: 5 AMNT: \$100,000

CONTACT: Lance Lindblom, Pres.

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Letter, proposal, or telephone

Copies of proposal: 1

Deadline(s): None

MAC ARTHUR (JOHN D. AND CATHERINE T.) FOUNDATION

140 South Dearborn St.
Chicago, IL 60603
(312) 726-8000

NO: 1 AMNT: \$300,000

CONTACT: James M. Furman, Exec. Dir.

LIM: No regional limitations

APPLICATION INFO: No further grants specifically for
AIDS to be awarded in the near future.

MARIN COMMUNITY FOUNDATION

1100 Larkspur Landing Circle, Suite 180
Larkspur, CA 94939
(415) 461-3333

NO: 3 AMNT: \$80,487

CONTACT: Intake Coordinator

LIM: Giving limited to Marin county, CA.

APPLICATION INFO:

Initial approach: Letter and proposal

Copies of proposal: 2

Deadline(s): None

MAURICE FALK MEDICAL FUND

3315 Grant Bldg.
Pittsburgh, PA 15219
(412) 261-2485

NO: 3 AMNT: \$5,600

CONTACT: Philip D. Halen

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Letter with 5013C

Copies of proposal: 1

Deadline(s): Oct. 1, and May 1

MC CORMICK (ROBERT R.) CHARITABLE TRUST

435 North Michigan Ave., Suite 1231
Chicago, IL 60611
(312) 222-3512

NO: 1 AMNT: \$40,000

CONTACT: Claude A. Smith, V.P.

LIM: Giving primarily in the Chicago, IL metropolitan area.

APPLICATION INFO:

Initial approach: Proposal

Deadline(s): Submit proposal preferably in Jan., Apr., July,
and Oct.; deadlines Feb 1, May 1, Aug 1, and Nov. 1

MC KNIGHT FOUNDATION, THE

410 Peavey Bldg.
Minneapolis, MN 55402
(612) 333-4220

NO: 1 AMNT: \$150,500

CONTACT: Russel V. Ewald, Exec. V.P.

LIM: No regional restrictions.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 7

Deadline(s): Mar. 1, June 1., Sept. 1, and Dec. 1

MEADOWS FOUNDATION, INC.

Wilson Historic Block
2922 Swiss Ave.
Dallas, TX 75204-5928
(214) 826-9431

NO: 3 AMNT: \$246,004

CONTACT: Dr. Sally R. Lancaster, Exec. V.P.

LIM: Giving limited to TX.

APPLICATION INFO:

Initial approach: Proposal

Copies of proposal: 1

Deadline(s): None

MERTZ-GILMORE (JOYCE) FOUNDATION

218 East 18th St.
New York, NY 10003

NO: 1 AMNT: \$10,000

CONTACT: Larry E. Condon, Pres.

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Letter

Deadline(s): Mar. 1, and Sept. 1

METROPOLITAN LIFE FOUNDATION

One Madison Ave.
New York, NY 10010-3690

NO: 1 AMNT: \$150,000

CONTACT: Sibyl C. Jacobson, Pres.

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Letter

Deadline(s): None

MEYER (EUGENE AND AGNES E.) FOUNDATION

1200 15th St., N.W., Suite 500
Washington, DC 20005
(202) 659-2435

NO: 8 AMNT: \$118,328

CONTACT: Julie L. Rogers, Exec. Sec.

LIM: Mainly giving in the metropolitan Washington,
DC area, including VA and MD

APPLICATION INFO:

Initial approach: Letter or proposal

Copies of proposal: 1

Deadline(s): Dec. 1, Apr. 1, and Aug. 1

MILWAUKEE FOUNDATION, WI

1020 North Broadway
Milwaukee, WI 53202
(212) 586-5404

NO: 2 AMNT: \$32,000

CONTACT: David M. G. Huntington, Exec. Dir.

LIM: Giving limited to the Milwaukee, WI, area.

APPLICATION INFO:

Initial approach: Proposal

Copies of proposal: 1

Deadline(s): Jan. 1, Apr. 1, July 1, and Oct. 1

MINNEAPOLIS FOUNDATION, THE

500 Foshay Tower, 821 Marquette Ave.
Minneapolis, MN 55402
(612) 339-7343

NO: 2 AMNT: \$40,000

CONTACT: Marion G. Elzwiler, Pres.

LIM: Giving primarily in the Minneapolis-St. Paul, MN,
seven county metropolitan area.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 15

Deadline(s): Mar. 15 and Sept. 15

MOODY FOUNDATION, THE

704 Moody National Bank Bldg.
Galveston, TX 77550
(409) 763-5333

NO: 1 AMNT: \$100,000

CONTACT: Peter M. Moore, Grants Officer

LIM: Giving limited to TX

APPLICATION INFO:

Initial approach: Letter or telephone

Deadline(s): 6 weeks prior to board meetings.

Board Meeting Date(s): Quarterly

MOUNTAIN BELL FOUNDATION

1801 California St., Rm. 5010
P.O. Box 1984
Denver, CO 80201
(303) 896-1711

NO: 2 AMNT: \$1,200

CONTACT: Larry Nash, Prog. Officer

LIM: Giving limited to the states served by the Mountain Bell calling areas, including AZ, CO, ID, MT, NM, UT, and WY.

APPLICATION INFO:

Initial approach: Proposal

Deadline(s): None

NEW HAVEN FOUNDATION, THE

One State St.
New Haven, CT 06510
(203) 777-2386

NO: 1 AMNT: \$34,000

CONTACT: Helmer Ekstrom, Dir.

LIM: Giving limited to south central CT.

APPLICATION INFO:

Initial approach: Telephone

Copies of proposal: 14

Deadline(s): Jan., Apr., Aug., and Oct.

NEW YORK COMMUNITY TRUST, THE

415 Madison Ave.
New York, NY 10017
(212) 758-0100

NO: 18 AMNT: \$549,000

CONTACT: Herbert B. West, Dir.

LIM: Giving primarily to New York, NY

APPLICATION INFO:

Initial approach: Proposal with cover letter

Copies of proposal: 1

Deadline(s): None

NEW YORK FOUNDATION

369 Lexington Ave.
New York, NY 10017
(212) 599-0330

NO: 7 AMNT: \$134,000

CONTACT: Ms. Madeline Lee, Exec. Dir.

LIM: Giving primarily within the New York, NY, metropolitan area.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 1

Deadline(s): Nov. 1, Mar. 1 and July 1

NEW YORK LIFE FOUNDATION

51 Madison Ave.
New York, NY 10010
(212) 576-7341

NO: 3 AMNT: \$195,000

CONTACT: Carol Reuter, Exec. Dir.

LIM: No regional limitations.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 1

Deadline(s): None

NEW YORK LIFE INSURANCE CO.

51 Madison Ave.
New York, NY 10010
(212) 578-7341

NO: 5 AMNT: \$ \$10,100,000

CONTACT: Carol Reuter, Asst. V.P.

LIM: No regional limitations.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 1

Deadline(s): None

OPPENSTEIN BROTHERS FOUNDATION

Commerce Trust Bldg., Rm. 617
922 Walnut St.
Kansas City, MO 64106
(816) 421-2647

NO: 1 AMNT: \$5,000

CONTACT: Karen M. Herman, Prog. Officer

LIM: Giving primarily in MO and KS.

APPLICATION INFO:

Initial approach: Telephone or Letter

Copies of proposal: 2

Deadline(s): None

PACIFIC MUTUAL FOUNDATION

700 Newport Center
Newport Beach, CA 92660
(714) 640-3014

NO: 13 AMNT: \$51,084

CONTACT: Robert G. Haskell, Pres.

LIM: Giving primarily in Orange County, CA.

APPLICATION INFO:

Initial approach: Proposal

Deadline(s): Sept. 14

PACIFIC TELESIS FOUNDATION

140 New Montgomery, Rm. 1723
San Francisco, CA 94105
(415) 882-8475

NO: 3 AMNT: \$35,000

CONTACT: Jere A. Jacobs, Pres.

LIM: Giving primarily in CA, NV, and other states where Pacific Telesis Group has business interests

APPLICATION INFO:

Initial approach: Letter

Deadline(s): None

PARKER FOUNDATION, THE

1200 Prospect St., Suite 575
La Jolla, CA 92037
(619) 456-3038

NO: 1 AMNT: \$10,000

CONTACT: Julie K. Benton, Asst. Secy.

LIM: Giving limited to San Diego county, CA.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 6

Deadline(s): None

PETTUS CROWE FUND

1616 P. St., N.W.
Washington, DC 20036

NO: 30 AMNT: \$58,967

CONTACT: Dr. Irene Crowe

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Letter with 501C3

Copies of proposal: 1

Deadline(s): Oct. 1, and May 1

PEW MEMORIAL TRUST

The Pew Charitable Trusts
Three Pkwy., Suite 501
Philadelphia, PA 19102-1305
(215) 568-3330

NO: 1 AMNT: \$240,000

CONTACT: Fred H. Billups, Jr., Exec. Dir.

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Letter, telephone, or proposal

Copies of proposal: 1

Deadline(s): None

PHILADELPHIA FOUNDATION, THE

Two Mellon Bank Center, Suite 2017
Philadelphia, PA 19102
(215) 563-6417

NO: 1 AMNT: \$14,837

CONTACT: John E. Ruthrauff, Dir.

LIM: Giving limited to Philadelphia and to Bucks, Chester, Delaware, and Montgomery counties in southeastern PA.

APPLICATION INFO:

Initial approach: Proposal, including cover sheet and statistical form

Copies of proposal: 1

Deadline(s): Submit proposal preferably during May/June or Nov/Dec; proposals not accepted Aug-Oct and Feb-Apr; deadlines July 31 & Jan 15

PHILLIPS (ELLIS L.) FOUNDATION

13 Dartmouth College Hwy.
Lyme, NH 03768
(603) 795-2790

NO: 1 AMNT: \$10,000

CONTACT: Patricia A. Cate, Exec. Dir.

LIM: Giving primarily in New England

APPLICATION INFO:

Initial approach: Letter of 1 to 3 pages

Board Meeting Date(s): Oct., Feb., and May.

PITTSBURGH FOUNDATION

301 Fifth Ave., Suite 1417
Pittsburgh, PA 15222-2494
(412) 391-5122

NO: 1 AMNT: \$10,000

CONTACT: Alfred W. Wishart, Jr., Exec. Dir.

LIM: Giving limited to Pittsburgh and Allegheny county, PA.

APPLICATION INFO:

Initial approach: Letter or proposal

Copies of proposal: 1

Deadline(s): 60 days prior to board meeting

Board meeting date(s): Mar., June, Sept., and Dec.

PRIMERICA FOUNDATION

(Formerly American Can Company)
American Ln, P.O. Box 3610
Greenwich, CT 06830-3610
(203) 552-2148

NO: 1 AMNT: \$5,000

CONTACT: Peter Goldberg, V.P., or William Ballbach, Mngr.

LIM: Giving primarily in areas of company organizations.

APPLICATION INFO:

Initial approach: Letter or proposal

Copies of proposal: 1

Deadline(s): None

PUBLIC WELFARE FOUNDATION, INC

2600 Virginia Ave., N.W., Rm. 505
Washington, DC 20037
202) 965-1800

NO: 6 AMNT: \$1,723,000

CONTACT: C. Glen Ihrig, Exec. Dir.

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Proposal with summary sheet

Copies of proposal: 1

Deadline(s): None

REYSON (CHARLES H.) FOUNDATION

444 Madison Ave., 30th Fl.
New York, NY 10022
(212) 925-3230

NO: 1 AMNT: \$110,000

CONTACT: Eli N. Evans, Press

LIM: Giving primarily in New York, NY.

APPLICATION INFO:

Initial approach: Letter or full proposal

Copies of proposal: 1

Deadline(s): None

REYNOLDS (Z. SMITH) FOUNDATION

101 Reynolda Village
Winston-Salem, NC 27106-5199
(919) 725-7541

NO: 1 AMNT: \$16,000

CONTACT: Thomsa W. Lambeth, Exec. Dir.

LIM: Giving limited to NC.

APPLICATION INFO:

Initial approach: Letter, telephone, or proposal

Copies of proposal: 1

Deadline(s): Feb. 1 and Aug. 1

RHODE ISLAND FOUNDATION, THE

957 North Main St.
Providence, RI 02904
(401) 274-4564

NO: 2 AMNT: \$84,560

CONTACT: Douglas M. Jansson, Exec. Dir.

LIM: Giving limited to RI.

APPLICATION INFO:

Initial approach: Telephone, meeting, or letter

Copies of proposal: 8

Board Meeting Date(s): Jan., Mar., May, July,
Sept., and Nov.

ROCHESTER AREA FOUNDATION

335 Main St. East, Suite 402
Rochester, NY 14604
(716) 325-4353

NO: 1 AMNT: \$4,000

CONTACT: Linda S. Weinstein, Pres.

LIM: Given limited to Monroe, Livingston, Ontario,
Orleans, Genesee, and Wayne counties.

APPLICATION INFO:

Board Meeting Date(s): Jan., Mar., May, July,
Sept., and Nov.

ROCKEFELLER BROTHERS FUND

1290 Ave. of the Americas
New York, NY 10104
(212) 373-4200

NO: 5 AMNT: \$206,000

CONTACT: Benjamin, R. Shute, Jr., Secy.

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Letter

Deadline(s): None

RUBINSTEIN (HELENA) FOUNDATION

405 Lexington Ave.
New York, NY 10174
(212) 986-0806

NO: 6 AMNT: \$340,000

CONTACT: Diane Moss, Exec. Dir.

LIM: Giving primarily in New York City, NY

APPLICATION INFO:

Initial approach: Letter

Deadline(s): None

ST. PAUL FOUNDATION, THE

1120 Northwest Corner
St. Paul, MN 55101
(612) 224-5463

NO: 2 AMNT: \$10,000

CONTACT: Paul A. Verret, Pres.

LIM: Giving limited to the St. Paul and Minneapolis,
MN, metropolitan area.

APPLICATION INFO:

Initial approach: Telephone, letter, or proposal

Copies of proposal: 1

Deadline(s): 3 months before the next board meeting
Board meeting date(s): Generally Mar, June, Sept.,
Nov, Dec.

SAN FRANCISCO FOUNDATION, THE

500 Washington St., 18th Fl.
San Francisco, CA 94111
(415) 392-0600

NO: 11 AMNT: \$260,430

CONTACT: Robert M. Fisher

LIM: Giving limited to the Bay Area, CA, counties of Alameda,
Contra Costa, Marin, San Francisco, and San Mateo

APPLICATION INFO:

Initial approach: Letter of intent

Deadline(s): Letters reviewed continuously; proposal
deadlines upon request

SCHERMAN FOUNDATION, INC., THE

315 West 57th St., Suite 2D
New York, NY 10019
(212) 489-7143

NO: 1 AMNT: \$15,000

CONTACT: David F. Freeman

LIM: Giving primarily in New York City, NY

APPLICATION INFO:

Initial approach: Proposal

Copies of proposal: 1

Deadline(s): None

SEATTLE FOUNDATION, THE

425 Pike St., Suite 510
Seattle, WA 98101
(206) 622-2294

NO: 1 AMNT: \$9,823

CONTACT: Mrs. Anne V. Farrell, Pres.

LIM: Giving limited to the Seattle, WA area

APPLICATION INFO:

Initial approach: Telephone, followed by proposal

Deadline(s): February 1, May 1, August 1, and November 1

SIERRA FOUNDATION, THE

(Formerly Sierra Foundation for Health)
11211 Gold Country Blvd.
Rancho Cordova, CA 95670
(916) 635-4755

NO: 6 AMNT: \$149,467

CONTACT: Len McCandless, Exec. Dir.

LIM: Giving limited to the following CA counties: El Dorado, Nevada,
Placer, Sacramento, San Joaquin and Yolo.

APPLICATION INFO:

Initial approach: Proposal

Copies of proposal: 3

Deadline(s): April 1, and Oct. 1

SKAGGS (L.J.) AND MARY C. SKAGGS FOUNDATION

1201 Broadway, 21st Fl.
Oakland, CA 94612
(415) 451-3300

NO: 1 AMNT: \$15,000

CONTACT: Philip M. Jolley, Fdn Mgr

LIM: Giving primarily in northern CA

APPLICATION INFO:

Initial approach: Letter

Deadline(s): June 1 for letter of intent,
Sept. 1 for invited proposal

SLOAN (ALFRED P.) FOUNDATION

630 Fifth Ave.
New York, NY 10111
(212) 582-0450

NO: 1 AMNT: \$113,00

CONTACT: Katherine Wallman, Exec. Dir.

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Letter

Deadline(s): None

SMITH (W. W.) CHARITABLE TRUST

c/o Philadelphia National Bank
100 Chetwynd Dr., Suite 200
Rosemont, DA 19010
(215) 525-9667

NO: 1 AMNT: \$20,000

CONTACT: Charles A. Frits III, V.P., Philadelphia
National Bank

LIM: Giving limited to the Delaware Valley, DA

APPLICATION INFO:

Initial approach: Proposal

Copies of proposal: 1

Deadline(s): Feb. 1, May 1, Aug. 1, and Nov. 1

SPENCER FOUNDATION, THE

875 North Michigan Ave.
Chicago, IL 60611
(312) 337-7000

NO: 2 AMNT: \$112,035

CONTACT: Marion M. Faldet, V.P.

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Letter or brief preliminary proposal

Copies of proposal: 3

Deadline(s): Mar. 1, July 1, and Nov. 1

STARR FOUNDATION, THE

70 Pine St.
New York, NY 10270
(212) 770-6882

NO: 1 AMNT: \$100,000

CONTACT: Dr. David Baltimore, Dir.

LIM: No regional limitations

APPLICATION INFO:

Initial approach: Letter

Deadline(s): None

**TARRANT COUNTY, THE COMMUNITY
TRUST OF METROPOLITAN**

210 East Ninth St.
Fort Worth, TX 76102
(817) 335-3473

NO: 1 AMNT: \$500

CONTACT: Stewart W. Stearns, Mgr.

LIM: Giving primarily in Tarrant County, TX

APPLICATION INFO:

Initial approach: Letter to request guidelines

Deadline(s): None

TIMES MIRROR FOUNDATION, THE

Times Mirror Square
Los Angeles, CA 90053
(213) 237-3945

NO: 1 AMNT: \$100,000

CONTACT: Cindy Beyl, Mgr. Corp. Contribs.

LIM: Giving primarily in communities served by the company's
subsidiaries, with emphasis on southern CA.

APPLICATION INFO:

Initial approach: 2-3 page letter

Deadline(s): May 1 and Oct. 15

UNITED HOSPITAL FUND

55 Fifth Ave.
New York, NY 10003-4392
(212) 645-2500

NO: 21 AMNT: \$764,127

CONTACT: Susan Wyant

LIM: Giving mainly targeted to within New York City.

APPLICATION INFO:

Initial approach: Letter or Telephone

Copies of proposal: 5

Deadline(s): Jan. 15, June 15, and Oct 15

UTICA FOUNDATION, INC.

233 Genesee St.
Utica, NY 13501
(315) 797-9200

NO: 1 AMNT: \$5,000

CONTACT: Addison M. White, Pres.

LIM: Giving limited to Utica, Oneida, and Herkimer counties, NY.

APPLICATION INFO:

Initial approach: Letter

Copies of proposal: 7

Board meeting date(s): 3 to 4 times a year, in May and as required

VAN AMERINGEN FOUNDATION, INC.

509 Madison Ave.
New York, NY 10022
(212) 758-6221

NO: 3 AMNT: \$235,000

CONTACT: Patricia Kind, Pres.

LIM: Giving primarily in the urban Northeast from Boston,
MA, to Washington, DC, including NY and PA.

APPLICATION INFO:

Initial approach: Proposal

Copies of proposal: 1

Deadline(s): 2 months before board meetings

Board meeting date(s): Mar., June, and Nov.

**VAN LOBEN SELS(ERNST D.) - ELEANOR SLATE
VAN LOBEN SELS CHARITABLE FOUNDATION**

225 Bush St., Rm. 708
San Francisco, CA 94104
(415) 983-1093

NO: 1 AMNT: \$50,000

CONTACT: Claude H. Hogan, Pres.

LIM: Giving limited to northern CA.

APPLICATION INFO:

Initial approach: Proposal, letter, or telephone

Copies of proposal: 3

Deadline(s): None

WARWICK (DIONNE) FOUNDATION

601 Pennsylvania Ave., Northwest, 9th Fl.
Washington, DC 80004
(202) 638-2747

NOTE: No grants for AIDS have previously been awarded

CONTACT: Guy Draper

LIM: No regional limitations.

APPLICATION INFO:

Initial approach: Letter for funding guidelines

**WASHINGTON, INC., THE COMMUNITY
FOUNDATION OF GREATER**

1002 Wisconsin Ave, N.W.
Washington, DC 20007
(202) 338-8993

NO: 3 AMNT: \$16,200

CONTACT: Jamie Kopp, Prog. Officer

LIM: Giving limited to the metropolitan
Washington, DC, area.

APPLICATION INFO:

Initial approach: Letter

Deadline(s): May and Oct.

WIEN (LAWRENCE A.) FOUNDATION, INC.

c/o Wien, Malkin, & Bettex
60 East 42nd St.
New York, NY 10165

NO: 1 AMNT: \$11,430

CONTACT: Lawrence A. Wien, Pres.

LIM: Giving primarily in New York, NY

APPLICATION INFO:

Initial approach: Letter

ZELLERBACH FAMILY FUND, THE

260 California St., Suite 1010
San Francisco, CA 94111
(415) 421-2629

NO: 1 AMNT: \$5,500

CONTACT: Edward A. Nathan, Exec. Dir.

LIM: Giving primarily in the San Francisco Bay Area, CA.

APPLICATION INFO:

Initial approach: Telephone or proposal

Copies of proposal: 1

Deadline(s): Submit proposal preferably 2 weeks
prior to board meeting

Board meeting date(s): Quarterly

AIDS:

**A STATUS REPORT ON FOUNDATION FUNDING
1988**

Scheduled for release this September

For more information or to order a copy, contact:

The Foundation Center • 1001 Connecticut Ave, NW,
Washington, DC 20036 • (202) 331-1400

The Centers for Disease Control (CDC) provides grants to state health departments for funding of community based AIDS education programs. Organizations seeking funding should contact their state AIDS coordinator. A listing is contained in the USCM publication *Local AIDS Services; The National Directory*.

Contact USCM at (202) 293-7330 for ordering the directory or for further information.

AIDS Information Exchange is a publication of The United States Conference of Mayors, with support from the U.S. Department of Health and Human Services under grant #U62/CCU300609-05. Arthur J. Holland, President; J. Thomas Cochran, Executive Director; Alan E. Gambrell, Editor. This issue of *AIDS Information Exchange* was prepared by Sara M. Wilson.

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ATLANTA COMMUNITY FOUNDATION, INC., METROPOLITAN

The Hurt Bldg., Suite 449
Atlanta, GA 30303
(404) 688-5525

NO: 3 AMNT: \$13,981

CONTACT: Alicia Philipp, Exec. Dir.

LIMITATIONS: Giving primarily in metropolitan Atlanta, GA, and surrounding regions.

APPLICATION INFO:

Initial approach: Letter or telephone

Copies of proposal: 1

Deadline(s): June 1, Sept. 1, Dec. 1, and Mar. 1.

BOOTH FERRIS FOUNDATION

30 Broad St.
New York, NY 10004
(212) 269-3850

NO: 1 AMNT: \$15,000

CONTACT: Robert J. Murtagh, Trustee

LIMITATIONS: Limited to support for the NY, NY metropolitan area.

APPLICATION INFO:

Initial approach: Telephone, letter or proposal

Copies of proposal: 1

Deadline(s): None

BORG-WARNER FOUNDATION, INC.

200 So. Michigan Ave.
Chicago, IL 60604
(312) 322-8659

NO: 1 AMNT: \$5,000

CONTACT: Ellen J. Benjamin, Dir., Corp. Contribs.

LIMITATIONS: Giving mainly in the Chicago, IL, area.

APPLICATION INFO:

Initial approach: Proposal preferably no longer than 10 pages.

Copies of proposal: 1

Deadline(s): None

BREMMER (OTTO) FOUNDATION

55 E. Fifth St., Suite 700
St. Paul, MN 55101
(612) 227-8036

NO: 2 AMNT: \$ 8,250

CONTACT: John Kostishack, Exec. Dir.

LIMITATIONS: Giving limited to MN, ND, and WI where there are Bremer Bank affiliates.

APPLICATION INFO:

Initial approach: Letter or telephone

Deadline(s): Submit proposal at least 3 months before funding is desired

BUFFALO FOUNDATION, THE

237 Main St.
Buffalo, NY 14203
(716) 852-2857

NOTE: No AIDS grants have been previously awarded.

CONTACT: W.L. Van Schoonhoven, Dir.

LIM: Giving primarily in Erie County, N.Y.

APPLICATION INFO:

Initial approach: Proposal

Copies of proposal: 1

Deadline(s): Mar. 31, June 30, Sept. 30, and Dec. 31

C.S. FUND

469 Bohemian Hwy.
Freestone, CA 95472
(707) 829-5444

NO: 1 AMNT: \$10,000

CONTACT: Marty Teitel, Exec. Dir.

LIMITATIONS: No regional restrictions.

APPLICATION INFO:

Initial Approach: Proposal

Copies of proposal: 1

Deadline(s): Jan. 15, May 15, and Sept. 15

CALDER (THE LOUIS) FOUNDATION

230 Park Ave., Rm. 1530-1
New York, NY 10169
(212) 687-1680

NO: 3 AMNT: \$175,000

CONTACT: Paul R. Brenner, Peter D. Calder, Manufacturers Hanover Trust Co.

LIMITATIONS: Giving primarily in New York, NY.

APPLICATION INFO:

Initial approach: Letter

Deadline(s): Submit proposal between Nov. 1 and Mar. 31; deadline March 31

CALIFORNIA COMMUNITY FOUNDATION

3580 Wilshire Blvd., Suite 1660
Los Angeles, CA 92268
(213) 413-4042

NO: 1 AMNT: \$29,332

CONTACT: Jack Shakely, Pres.

LIMITATIONS: Only giving in Los Angeles, Orange, Riverside, San Bernadino and Ventura counties, CA.

APPLICATION INFO:

Initial approach: Proposal

Copies of proposal: 1

Deadline(s): None

CENTRAL NEW YORK COMMUNITY FOUNDATION, INC.

500 So. Salina St., Suite 330
Syracuse, NY 13202
(315) 422-9538

NO: 1 AMNT: \$10,000

CONTACT: John S. Diets, Secy. & C.E.O.

LIMITATIONS: Giving limited to Onondaga and Madison counties, NY.

APPLICATION INFO:

Initial approach: Letter or telephone

Copies of proposal: 12

Deadline(s): 6 weeks before board meetings

Board meeting date(s): Mar., May, Sept., and Dec.

CHICAGO COMMUNITY TRUST

222 N. LaSalle St., Suite 1400
Chicago, IL 60601
(312) 372-3356

NO: 4 AMNT: \$307,000

CONTACT: Ms. Trinita Logue

LIMITATIONS: Giving primarily in Cook County, IL

APPLICATION INFO:

Initial approach: Proposal

Copies of proposal: 2

Deadline(s): None

Figure 1. AIDS annual rates per 100,000 population, for cases reported March 1990 through February 1991, United States

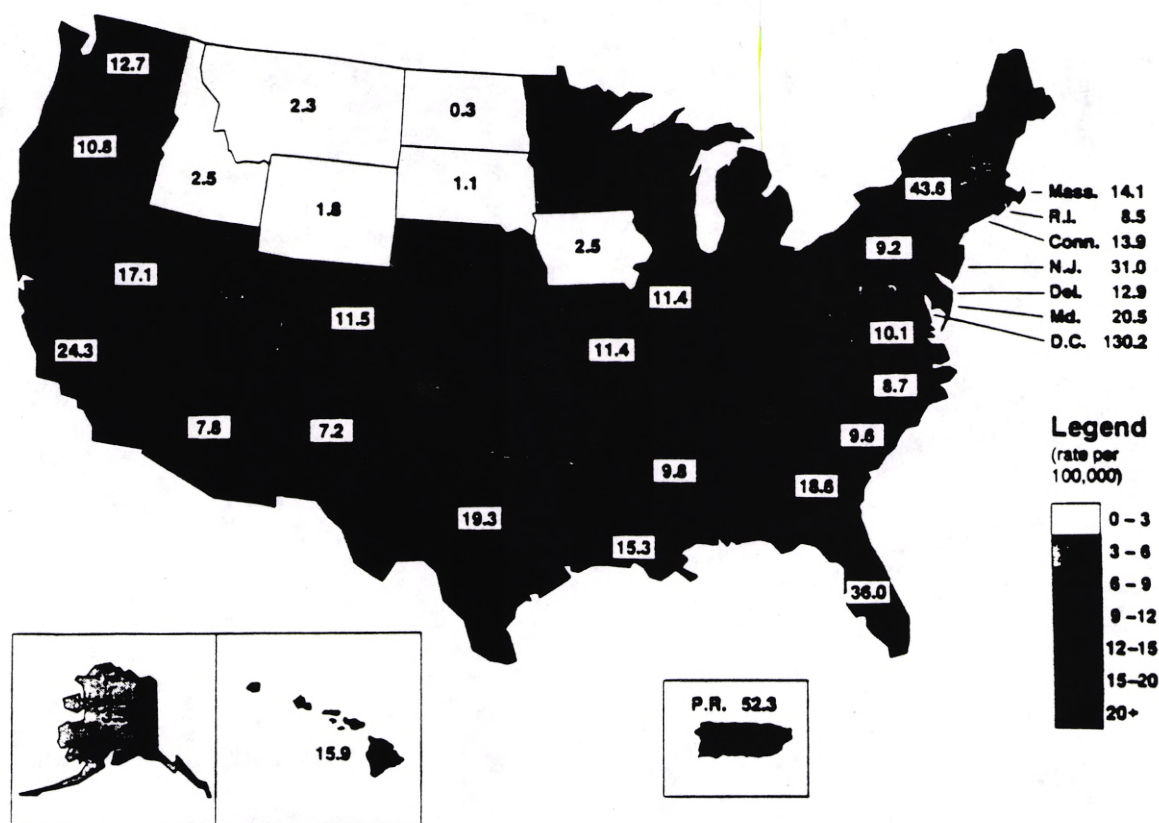


Figure 2. Adult/adolescent and pediatric AIDS cases, reported March 1990 through February 1991, United States

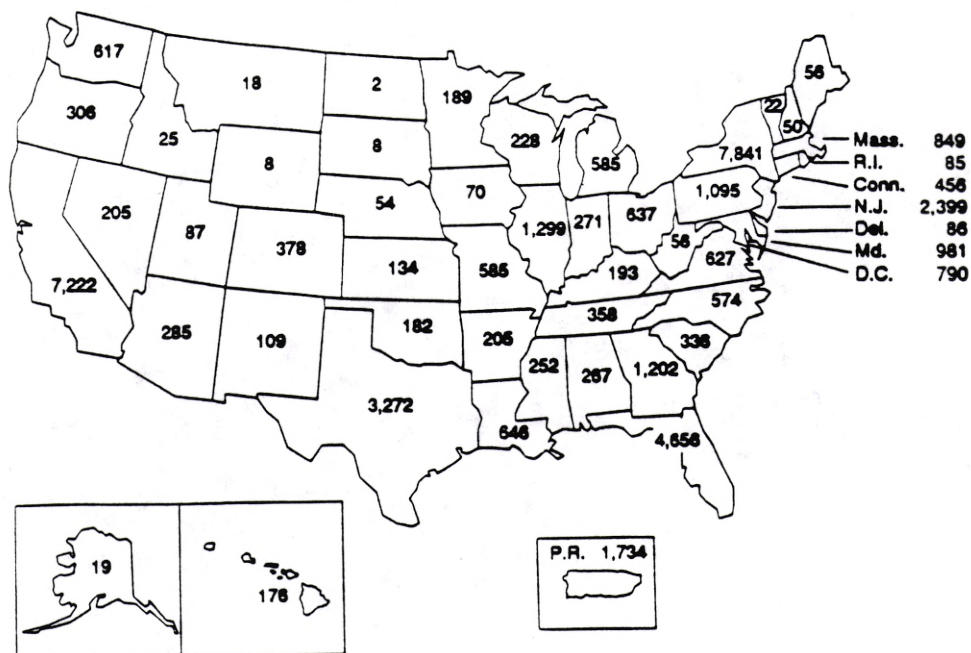


Figure 3. Pediatric AIDS cases, reported March 1990 through February 1991, United States

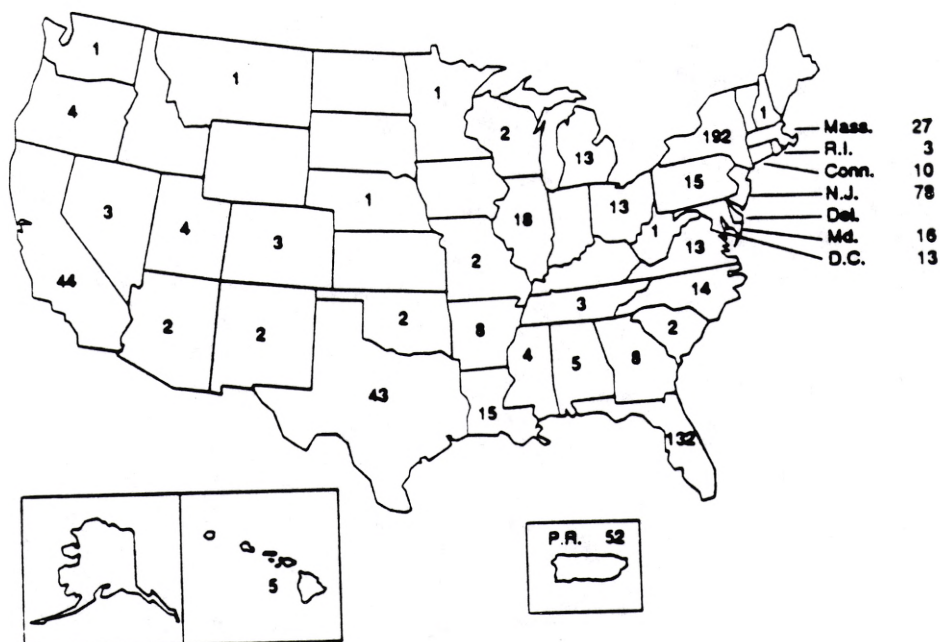


Table 1. AIDS cases and annual rates per 100,000 population, by state, reported March 1989 through February 1990, March 1990 through February 1991; and cumulative totals, by state and age group, through February 1991¹

State of residence	Mar. 1989- Feb. 1990		Mar. 1990- Feb. 1991		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children < 13 years old	Total
Alabama	211	5.2	267	6.6	934	21	95
Alaska	23	4.3	19	3.5	100	2	10
Arizona	350	9.8	285	7.8	1,326	9	1.33
Arkansas	93	4.0	205	8.7	472	11	48
California	6,573	22.5	7,222	24.3	31,351	215	31.56
Colorado	385	11.8	378	11.5	1,657	11	1.66
Connecticut	438	13.4	456	13.9	1,918	63	1.98
Delaware	74	11.2	86	12.9	321	4	32
District of Columbia	470	77.0	790	130.2	2,764	42	2.80
Florida	3,338	26.5	4,656	36.0	14,439	408	14.84
Georgia	1,150	18.0	1,202	18.6	4,434	48	4.48
Hawaii	204	18.7	176	15.9	667	7	67
Idaho	27	2.7	25	2.5	80	2	8
Illinois	1,162	10.2	1,299	11.4	4,868	70	4.93
Indiana	355	6.4	271	4.9	1,066	10	1.07
Iowa	46	1.6	70	2.5	238	3	24
Kansas	126	5.1	134	5.4	461	3	46
Kentucky	120	3.3	193	5.2	533	5	53
Louisiana	566	13.4	646	15.3	2,335	42	2.37
Maine	65	5.3	56	4.6	222	2	22
Maryland	780	16.5	981	20.5	3,237	68	3.30
Massachusetts	791	13.2	849	14.1	3,432	78	3.51
Michigan	492	5.3	585	6.3	2,061	35	2.09
Minnesota	180	4.1	189	4.3	839	8	84
Mississippi	208	8.1	252	9.8	677	10	68
Missouri	481	9.4	585	11.4	1,940	12	1.95
Montana	16	2.0	18	2.3	59	1	6
Nebraska	46	2.9	54	3.4	194	2	19
Nevada	174	15.0	205	17.1	662	7	66
New Hampshire	53	4.9	50	4.5	197	5	20
New Jersey	2,300	29.9	2,399	31.0	10,453	300	10.75
New Mexico	95	6.4	109	7.2	357	3	36
New York	6,983	38.9	7,841	43.6	34,996	827	35.82
North Carolina	392	6.0	574	8.7	1,698	37	1.73
North Dakota	7	1.1	2	0.3	20	—	2
Ohio	525	4.8	637	5.9	2,346	40	2.38
Oklahoma	208	6.6	182	5.8	719	11	73
Oregon	245	8.7	306	10.8	1,040	7	1.04
Pennsylvania	1,187	10.0	1,095	9.2	4,511	75	4.58
Rhode Island	85	8.5	85	8.5	380	10	39
South Carolina	345	10.0	336	9.6	1,070	21	1.09
South Dakota	2	0.3	8	1.1	25	—	2
Tennessee	248	5.1	358	7.3	1,135	15	1.15
Texas	2,590	15.5	3,272	19.3	11,785	116	11.90
Utah	87	5.1	87	5.0	341	9	35
Vermont	21	3.8	22	3.9	80	1	8
Virginia	575	9.4	627	10.1	2,119	38	2.15
Washington	497	10.4	617	12.7	2,227	12	2.23
West Virginia	59	3.3	56	3.1	181	3	18
Wisconsin	146	3.0	228	4.7	669	4	67
Wyoming	12	2.6	8	1.8	39	—	3
U.S. total	35,606	14.4	41,053	16.5	159,675	2,733	162,40
Guam	1	0.7	2	1.4	8	—	—
Pacific Islands, U.S.	—	—	1	0.5	2	—	—
Puerto Rico	1,570	47.5	1,734	52.3	5,139	166	5.30
Virgin Islands, U.S.	16	13.9	10	8.6	76	4	8
Total	37,193	14.9	42,800	17.0	164,900	2,903	167,80

¹During February 1991, 3,612 cases and 3,535 deaths among adults/adolescents and 62 cases and 23 deaths among children were reported to the CDC.

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported March 1989 through February 1990, March 1990 through February 1991; and cumulative totals, by area and age group, through February 1991

Metropolitan area of residence	Mar. 1989- Feb. 1990		Mar. 1990- Feb. 1991		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Akron, Ohio	19	2.9	29	4.4	109	—	109
Albany-Schenectady, N.Y.	66	7.6	98	11.2	341	4	345
Allentown, Pa.	46	6.7	47	6.8	163	4	167
Anaheim, Calif.	284	12.0	387	16.1	1,364	9	1,373
Atlanta, Ga.	872	31.5	945	33.4	3,395	29	3,424
Austin, Tex.	224	29.6	221	28.3	747	7	754
Bakersfield, Calif.	35	6.6	37	6.8	118	—	118
Baltimore, Md.	512	21.7	653	27.4	1,964	49	2,013
Baton Rouge, La.	54	10.3	48	9.1	194	4	198
Bergen-Passaic, N.J.	256	20.0	306	23.9	1,357	29	1,386
Birmingham, Ala.	67	7.4	84	9.3	299	6	305
Boston, Mass.	617	16.4	584	15.4	2,660	55	2,715
Bridgeport, Conn.	132	16.0	122	14.7	567	20	587
Buffalo, N.Y.	62	6.4	111	11.5	280	2	282
Charleston, S.C.	68	13.6	72	14.2	237	—	237
Charlotte, N.C.	80	7.0	87	7.5	327	7	334
Chicago, Ill.	940	15.5	1,105	18.2	4,117	53	4,170
Cincinnati, Ohio	75	5.2	126	8.7	361	6	367
Cleveland, Ohio	138	7.5	136	7.4	598	10	608
Columbus, Ohio	109	8.0	147	10.7	520	4	524
Dallas, Tex.	602	24.1	716	28.0	2,840	16	2,856
Dayton, Ohio	60	6.3	69	7.3	242	6	248
Denver, Colo.	308	19.2	316	19.5	1,356	7	1,363
Detroit, Mich.	346	7.9	398	9.1	1,440	25	1,465
El Paso, Tex.	34	5.9	52	8.8	128	1	129
Fort Lauderdale, Fla.	548	44.5	993	79.1	2,636	51	2,687
Fort Worth, Tex.	146	11.3	209	15.7	657	8	665
Fresno, Calif.	52	8.0	56	8.4	197	2	199
Gary, Ind.	43	7.1	21	3.5	99	—	99
Grand Rapids, Mich.	20	2.9	40	5.8	109	1	110
Greensboro, N.C.	55	5.9	98	10.4	263	6	269
Greenville, S.C.	36	5.7	51	8.0	136	—	136
Harrisburg, Pa.	48	8.2	36	6.1	166	4	170
Hartford, Conn.	146	13.1	159	14.1	579	15	594
Honolulu, Hawaii	137	16.5	122	14.6	502	4	506
Houston, Tex.	984	30.3	1,344	40.7	4,961	49	5,010
Indianapolis, Ind.	179	14.4	130	10.4	504	3	507
Jacksonville, Fla.	210	23.6	287	31.7	791	27	818
Jersey City, N.J.	309	55.8	374	67.6	1,769	46	1,815
Kansas City, Mo.	259	16.7	271	17.3	1,022	4	1,026
Knoxville, Tenn.	22	3.7	32	5.3	115	1	116
Lake County, Ill.	21	4.1	16	3.1	76	2	78
Las Vegas, Nev.	126	17.7	166	22.4	493	7	500
Little Rock, Ark.	43	8.4	77	15.0	193	5	198
Los Angeles, Calif.	2,302	26.4	2,294	25.9	10,969	93	11,062
Louisville, Ky.	53	5.6	69	7.2	221	2	223
Memphis, Tenn.	75	7.7	115	11.7	363	6	369
Miami, Fla.	972	51.0	1,278	66.0	4,340	169	4,509
Middlesex, N.J.	185	18.4	180	17.6	840	24	864
Milwaukee, Wis.	82	5.7	120	8.4	374	2	376
Minneapolis-Saint Paul, Minn.	163	6.7	166	6.7	749	6	755
Monmouth-Ocean City, N.J.	185	19.0	204	20.7	683	25	708
Nashville, Tenn.	76	7.8	116	11.8	376	6	382
Nassau-Suffolk, N.Y.	359	13.8	430	16.5	1,690	43	1,733
New Bedford, Mass.	44	8.7	59	11.7	167	4	171
New Haven, Conn.	121	15.1	142	17.7	614	27	641
New Orleans, La.	349	28.1	366	29.5	1,474	22	1,496
New York, N.Y.	5,987	70.3	6,591	77.1	30,336	746	31,082

Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported March 1989 through February 1990, March 1990 through February 1991; and cumulative totals, by area and age group, through February 1991 — Continued

Metropolitan area of residence	Mar. 1989- Feb. 1990		Mar. 1990- Feb. 1991		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Newark, N.J.	983	53.7	954	52.3	4,360	137	4,497
Norfolk, Va.	127	9.3	148	10.6	471	7	478
Oakland, Calif.	407	19.8	560	26.9	2,064	14	2,078
Oklahoma City, Okla.	108	11.4	91	9.5	367	—	367
Omaha, Neb.	33	5.4	35	5.7	134	1	135
Orlando, Fla.	165	15.9	314	29.3	802	9	811
Oxnard-Ventura, Calif.	35	5.3	45	6.7	159	—	159
Philadelphia, Pa.	850	17.6	836	17.2	3,415	53	3,468
Phoenix, Ariz.	263	12.8	204	9.6	969	6	975
Pittsburgh, Pa.	174	8.4	124	6.0	567	2	569
Portland, Oreg.	185	15.1	247	19.9	822	4	826
Providence, R.I.	79	8.7	82	8.9	356	9	365
Raleigh-Durham, N.C.	96	13.4	117	15.9	371	10	381
Richmond, Va.	122	14.3	118	13.6	400	9	409
Riverside-San Bernardino, Calif.	294	11.8	283	10.9	1,068	16	1,084
Rochester, N.Y.	60	6.0	93	9.3	364	3	367
Sacramento, Calif.	152	10.5	148	10.0	650	9	659
Saint Louis, Mo.	207	8.5	292	11.9	885	7	892
Salt Lake City, Utah	73	6.9	80	7.5	303	6	309
San Antonio, Tex.	207	16.2	237	18.2	843	12	855
San Diego, Calif.	560	23.0	674	27.0	2,402	19	2,421
San Francisco, Calif.	1,835	115.2	2,092	130.5	9,700	17	9,717
San Jose, Calif.	134	9.1	187	12.5	735	8	743
San Juan, P.R.	962	60.6	1,118	70.0	3,226	111	3,337
Scranton, Pa.	35	4.8	40	5.4	131	3	134
Seattle, Wash.	376	19.4	457	23.2	1,687	10	1,697
Springfield, Mass.	45	7.5	101	16.8	216	11	227
Syracuse, N.Y.	39	5.9	44	6.7	161	6	167
Tacoma, Wash.	38	6.6	45	7.7	148	2	150
Tampa-Saint Petersburg, Fla.	358	17.7	486	23.5	1,622	28	1,650
Toledo, Ohio	27	4.4	39	6.4	118	3	121
Tucson, Ariz.	58	8.9	55	8.2	251	2	253
Tulsa, Okla.	63	9.0	46	6.5	202	3	205
Washington, D.C.	902	23.4	1,303	33.2	4,698	72	4,770
West Palm Beach, Fla.	313	37.5	407	47.1	1,430	58	1,488
Wilmington, Del.	65	11.3	74	12.8	269	3	272
Worcester, Mass.	36	5.1	56	7.9	182	4	186
Metropolitan area subtotal¹	30,809	21.2	35,740	24.3	140,736	2,437	143,173
All other areas	6,384	6.1	7,060	6.7	24,164	466	24,630
Total	37,193	14.9	42,800	17.0	164,900	2,903	167,803

¹ Includes data from metropolitan areas which have populations of 500,000 or more.

Table 3. AIDS cases by age group, exposure category, and sex, reported March 1989 through February 1990, March 1990 through February 1991; and cumulative totals, by age group and exposure category, through February 1991, United States

Adult/adolescent exposure category	Males		Females		Totals		
	Mar. 1989-Feb. 1990	Mar. 1990-Feb. 1991	Mar. 1989-Feb. 1990	Mar. 1990-Feb. 1991	Mar. 1989-Feb. 1990	Mar. 1990-Feb. 1991	Cumulative total ¹
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Male homosexual/bisexual contact	20,838 (64)	23,345 (63)	—	—	20,838 (57)	23,345 (56)	97,687 (59)
Intravenous (IV) drug use (female and heterosexual male)	6,733 (21)	7,526 (20)	2,006 (51)	2,333 (47)	8,739 (24)	9,859 (23)	36,155 (22)
Male homosexual/bisexual contact and IV drug use	2,287 (7)	2,236 (6)	—	—	2,287 (6)	2,236 (5)	10,916 (7)
Hemophilia/coagulation disorder	269 (1)	317 (1)	7 (0)	10 (0)	276 (1)	327 (1)	1,434 (1)
Heterosexual contact:	806 (2)	1,105 (3)	1,323 (34)	1,697 (34)	2,129 (6)	2,802 (7)	8,907 (5)
Sex with IV drug user	384	507	850	1,051	1,234	1,558	4,717
Sex with bisexual male	—	—	111	143	111	143	525
Sex with person with hemophilia	1	2	22	27	23	29	82
Born in Pattern-II country	274	299	130	115	404	414	2,104
Sex with person born in Pattern-II country	16	27	13	22	29	49	139
Sex with transfusion recipient with HIV infection	13	29	24	45	37	74	169
Sex with HIV-infected person, risk not specified	118	241	173	294	291	535	1,171
Receipt of blood transfusion, blood components, or tissue ³	485 (1)	483 (1)	324 (8)	330 (7)	809 (2)	813 (2)	3,787 (2)
Other/undetermined ⁴	1,182 (4)	2,089 (6)	255 (7)	553 (11)	1,437 (4)	2,642 (6)	6,014 (4)
Adult/adolescent subtotal	32,600 (100)	37,101 (100)	3,915 (100)	4,923 (100)	36,515 (100)	42,024 (100)	164,900 (100)
Pediatric (<13 years old) exposure category							
Hemophilia/coagulation disorder	23 (6)	34 (8)	—	1 (0)	23 (3)	35 (5)	145 (5)
Mother with/at risk for HIV infection:	302 (85)	334 (82)	295 (92)	343 (93)	597 (88)	677 (87)	2,433 (84)
IV drug use	141	167	122	156	263	323	1,212
Sex with IV drug user	77	64	69	73	146	137	504
Sex with bisexual male	9	3	9	5	18	8	52
Sex with person with hemophilia	—	2	—	1	—	3	10
Born in Pattern-II country	27	22	27	16	54	38	219
Sex with person born in Pattern-II country	1	2	3	3	4	5	12
Sex with transfusion recipient with HIV infection	1	1	5	1	6	2	13
Sex with HIV-infected person, risk not specified	9	18	16	21	25	39	106
Receipt of blood transfusion, blood components, or tissue	5	5	7	6	12	11	49
Has HIV infection, risk not specified	32	50	37	61	69	111	256
Receipt of blood transfusion, blood components, or tissue	25 (7)	23 (6)	16 (5)	12 (3)	41 (6)	35 (5)	255 (9)
Undetermined	6 (2)	16 (4)	11 (3)	13 (4)	17 (3)	29 (4)	70 (2)
Pediatric subtotal	356 (100)	407 (100)	322 (100)	369 (100)	678 (100)	776 (100)	2,903 (100)
Total	32,956	37,508	4,237	5,292	37,193	42,800	167,803

¹ Includes 3 patients known to be infected with human immunodeficiency virus type 2 (HIV-2). See MMWR 1989;38:572-580

² See technical notes.

³ Thirteen adult/adolescents and 2 children developed AIDS after receiving blood screened for HIV antibody. One additional person received only HIV-infected tissue.

⁴ "Other" refers to 3 health-care workers who seroconverted to HIV and developed AIDS after occupational exposure to HIV-infected blood. "Undetermined" refers to patients whose mode of exposure to HIV is unknown. This includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation. See Figure 4.

Table 4. AIDS cases by age group, exposure category, and race/ethnicity, reported through February 1991, United States

Adult/adolescent exposure category	White, not Hispanic	Black, not Hispanic	Hispanic	Asian/Pacific Islander	American Indian/Alaskan Native	Total ⁴
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Male homosexual/bisexual contact	69,482 (76)	16,612 (36)	10,490 (40)	761 (75)	128 (54)	97,687 (59)
Intravenous (IV) drug use (female and heterosexual male)	7,329 (8)	18,100 (39)	10,553 (40)	45 (4)	39 (16)	36,155 (22)
Male homosexual/bisexual contact and IV drug use	6,324 (7)	2,952 (6)	1,572 (6)	21 (2)	32 (14)	10,916 (7)
Hemophilia/coagulation disorder	1,190 (1)	100 (0)	115 (0)	17 (2)	8 (3)	1,434 (1)
Heterosexual contact:	1,900 (2)	5,313 (12)	1,623 (6)	38 (4)	10 (4)	8,907 (5)
Sex with IV drug user	1,021	2,409	1,251	16	7	4,717
Sex with bisexual male	285	165	63	9	1	525
Sex with person with hemophilia	71	7	3	1	—	82
Born in Pattern-II ¹ country	8	2,071	17	4	—	2,104
Sex with person born in Pattern-II country	44	86	8	—	—	139
Sex with transfusion recipient with HIV infection	111	27	28	1	—	169
Sex with HIV-infected person, risk not specified	360	548	253	7	2	1,171
Receipt of blood transfusion, blood components, or tissue ²	2,653 (3)	656 (1)	391 (1)	71 (7)	6 (3)	3,787 (2)
Other/undetermined ³	2,147 (2)	2,360 (5)	1,375 (5)	66 (6)	14 (6)	6,014 (4)
Adult/adolescent subtotal	91,025(100)	46,093 (100)	26,119(100)	1,019 (100)	237(100)	164,900(100)
Pediatric (<13 years old) exposure category						
Hemophilia/coagulation disorder	100 (16)	19 (1)	23 (3)	3 (20)	—	145 (5)
Mother with/at risk for HIV infection:	382 (61)	1,397 (93)	633 (86)	7 (47)	6 (86)	2,433 (84)
IV drug use	189	691	324	2	2	1,212
Sex with IV drug user	79	223	199	1	1	504
Sex with bisexual male	18	23	10	1	—	52
Sex with person with hemophilia	7	2	1	—	—	10
Born in Pattern-II country	2	214	3	—	—	219
Sex with person born in Pattern-II country	—	11	—	—	—	12
Sex with transfusion recipient with HIV infection	5	4	3	—	—	13
Sex with HIV-infected person, risk not specified	21	52	30	1	1	106
Receipt of blood transfusion, blood components, or tissue	17	19	13	—	—	49
Has HIV infection, risk not specified	44	158	50	2	2	256
Receipt of blood transfusion, blood components, or tissue	137 (22)	55 (4)	58 (8)	5 (33)	—	255 (9)
Undetermined	10 (2)	39 (3)	20 (3)	—	1 (14)	70 (2)
Pediatric subtotal	629(100)	1,510 (100)	734(100)	15 (100)	7(100)	2,903(100)
Total	91,654	47,603	26,853	1,034	244	167,803

¹ See technical notes.

² Thirteen adult/adolescents and 2 children developed AIDS after receiving blood screened for HIV antibody. One additional person received only HIV-infected tissue.

³ "Other" refers to 3 health-care workers who seroconverted to HIV and developed AIDS after occupational exposure to HIV-infected blood. "Undetermined" refers to patients whose mode of exposure to HIV is unknown. This includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation. See Figure 4.

⁴ Includes 415 persons whose race/ethnicity is unknown.

Table 5. Adult/adolescent AIDS cases by sex, exposure category, and race/ethnicity, reported through February 1991, United States

Male exposure category	White, not Hispanic	Black, not Hispanic	Hispanic	Asian/Pacific Islander	American Indian/ Alaskan Native	Total ⁴
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Male homosexual/bisexual contact	69,482 (80)	16,612 (44)	10,490 (46)	761 (81)	128 (63)	97,687 (66)
Intravenous (IV) drug use (heterosexual)	5,595 (6)	13,278 (35)	8,855 (39)	31 (3)	22 (11)	27,854 (19)
Male homosexual/bisexual contact and IV drug use	6,324 (7)	2,952 (8)	1,572 (7)	21 (2)	32 (16)	10,916 (7)
Hemophilia/coagulation disorder	1,163 (1)	95 (0)	113 (0)	17 (2)	8 (4)	1,400 (1)
Heterosexual contact:	606 (1)	2,558 (7)	373 (2)	9 (1)	2 (1)	3,553 (2)
<i>Sex with IV drug user</i>	370	759	234	5	2	1,370
<i>Sex with person with hemophilia</i>	5	—	1	—	—	6
<i>Born in Pattern-II¹ country</i>	5	1,510	12	3	—	1,533
<i>Sex with person born in Pattern-II country</i>	37	39	7	—	—	83
<i>Sex with transfusion recipient with HIV infection</i>	32	14	8	—	—	55
<i>Sex with HIV-infected person, risk not specified</i>	157	236	111	1	—	506
Receipt of blood transfusion, blood components, or tissue ²	1,707 (2)	352 (1)	208 (1)	44 (5)	2 (1)	2,319 (2)
Other/undetermined ³	1,845 (2)	1,739 (5)	1,149 (5)	52 (6)	10 (5)	4,841 (3)
Male subtotal	86,722 (100)	37,586 (100)	22,760 (100)	935 (100)	204 (100)	148,570 (100)
Female						
exposure category						
IV drug use	1,734 (40)	4,822 (57)	1,698 (51)	14 (17)	17 (52)	8,301 (51)
Hemophilia/coagulation disorder	27 (1)	5 (0)	2 (0)	—	—	34 (0)
Heterosexual contact:	1,294 (30)	2,755 (32)	1,250 (37)	29 (35)	8 (24)	5,354 (33)
<i>Sex with IV drug user</i>	651	1,650	1,017	11	5	3,347
<i>Sex with bisexual male</i>	285	165	63	9	1	525
<i>Sex with person with hemophilia</i>	66	7	2	1	—	76
<i>Born in Pattern-II country</i>	3	561	5	1	—	571
<i>Sex with person born in Pattern-II country</i>	7	47	1	—	—	56
<i>Sex with transfusion recipient with HIV infection</i>	79	13	20	1	—	114
<i>Sex with HIV-infected person, risk not specified</i>	203	512	142	6	2	665
Receipt of blood transfusion, blood components, or tissue	946 (22)	304 (4)	183 (5)	27 (32)	4 (12)	1,468 (9)
Other/undetermined	302 (7)	621 (7)	226 (7)	14 (17)	4 (12)	1,173 (7)
Female subtotal	4,303 (100)	8,507 (100)	3,359 (100)	84 (100)	33 (100)	16,330 (100)
Total	91,025	46,093	26,119	1,019	237	164,900

¹ See technical notes.

² Thirteen adult/adolescents and 2 children developed AIDS after receiving blood screened for HIV antibody. One additional person received only HIV-infected tissue.

³ "Other" refers to 3 health-care workers who seroconverted to HIV and developed AIDS after occupational exposure to HIV-infected blood. "Undetermined" refers to patients whose mode of exposure to HIV is unknown. This includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation. See Figure 4.

⁴ Includes 363 males and 44 females whose race/ethnicity is unknown.

Table 6. AIDS cases in adolescents and adults under age 25, by exposure category, reported March 1989 through February 1990, March 1990 through February 1991, and cumulative totals through February 1991, United States

Exposure category	13-19 years old			20-24 years old		
	Mar. 1989- Feb. 1990	Mar. 1990- Feb. 1991	Cumulative total	Mar. 1989- Feb. 1990	Mar. 1990- Feb. 1991	Cumulative total
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Male homosexual/bisexual contact	37 (28)	30 (18)	173 (26)	809 (54)	791 (49)	3,917 (56)
Intravenous (IV) drug use						
(female and heterosexual male)	15 (11)	14 (8)	71 (11)	287 (19)	291 (18)	1,152 (17)
Male homosexual/bisexual contact and IV drug use	3 (2)	5 (3)	28 (4)	134 (9)	125 (8)	634 (9)
Hemophilia/coagulation disorder	39 (30)	53 (31)	202 (31)	34 (2)	33 (2)	174 (3)
Heterosexual contact:	22 (17)	34 (20)	90 (14)	165 (11)	208 (13)	676 (10)
<i>Sex with IV drug user</i>	16	26	59	96	128	382
<i>Sex with bisexual male</i>	1	1	4	9	10	52
<i>Sex with person with hemophilia</i>	1	1	2	8	4	16
<i>Born in Pattern-II¹ country</i>	1	1	13	23	17	113
<i>Sex with person born in Pattern-II country</i>	—	—	—	1	7	10
<i>Sex with transfusion recipient with HIV infection</i>	—	1	1	1	5	7
<i>Sex with HIV-infected person, risk not specified</i>	3	4	11	27	37	96
Receipt of blood transfusion, blood components, or tissue	4 (3)	12 (7)	49 (7)	9 (1)	23 (1)	99 (1)
Undetermined ²	11 (8)	23 (13)	46 (7)	62 (4)	130 (8)	306 (4)
Total	131 (100)	171 (100)	659 (100)	1,500 (100)	1,601 (100)	6,958 (100)

¹ See technical notes.

² "Undetermined" refers to patients whose mode of exposure to HIV is unknown. This includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation. See Figure 4.

Table 7. AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through February 1991, United States

Males Age at diagnosis (years)	White, not Hispanic	Black, not Hispanic	Hispanic	Asian/Pacific Islander	American Indian/ Alaskan Native	Total ¹
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Under 5	210 (0)	675 (2)	315 (1)	5 (1)	3 (1)	1,212 (1)
5-12	166 (0)	100 (0)	73 (0)	5 (1)	—	346 (0)
13-19	231 (0)	151 (0)	98 (0)	8 (1)	5 (2)	494 (0)
20-24	2,965 (3)	1,769 (5)	1,058 (5)	30 (3)	12 (6)	5,844 (3)
25-29	13,154 (15)	6,027 (16)	3,958 (17)	127 (13)	44 (21)	23,354 (15)
30-34	20,375 (23)	9,536 (25)	5,843 (25)	198 (21)	52 (25)	36,084 (23)
35-39	19,126 (22)	8,842 (23)	5,098 (22)	213 (23)	38 (18)	33,406 (22)
40-44	13,133 (15)	5,169 (13)	3,158 (14)	151 (16)	23 (11)	21,697 (15)
45-49	7,800 (9)	2,810 (7)	1,645 (7)	91 (10)	15 (7)	12,393 (9)
50-54	4,308 (5)	1,537 (4)	916 (4)	50 (5)	4 (2)	6,835 (5)
55-59	2,717 (3)	943 (2)	554 (2)	32 (3)	6 (3)	4,268 (3)
60-64	1,547 (2)	490 (1)	257 (1)	9 (1)	4 (2)	2,310 (2)
65 or older	1,366 (2)	312 (1)	175 (1)	26 (3)	1 (0)	1,885 (2)
Male subtotal	87,098 (100)	38,361 (100)	23,148 (100)	945 (100)	207 (100)	150,128 (100)
Females						
Age at diagnosis (years)						
Under 5	203 (4)	648 (7)	291 (8)	1 (1)	4 (11)	1,148 (4)
5-12	50 (1)	87 (1)	55 (1)	4 (4)	—	197 (1)
13-19	44 (1)	94 (1)	25 (1)	1 (1)	1 (3)	165 (1)
20-24	296 (6)	534 (6)	271 (7)	4 (4)	5 (14)	1,114 (6)
25-29	813 (18)	1,645 (18)	778 (21)	8 (9)	4 (11)	3,256 (18)
30-34	977 (21)	2,440 (26)	900 (24)	17 (19)	11 (30)	4,357 (21)
35-39	683 (15)	1,914 (21)	648 (17)	12 (13)	5 (14)	3,270 (15)
40-44	388 (9)	904 (10)	352 (10)	17 (19)	2 (5)	1,666 (9)
45-49	208 (5)	407 (4)	162 (4)	7 (8)	2 (5)	791 (5)
50-54	153 (3)	230 (2)	98 (3)	5 (6)	1 (3)	487 (3)
55-59	174 (4)	141 (1)	53 (1)	3 (3)	—	373 (4)
60-64	161 (4)	97 (1)	30 (1)	7 (8)	1 (3)	296 (4)
65 or older	406 (9)	101 (1)	42 (1)	3 (3)	1 (3)	555 (9)
Female subtotal	4,556 (100)	9,242 (100)	3,705 (100)	89 (100)	37 (100)	17,675 (100)
Total	91,654	47,603	26,853	1,034	244	167,803

¹ Includes 415 persons whose race/ethnicity is unknown.

Table 10. Adult/adolescent AIDS cases by single and multiple exposure categories, reported through February 1991, United States

Exposure category	AIDS cases	
	No.	(%)
Single mode of exposure		
Male homosexual/bisexual contact	93,850	(57)
Intravenous (IV) drug use (female and heterosexual male)	31,003	(19)
Hemophilia/coagulation disorder	888	(1)
Heterosexual contact	8,494	(5)
Receipt of transfusion of blood, blood component, or tissue	3,787	(2)
Other/undetermined	6,014	(4)
Single mode of exposure subtotal	144,036	(87)
Multiple modes of exposure		
Male homosexual/bisexual contact; IV drug use	9,825	(6)
Male homosexual/bisexual contact; hemophilia	37	(0)
Male homosexual/bisexual contact; heterosexual contact	1,980	(1)
Male homosexual/bisexual contact; receipt of transfusion	1,699	(1)
IV drug use; hemophilia	39	(0)
IV drug use; heterosexual contact	4,148	(3)
IV drug use; receipt of transfusion	724	(0)
Hemophilia; heterosexual contact	10	(0)
Hemophilia; receipt of transfusion	521	(0)
Heterosexual contact; receipt of transfusion	413	(0)
Male homosexual/bisexual contact; IV drug use; hemophilia	7	(0)
Male homosexual/bisexual contact; IV drug use; heterosexual contact	773	(0)
Male homosexual/bisexual contact; IV drug use; receipt of transfusion	268	(0)
Male homosexual/bisexual contact; hemophilia; heterosexual contact	3	(0)
Male homosexual/bisexual contact; hemophilia; receipt of transfusion	18	(0)
Male homosexual/bisexual contact; heterosexual contact; receipt of transfusion	100	(0)
IV drug use; hemophilia; heterosexual contact	2	(0)
IV drug use; hemophilia; receipt of transfusion	19	(0)
IV drug use; heterosexual contact; receipt of transfusion	215	(0)
Hemophilia; heterosexual contact; receipt of transfusion	15	(0)
Male homosexual/bisexual contact; IV drug use; hemophilia; receipt of transfusion	7	(0)
Male homosexual/bisexual contact; IV drug use; heterosexual contact; receipt of transfusion	36	(0)
IV drug use; hemophilia; heterosexual contact; receipt of transfusion	5	(0)
Multiple modes of exposure subtotal	20,864	(13)
Total	164,900	(100)

MEMO

TO: Terry

FROM: Jim

RE: Answers to Workshop Preparation Questionnaire by Jim Jackson
(Afro-American Community)

DATE: April 30, 1991

1. Brief Cultural History of Afro-Americans 1609-1991. Slaves and Freedmen. Implications of Northern "Integration" and Southern Segregation. Religious and class differences. Education and educational institutions. Music and cuisine. The current Caribbean-African connection. 20th century diversity, Soul and Roots.
2. The Afro-American Community is a diverse and constantly changing entity. Opinions range in the Afro-American Community from the conservative, fundamentalist, religious faction which is anti-needle exchange and believes that HIV is the result of genetic engineering and is spread by the White Man along with "dope" among Afro-Americans, like they spread smallpox among the Indians with the blankets they gave them. On the other hand there are some Afro-Americans who still believe that HIV disease is a White, gay disease or that it is recompense for the sinful lives of the gay, the prostitute and the dope addict." The reality of the matter is that more and more Afro-Americans are becoming knowledgeable and understanding about HIV disease by direct contact with a family member or friend who has contracted the disease.
3. There is lack of a tradition of "family medicine" which defeats early intervention. IVUDU and its many ramifications has caused Ignorance; e.g., of basic sex education. Discrimination - and its active and passive effect on other barriers. Cultural "attitudes" and "habit" perpetuated by both men and women. Poverty and its multifaceted attack on public health.
4. Education - sex education, in school, in church or by public institutions and interventions. Strategies to effectuate the use of condoms by everyone and prophylaxis and needle exchange among IVUDU.

Asian /Pacific Islander



Ford Hatamiya

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6. AIDS Prevalence in U.S. Asian and Pacific Islander Populations

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This chapter examines the current data regarding the prevalence of the HIV virus and AIDS in Asian and Pacific Islander populations in the United States. Three cities are discussed: New York, Los Angeles, and San Francisco. These cities were chosen because of their large Asian populations and their considerable AIDS mortality figures. Hypotheses are offered regarding the currently small numbers of reported Asian AIDS cases, and brief recommendations for action are made.

CURRENT INCIDENCE RATES

As is true with all population groups in America—black, white, red, or brown—Asians are dying of AIDS. As of November 23, 1987, the number of reported cases of Asians with AIDS was 274 of the 46,340 total U.S. cases (CDC 1987). While Asians make up approximately 2 percent of the total U.S. population, the 274 reported cases represent just 0.6 percent of the total adult/adolescent AIDS cases in this country.

Unfortunately, the relatively small numbers have resulted in virtual data obscurity for Asians, with important information usually lumped into the "other" categories noted in most documents with multiple asterisks. The small

Research for this paper was supported in part by National Institute on Drug Abuse training grant T32 DA07209.

numbers have also created a false sense of security in both the Asian communities and in government officials responsible for health care interventions and monitoring. This perception of Asians as being somehow less affected by AIDS has resulted in the forestalling of timely and critical action.

In 1987, Asians were 4 percent of the New York City population¹, and 0.5 percent of the total AIDS cases in the city (see table 1). Of the 11,939 total reported, 62 were classified as Asian or Pacific Islander. Homosexual/bisexual Asians constituted a majority of the cases (77 percent), while IV drug use was implicated in only three instances (5 percent). No information is available at this time on 11 of the 62 cases (18 percent).

As of November 30, 1987, Asians in Los Angeles County constituted approximately 8 percent of the population and 1 percent of the total AIDS cases in the city, with 40 of 3,847 reported AIDS cases classified as Asian or Pacific Islander (see table 2). Homosexual/bisexual behavior constituted the largest category of possible AIDS transmission modes (73 percent), with IV drug use implicated as a risk factor in only one individual who also reported homosexual/bisexual behavior as a risk factor. The remaining cases were attributed to transmission via contaminated blood products (25 percent).

In San Francisco, 65 of the 3,955 reported AIDS cases were Asian or Pacific Islander (1.6 percent). This compares to 3,347 AIDS cases among whites (84.6 percent), 252 cases among blacks (6.4 percent), 287 cases among Hispanics (7.3 percent), and 4 Native American AIDS cases (0.1 percent) (see table 3).

Breaking down the numbers further by race and risk group (table 4), 56 of the 65 (86.2 percent) Asian AIDS cases involved homosexual/bisexual behavior as the only identified risk factor. This constitutes the same percentage of individuals in this category as in Hispanic populations (86.1 percent). In all, Asians/Pacific Islanders made up 1.7 percent of the total cases attributed to homosexual/bisexual behavior.

Intravenous drug use alone was implicated in 2 of 65 (3.1 percent) Asian AIDS cases. This compares with 25 of 252 (9.9 percent) IVDU-only cases in the black population, 9 of 287 (3.1 percent) IVDU-only cases in the Hispanic population, and 14 of 3,347 (0.4 percent) IVDU-only cases in the white population. The numbers, however, are subject to interpretation in that they represent a cumulative total and are greatly influenced by factors such as time of viral introduction and mode of viral infection transmission into the various subgroups.

¹Population estimate derived from 1980 U.S. Bureau of Census figures.

Table 1.—Asians with AIDS in New York City

Homosexual/bisexual	48
I.V. drug users	3
Information not available	11
Total	62 ^a

^a0.5% of 11,939 total AIDS cases

Source: New York City Health Department, AIDS Surveillance Office, October 28, 1987.

Table 2.—Asians with AIDS in Los Angeles County

Homosexual/bisexual	29
I.V. drug abusers	0
Homo-/bisexual IVDU	1
Hemophilia	1
Transfusion	9
Total	40 ^a

^a1% of 3,847 total AIDS cases

Source: Los Angeles County Health Department, AIDS Surveillance Office, November 30, 1987.

Table 3.—AIDS cases in San Francisco by race

Race	Number
White	3,347
Black	252
Hispanic	287
Asian/Pacific Islander	65
Native American	4
Total	3,955

Source: San Francisco AIDS Surveillance Office, October 31, 1987.

Table 4.—AIDS patients in San Francisco: Race by risk group

	White	Black	Hispanic	Asian/Pacific Islander
Homo/bisexual	2,865	169	247	56
Homo/bisexual IVDU	419	38	21	2
IV drug user	14	25	9	2
Heterosexual	9	7	1	0
Transfusion	22	4	2	5
Hemophilia	5	0	1	0
Other	13	9	6	0
Total	3,347	252	287	65

Source: San Francisco AIDS Surveillance Office, October 31, 1987.

Table 5.—Asian/Pacific Islander AIDS cases by ethnic group in San Francisco

	Percent of Population	Number of Cases
Chinese	12.1	15
Filipino	5.6	28
Japanese	1.8	16
Vietnamese	0.8	2
Pacific Islander	n.a.	3
Other	n.a.	1

Source: San Francisco AIDS Surveillance Office, October 31, 1987.

Another factor to consider when examining data in the Asian/Pacific Islander category is the tremendous heterogeneity of this population. As many as 32 distinct Asian ethnic groups have been identified in the San Francisco area, involving distinct languages, traditions, and behaviors. Table 5 provides a breakdown of the Asian/Pacific Islander category by ethnic groups, with city population estimates also provided.

As is apparent in this table, some populations are overrepresented in terms of their number of AIDS cases versus population percentage. Filipinos, for

example, are outnumbered by the Chinese population by better than a 2 to 1 margin, yet they account for nearly twice as many AIDS cases. Japanese are outnumbered by a more than 6 to 1 margin by the Chinese, yet there are a nearly equal number of AIDS cases in each population.

Clearly, some Asian ethnic groups are at greater risk than others (San Francisco Department of Public Health 1987). Factors that might account for this disparity would appear to be worthy of investigation. It has been suggested, for example, that the greater number of AIDS cases in the Filipino community is due to their considerable genetic and sociobehavioral overlap with the Hispanic population. This overlap could provide transmission routes into this community not found in other Asian subgroups. Unfortunately, little data are available to do more than speculate.

HYPOTHESES REGARDING CURRENT LOW INCIDENCE RATES

There are a number of alternative explanations for the current low AIDS incidence rates among Asians including:

- insular communities
- underreporting
- behavioral differences
- genetic differences
- later time of viral introduction

Insular Communities

Asian communities in the United States tend to be extremely insular. In largely urban areas, they often exist as highly identifiable entities where other ethnic groups go only when desiring a semiexotic meal. The general sociobehavioral isolation of Asian subgroups is not necessarily always a strictly voluntary one. While Asians often prefer to stay within the enclaves of their own family-oriented and highly structured societies, they are often helped into this isolation by other ethnic groups who tend to shun them. Asian homosexuals, for example, have been described as existing outside the general gay community due to their ethnicity and inability to meet the stereotypic "beautiful people" profile (San Francisco Department of Public Health 1987). This social isolation would, however, have the fortunate side effect of limiting some of the possible avenues of viral introduction into the Asian communities.

The problem of underreporting is admittedly not unique to Asian communities. There are, however, some cultural factors that might account for greater underreporting than evidenced in other groups. Among many Asians, discussions of sexual issues are greatly inhibited, and discussions of terminal illness may be believed to result in its occurrence (San Francisco Department of Public Health 1987). Such considerations, along with the strong and prevalent concept of shame or loss of face, might result in community physicians avoiding diagnosing a patient as having AIDS. Extreme cultural pressures might also result in suicide attempts or suspicious deaths in the Asian community as an alternative to such a diagnosis.

Underreporting might also be expected to occur on other levels. The numbers received by public health departments and the CDC are through the established and more traditional health care channels. It is possible that many Asians might not access the same health care resources as other ethnic populations. While there are little data regarding this possibility, such health care alternatives as acupuncture and herbal medicines are often sought.

The manner in which AIDS study samples are developed may also influence the overall picture. A recent seroprevalence study by Samuel and Winkelstein (1987), for example, reported a 27 percent HIV seropositivity rate in the 11 Asians tested in their cohort of 800 homosexual/bisexual men. The San Francisco-based sampling was said to be based on an "area probability" distribution, but the underrepresentation of Asians would appear to be relatively extreme. The study took place in a city in which over 20 percent of the population is Asian, and Asians are thought to account for as much as 10 percent of the San Francisco gay population, yet 11 of 800 is a representation of only 1.4 percent.

Behavioral Differences

AIDS is a disease that is transmitted through participation in specific high-risk behaviors that allow for viral transmission such as IV needle sharing or sexual activity with an infected partner. Little data are available regarding the specifics of sexual behaviors in U.S. Asian communities, but there are some clues. The prevalence of sexually transmitted diseases such as gonorrhea and syphilis in Los Angeles Asian communities, for example, is said to be 0.4 percent and less than 1 percent, respectively, of the total number of cases.² In San Francisco, approximately 1.1 percent of rectal gonorrhea cases reported in 1981 and 2.1 percent of the rectal gonorrhea cases reported in 1983 were said to be attributed

²Los Angeles County Health Department, Office of Sexually Transmitted Diseases, 1987.

approximately 80 percent of this category.

Little is known of the IV drug use problem in Asian communities except that there are not many Asians in drug treatment programs. In New York City, only 33 of the 36,365 or 0.1 percent of the total drug treatment slots are utilized by Asians/Pacific Islanders.⁴ While these numbers may not be an accurate reflection of Asian drug use, it would appear that the low involvement of Asians in the IV drug use mainstream is one possible explanation for the low rate of infection.

This does not mean, however, that IV drug use does not exist. As noted above, Asians do not always access the traditional services, and may not utilize drug treatment programs for a variety of reasons. The experience of Asian American Recovery Services, Inc., in San Francisco for example, is that if an Asian-run agency is established in an Asian community, it is suddenly discovered that there are Asian drug addicts—many of them IV drug users.

Genetic Differences

There is little or no evidence to suggest that the currently low incidence rates among Asians are due to genetic factors. On the contrary, an examination of AIDS cases related to transfusions or blood products would appear to support the hypothesis that Asians are equally susceptible to infection. The transfusion/blood components category is the only risk factor group that might be expected to reflect a similar time of introduction, a degree of racial blindness, and a common behavioral pattern across ethnic boundaries.

Table 6 presents national transfusion-related AIDS cases by racial/ethnic group and national population estimate. The numbers from San Francisco indicate that Asians accounted for 15.2 percent of the total transfusion-related cases and 21 percent of the total population, while in Los Angeles county they account for 10.6 percent and 8 percent respectively. Nationally, the "other" category accounted for 2.8 percent of the transfusion/blood products category and approximately 2.2 percent of the total population.

Later Time of Viral Introduction

Another possible explanation for the currently low incidence rates is a later time of viral introduction into the Asian communities. The above-mentioned cultural/behavioral insulation from other subgroups may have served to retard the process of community infection. Unfortunately, this cultural/behavioral

³San Francisco Department of Health, Office of Sexually Transmitted Diseases, 1987.
⁴Division of Substance Abuse Services, State of New York, 1987.

	Number of Cases ^a	Percent	Population Est. In Thousands ^b	Percent of Population
White	784	75.5	153,730	80.6
Black	155	14.9	20,430	10.7
Hispanic	71	6.8	12,450	6.5
Other	29	2.8	4,180	2.2

^aSource: Centers for Disease Control, November 1987.

^bSource: National Institute on Drug Abuse, *National Household Survey on Drug Abuse*. 1985 population estimates.

isolation might also serve to accelerate the spread of the disease once it penetrates these tightly knit communities. The insularity might make intervention by traditional health care resources a difficult undertaking as language and cultural differences may serve as formidable barriers to effective intervention.

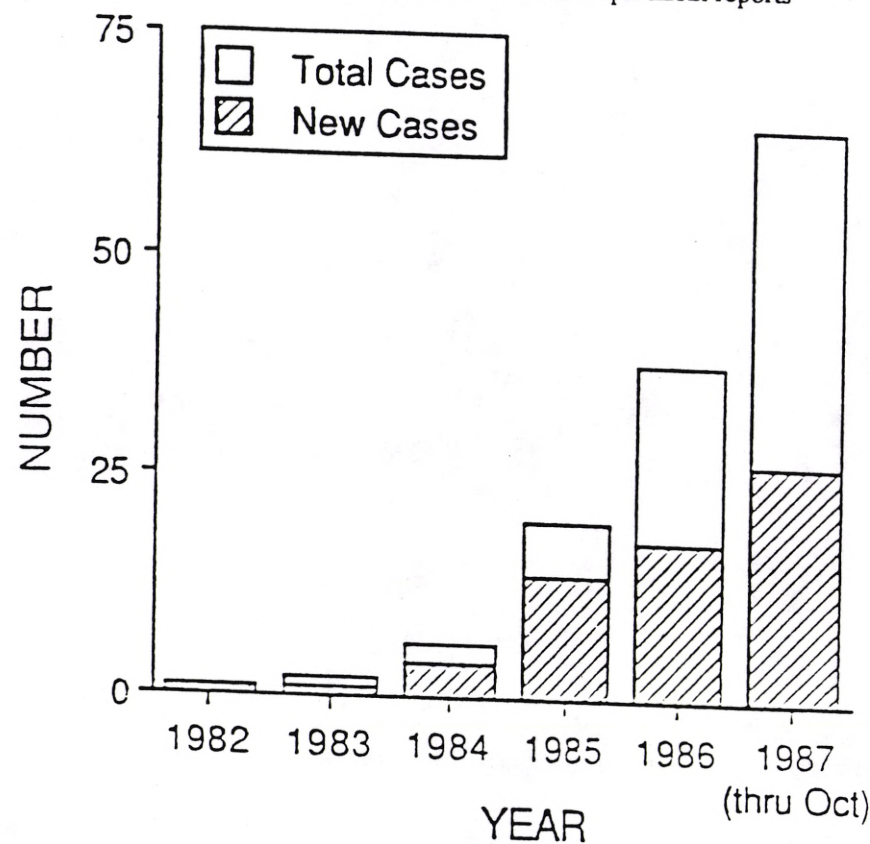
DISCUSSION

There is no doubt that the Asian community is fortunate to have experienced the relatively low infection and mortality rates to date. The problem, however, is the complacency such numbers may falsely engender in both the Asian communities and the government agencies assigned the task of safeguarding their health. Figure 1 illustrates the reason for concern as it shows the number of Asian AIDS cases in San Francisco is accelerating annually.

At present, there is a great need to improve the collection, reporting, and availability of Asian and other minority statistics. The lack of an adequate data base prevents the formulation of effective interventions in minority communities with respect to this deadly virus. It also allows the Asian communities to continue in their comfortable ignorance of the dangers, and it prevents communicating the need for necessary changes in behavior.

If it should turn out that the current numbers are reflective of an enduring low incidence rate, then the Asian community might serve as a useful comparison group with respect to sociobehavioral factors that are effective in preventing the rampant spread of AIDS. That possibility in itself should justify a further examination of the Asian AIDS picture.

Figure 1. Cumulative number of Asian AIDS cases in San Francisco since the first diagnosed case in 1982 through October 1987. Data collected by the Asian AIDS Project from San Francisco Health Department reports



NATIVE AMERICANS, STEREOTYPES, AND HIV/AIDS

Our Continuing Struggle for Survival

Ronald M. Rowell, MPH

Executive Director, National Native American AIDS Prevention Center

A discussion of the AIDS epidemic among Native American people requires a brief introduction to some of the facts of modern Indian life. Moreover, in order to make sense of the problem of HIV/AIDS among Native Americans, some stereotypes must be laid to rest and the reader must be given a contextual framework within which to place such information.

The Impact of Stereotypes On Indian Life

The realities of Indian life have been obscured due to centuries of multilayered stereotypes which continue to confound understanding and communication. Vine Deloria put it succinctly when he said: "People can tell just by looking at us what we want, what should be done to help us, how we feel, and what a 'real' Indian is really like...To be an Indian in modern American society is in a very real sense to be unreal and ahistorical."¹

Unfortunately, the cigar store, befeathered Indian caricature is still considered acceptable by a majority of non-Indians: for example, it still serves as a mascot for football teams, and it is still used as a model for dressing young children in costumes on Halloween. It is difficult for non-Indians to understand how irritating, depressing, and destructive this type of stereotyping is, and how little it represents the Indian cultures of today.

It is especially damaging to younger Indians, who are struggling with their identities. Try to imagine and understand what it would be like, when one is in school, in one's country of origin, to have one's own history and culture ignored — or, at best, mentioned only in passing. Or, what it would be like, as an adult or young person *never* to be treated as a real person — and to have non-Indian people constantly invalidating your identity because you do not fit their stereotypes. Such behavior toward Indians — as true today as it ever was — is part of what we mean when we speak of "cultural genocide." When these stereotypes get in the way of health professionals providing education, prevention, surveillance, and information, the results can be tragic.

The number and sheer depth of stereotypes about Indians create stress and anxiety for many Native Americans. These stereotypes also create barriers in acknowl-

"The number, and sheer depth, of stereotypes about American Indians create stress and anxiety for many Native Americans... At the root of such stereotypes is the mistaken view that we are one people. Like Europeans, Native Americans are not one people."

edging the existence of AIDS in our communities, and in recognizing individuals who have AIDS for AIDS case surveillance.

We Are Not One People

At the root of such stereotypes is the mistaken view that we are *one* people. Like Europeans, Native Americans are not one people, although our experiences with the outside world have helped to create a pan-Indian identity. One's tribe (nation) — Choctaw, Peoria, Tlingit, Malecite, Arikara, Okanagan, Snohomish, Caddo — is where one's primary ethnic identity lies. Each tribe has developed its own language, customs, and beliefs; each has had a different history; and each has exercised its own strategy for dealing with the relentless invasion of new peoples and with the catastrophic changes that have taken place in their traditional lifestyles.

How We Are Labeled by Others and By Ourselves

All Native Americans, in our languages, are and always have been "the people." But, among most of us today, "Indian" is the most common term used when we talk with one another in English. Nonetheless, it is important to understand that, until the Europeans arrived and thought they had come upon India, among the indigenous population there were no so-called Indians.

Several terms will be used in this article, interchangeably, for the aboriginal inhabitants of North America, none of which is at all, or entirely, accurate, though all of which have been accepted in American English to some degree or another. "Native American" and "Indian"

HIV/AIDS AND THE ASIAN AND PACIFIC ISLANDER COMMUNITY

Contributed by:
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"We are sitting on a time bomb that is wired to cultural and medical issues that are being ignored and neglected. The disease has also spotlighted inadequate health care services for the poor, as AIDS becomes less a terminal illness, and more a chronic disease. If the disease doesn't kill us, the continued lack of medical services surely will."

— Dr. Bertie Mo, medical anthropologist and AIDS educator¹

The year 1990 marks a new decade, with a renewed emphasis on a *multicultural approach* to AIDS education outreach efforts and services for the ethnic populations of the United States, including the Asian and Pacific Islander communities. The need for multilingual/multicultural services for these communities has become imperative, while funding for serving this growing population unfortunately has dwindled, seriously affecting an already inadequate health care system.

Some Background Information on This Population

Asians and Pacific Islanders are expected to account for about 15% of the nation's total population growth between 1990 and 2000 (they accounted for 12% between 1980 and 1990), and 18% between 2000 and 2010.² In essence, they are the nation's fastest growing minority group measured in percentage growth. Between 1970 and 1980, the Asian and Pacific Islander population increased from 1.5 million to more than 3.7 million, a 141% increase as compared to a 11% increase for the general U.S. population.³ This tremendous rate of growth continued into the eighties, with estimates by the Population Reference Bureau of an increase of 1.6 million between 1980 and 1985, which brought the total Asian and Pacific Islander population to 5.2 million in 1985.⁴ This increase can be attributed, in part, to changes in immigration laws during the mid-1960s, which lifted restrictions to immigration (Filipinos, Japa-

nese, Koreans, Asian Indians) and, since 1975, to the admission of Southeast Asian refugees (Vietnamese, Cambodians, Laotians, and other ethnic subgroups).

During the last eight years, more than 800,000 Southeast Asians have settled in the United States; the largest percentage reside in California, Hawaii, New York, Illinois, and Texas.⁶ Of the total Asian Pacific Islander population, 1980 census figures indicate that 59% are foreign-born, and that 69% speak a language, other than English, at home.⁷

Asians and Pacific Islanders are Culturally Diverse, Yet Similar

One must be sensitive to the "lumping" of Asians and Pacific Islanders together as one homogenous group. In addressing the health care/AIDS information and education needs of Asians and Pacific Islanders in the United States, it is necessary to recognize the cultural diversity of this population. There are at least 43 different Asian and Pacific Islander groups (see box on page 17), from more than 40 countries and territories, who speak more than 100 different languages and dialects (some unwritten). Each group has a distinct culture and heritage.

Recognizing and understanding the distinctions among the different groups are especially important when attempting to address their needs, and to reach them with appropriate information and education programs. For example, nearly 90% of Filipino Americans are Catholic and come from a country where the institutions are modeled after those of the U.S., but most Vietnamese are Buddhist and, until the last few decades, came from a tradition of a monarchy government.

The nuances that occur within the individual communities must be seriously considered — American-born *vs* foreign-born, gay *vs* straight, the traditional roles of parents and children, female and male issues, the internal class structures, and the "generation gaps" (new immigrants and refugees, and old; age differences) — to name just a few.

One must also understand that there are, as well, certain basic similarities that pervade all Asian and Pacific Islander cultures. *First*, the family and community are a

Asians and Pacific Islanders As Listed By the U.S. Census Bureau

Asian Groups

Chinese	Okinawan
Filipino	Pakistani
Japanese	Sri Lankan
Asian Indian	Thai
Korean	Bhutanese
Vietnamese	Borneo
Bangladeshi	Celebesian
Burmese	Cernan
Cambodian	Indochinese
Hmong	Iwo Jiman
Indonesian	Javanese
Loatian	Maldivian
Malayan	Nepali
Sikkimese	Singaporean

Pacific Islander Groups

Polynesian

Hawaiian
Samoan
Tahitian
Tongan
Tokelauan

Micronesian

Guamanian
Saipanese
Tinian Islander
Mariana Islander
Marshallese
Palauan

Melanesian

Fiji
Papua New Guinean
Solomon Islander
New Hebrides Islander

vital part of each individual's lifestyle, to the point that the needs of the family almost always supercede the needs of the individual. *Secondly*, sexual discussions are virtually taboo within these cultures. *Thirdly*, homosexuality is not accepted, either within the families or within the communities, which are considered one and the same among these groups. And *lastly*, any discussion of illness and death, in many of these cultures, is seen as a self-fulfilling prophecy; therefore such discussion is generally forbidden.

AIDS, unfortunately, integrates all of these factors, which makes any discussion concerning the disease difficult and complex. Moreover, Asians and Pacific Island-

ers have enormous problems with discussing sexual behaviors — despite the threat that HIV/AIDS represents to their lives — and, particularly, in the detail required for understanding the transmission of HIV. They tend to believe that if members of their communities adhere to traditional cultural norms and do not engage in sexual behaviors, or marry, outside of the community, they will not be at high-risk, and there will be no need to be concerned about HIV/AIDS — "Do not fool around with the 'white devils!'" they caution.

The "Model Minority" Myth

Some say that, while Asians and Pacific Islanders are often high achievers, the "model minority" myth — which is perpetuated by the media — that *they are always* academic and economic achievers, and are successful, compliant, quiet, and appropriately subservient — obscures serious problems in these communities, including poverty, substance abuse, mental illness, and domestic violence. The "model minority" label also puts Asians and Pacific Islanders in an uncomfortable comparative position. Other minorities, in effect, are told: "Why can't you be more like Asians and Pacific Islanders? Just work hard, keep quiet, and stop asking for handouts." Thus, they are targets for resentment, while the government and businesses play down the obstacles that hinder the progress of other minority groups. Lastly, the seeming superiority of this "model minority" alarms some Americans, who feel that Asians and Pacific Islanders are "taking over." Because they are not regarded as "real Americans," they are seen as a threat, rather than as an asset, in American society.

The median income for Asian and Pacific Islander families is slightly higher than the national average, but the statistics are skewed by the existence of a number of Asian Pacific people in the higher socioeconomic groups, which distorts the actual situation of this community.⁸ Contrary to popular belief, a large number of Asians and Pacific Islanders — most often immigrants or refugees — live below the poverty level (they have an average poverty rate of 13% as compared to the national poverty rate of 12%), speak limited English, are limited to accessible and affordable health care, and suffer from numerous health problems. This bipolar or bimodal distribution of Asians and Pacific Islanders is frequently overlooked when studying this community, which reinforces the view that they have few, if any, problems of any kind.

The model minority myth also portrays Asians and Pacific Islanders as having excellent health, as does existing medical literature and government data, which reinforces the belief by policymakers, planners, and funders that there are no significant health problems within this population.

But, the studies that such conclusions are based on have serious shortcomings and are severely lacking in conclusive evidence. The main problem with the data is that crucial distinctions are not made between the various ethnic and socioeconomic subgroups within the overall population; the health care needs of one subgroup do not necessarily apply to the others. In addition, differences between recently arrivals and United States-

born Asians and Pacific Islanders are typically overlooked, yet such differences are extremely important when attempting to reach these groups with information and services. Current data is weighted against the longer, more established, healthier, ethnic groups, rather than the less settled, immigrant and refugee groups.¹⁰ The studies also frequently make conclusions about Asians and Pacific Islanders using an insufficient sample size, and offer limited data on mortality and other health status indicators.

The lack of available data helps to perpetuate the model minority myth, and generalized interpretations of current data poses a problem in identifying the real health needs of Asians and Pacific Islanders. This leads decision-makers to conclude that there is no need for social services, affirmative action programs, and other necessary supports. It is important that this situation be addressed. Diminished funding for important and necessary health programs, vital to the health status and care of the Asian and Pacific Islander population, including people with AIDS, will otherwise mean the elimination of absolutely crucial services.

Denial — "Asians and Pacific Islanders Do Not Get AIDS"

"Suffering in silence is one of the great tragedies of the Asian culture."

— Amy Tan, author of *The Joy Luck Club*¹¹

The fact that Asians and Pacific Islanders are viewed as a "model minority" lends itself to misconceptions that tend to perpetuate stereotypes, not only by the greater society, but even among Asians and Pacific Islanders themselves. *Even they see themselves as the model minority — the achievers who do not engage in high-risk sexual behaviors or shoot drugs.*

To a great extent, the Chinese, Japanese, Koreans, Southeast Asians, and Filipinos all reflect similar cultural attitudes towards sexuality. Sexuality is not considered an appropriate topic for discussion, and by some religious (Catholic) and institutional (Confucian) norms, such discussion is even considered immoral. It is, therefore, easy to understand that most heterosexual Asians and Pacific Islanders do not believe that members of their communities engage in high-risk sexual behaviors or use drugs.

The youth in these cultures are expected to be obedient and filial. They feel pressure, because of traditional customs, to please their parents by excelling in school, for example, or by becoming betrothed in their early teens. In some of these cultures, once the females start menstruating, they are expected to procreate (possibly a child every two years) and carry on the family name. Many of them succumb to the pressures of living in a bicultural society and turn to drugs and alcohol.

There is even greater reluctance to believe that a significant gay and lesbian population exists within their communities. Homosexuality, despite its existence in all Asian and Pacific Islander countries, is suppressed — most homosexuals are "in the closet." Moreover, fami-

lies with homosexual members are often stigmatized. Familial, economic, and cultural ties to the community and family lead gay Asians and Pacific Islanders (especially immigrants who find it difficult to assimilate into the white, gay subculture) to have sexual contacts with those of other ethnic groups and to have more anonymous contacts. Also, many men fulfill their familial obligation of marriage and children, but continue to engage in homosexual behaviors; bisexual men are especially hard to reach because of their low visibility; and members of these communities are generally ignorant in regard to safer sex practices.

Because of denial, misperceptions, and inaccurate information, many heterosexuals have continued to deny the existence of AIDS in their communities, believing that if individuals in their communities adhere to cultural norms, there will be no need to be concerned about AIDS. AIDS, perceived as a "gay, white" disease, is looked upon with intense homophobia. The prevailing attitude, that if Asians and Pacific Islanders stick with their own, they will not get AIDS, reinforces the overall community's continuing reluctance to accept the AIDS epidemic as a problem, which is a great barrier in providing adequate services to the HIV-infected. This denial is especially evident when working with people with AIDS, as will be seen in the examples that follow. It is also important to understand that terminal illnesses such as cancer are taboo topics of discussion. Because of traditional beliefs about "fate," such illnesses, which now include AIDS, may cause shame within a family. Responsibility for contracting such diseases is frequently placed on the family, by themselves and by others — the disease is the result of bad spirits, karma, "I did something to offend my ancestors," for instance.

Many Asian and Pacific Islanders with HIV/AIDS hide their illness until the last stages of the disease, or even worse, they suffer and die in isolation. The following examples may help to clarify the importance of family and of not disgracing the family, duty, filial piety, fear and ignorance, shame, and saving face in these cultures — concerns not generally perceived nor understood by mainstream AIDS agencies.

A Vietnamese immigrant, a gay man in his 30s who lives with his mother and sister, visits an AIDS health care agency. Primarily monolingual, he refuses the services of a translator — another gay man — because he fears that he might know the person. Sacrificing his own health, he protects his secret from his family and his community.¹²

A 24-year-old Japanese student mysteriously left Los Angeles two months after he had bought a condominium. Friends said he returned to Japan because he found out that he had AIDS. His family claimed he died two years later of a heart attack.¹³

A gay Hawaiian man with AIDS is admitted to the hospital with pneumocystis for the third time. When he calls his mother to inform her of his situation, she hangs up.¹⁴

A San Francisco AIDS/ARC hospice approves an Asian contractor's bid to renovate the outside of their building. Before any work is done, the contractor refuses the job saying his crew is at-risk because there are people with AIDS inside. Despite attempts by the Human Rights commission to educate the contractor and his employees in their native language, they respond by burning their "contaminated" clothes and educational materials.¹⁵

A Cambodian woman with AIDS is ostracized by the close-knit community in which she socialized. The people in her community believe that AIDS is easily transmitted. After she dies, her husband and five children are exiled from their community.¹⁶

Reported AIDS Cases

In early 1983, one of the first public AIDS conferences was held in San Francisco at the University of California Medical Center. An epidemiologist stated to the 100 people in the audience that Asians were believed immune to the deadly virus.¹⁷ There were no reported cases of AIDS for either Asian men or men of Italian ethnicity at that time. The medical community looked upon this with hope, as studying a group that

appeared to be immune might give important clues concerning the nature of the disease itself, about which very little was known. In the early stages of the disease, 1982-84, personal ads soliciting Asian men for relationships substantially increased.¹⁸ Some concluded that this happened because white men assumed that they would be safe from the disease if they had Asian partners. Myths, stereotypes, and misinformation, such as the belief that Asian men were immune and lived clean lifestyles — free of drug and alcohol abuse — may have led to social/sexual partnering that possibly helped spread AIDS from the mainstream gay community to Asian gays. Asian men, as well, may have endangered themselves by being misled by the popular opinion that they could not be affected by the virus.

The hypothesis that Asians and Pacific Islanders were immune, unfortunately, was sadly disproved as the first case of AIDS in an Asian person was diagnosed three weeks later in California.¹⁹ Between 1983 and 1987, statistics were kept only for whites, blacks, Hispanics, and "others" (Asians and Pacific Islanders, Native Americans, etc. were all lumped together under this category), so there was no national record of Asian and Pacific Islander AIDS cases until 1988, when the government finally created the "Asian/Pacific Islander" category — the result of nationwide advocacy efforts by many different groups.²⁰ Asians/Pacific Islanders and Native Americans

BEHIND THE MASK... AIDS: IT AFFECTS ALL OF US

A Review by Carolyn Patierno, SIECUS AIDS Associate

The Asian and Pacific Islander community, which is the focus of the videotape *Behind the Mask... AIDS: It Affects All of Us*, tends to evoke images of mystery, of the exotic, and of serene simplicity. The mask of silence therefore prevails. The AIDS crisis, a crisis of great difficulty and devastation, does not lend itself to open discussion within Asian and Pacific communities; however, open discussion is precisely what is needed.

The powerful feature of this video, then, is that it profiles Asian-Pacific people with AIDS (PWAs), and their families, and reveals the harsh reality of living with AIDS within their communities. Those profiled in the video share their experiences and their pain, encouraging viewers to protect themselves and those they love. The most effective means of protection — communication — is encouraged throughout the video. One PWA explains that Asian-Pacific Islanders are taught not to show their emotions. (Not unlike many other cultures). However, she says, "education is the key," and in order to educate and be educated, people must communicate.

The family of a man who has died of AIDS-related illnesses is profiled; each is supportive and shows great love for the man, who is their son, brother, and uncle. Dealing with AIDS as a family, they rally around him. One nephew says, "We had him until the following June" (one year after he had been diagnosed). The same young man, in-

spired by his family's experience, goes on to say that people "have to think about what to do to protect themselves or to help other people who have AIDS."

Another PWA, a woman, emphatically states that "there is no shame in finding out how to protect ourselves and our families." Despite her diagnosis, she remains positive in her attitude regarding sexuality: "Sex, like anything else, is there to be enjoyed." However, she adds, protection is of utmost importance.

The video covers the epidemiology of the virus and avenues of transmission — and the information is accurate. Also acknowledged are medications that are Eastern in their origins. It is during these segments that the video tends to be clinical. A bit of a chasm is created between the more personal accounts of HIV/AIDS and the more clinical sections. Nonetheless, the video is professionally and sensitively produced, and the message is clearly stated over and over again: AIDS is everyone's problem. It affects all communities. So, it is up to all of us to try to bring its devastation to a halt.

Association of Asian/Pacific Community Health Organizations, 310 8th Street, Suite 310, Oakland, CA 94607, 415/272-9536. Price per videotape: \$50, nonprofit \$35; set of 1/2" videotapes in six languages (English, Cantonese, Korean, Samoan, Tagalog and Vietnamese): \$250, nonprofit \$175. Free audiocassette available.

now are separate subgroups. However, in looking at local statistics, in San Francisco alone the Asian and Pacific Islander community experienced a 77% jump in cases between 1987 and 1988.²¹

As of January 1990, the total number of Asian and Pacific Islander AIDS cases reported to the Centers for Disease Control was 757. Seventy-five percent of all adult cases of AIDS in this community have been attributed to male homosexual/bisexual contact, 4% to IV drug use, 2% to coagulation disorders; and 8% to blood transfusions (received before 1985). Fourteen percent of AIDS cases occur in persons over age 50, a higher rate than found among whites, blacks, Hispanics, or Native Americans. One percent of males, and 35% of females, contracted HIV through heterosexual contact, which is higher than the rate found among white, black, Hispanic, or Native American women. Nine cases of pediatric AIDS have been reported: three are children with hemophilia; three have mothers who tested positive for HIV; and three contracted the virus through blood transfusions.²²

National statistics are not available by ethnic subgroups, however, which is a major issue among the educators and researchers of this community. When statistics were gathered for the subgroups in San Francisco, however, the Filipino community was found to have been most affected by HIV/AIDS, accounting for nearly 46% of Asian and Pacific Islander AIDS cases. They were followed by the Japanese, 19%; the Chinese, 20%; the Polynesian/Hawaiian, 7%; and the Vietnamese, 4%.²³

The above figure of total AIDS cases (757) must be considered neither complete nor absolutely reliable as an indicator of AIDS cases within the Asian and Pacific Islander community for a number of reasons. Most importantly, of course, is the fact that statistics were not kept for Asians as a separate ethnic group until one year ago.

Moreover, there has been widespread underreporting. One instance of this is illustrated by the following: at a recent HIV/AIDS support group in Los Angeles, only nine of the 16 individuals claimed that their cases were recorded by the CDC as "Asian/Pacific Islander"; two were of mixed heritage, but were reported as "white"; and the remaining five, to their knowledge, were not reported at all.²⁴

But, there are other reasons as well. If the person with AIDS is an immigrant, s/he may return to his or her birth country before the case is reported in the United States. Or s/he might stay in this country, but fail to seek treatment because of the stigma of homosexuality and drug use attached to the disease. In addition, some traditional Asian and Pacific Islander doctors do not feel that reporting is of great importance, and therefore do not report their patients' cases.

Many individuals also mask their illness as cancer, leukemia, or other illnesses, to avoid possible deportation by immigration officials. Restrictive immigration and naturalization laws and regulations inhibit newcomers from seeking health care. If an applicant seeking perma-

nent residency applies for welfare or Medicaid assistance, information will be documented that could possibly be used to deny the applicant citizenship or lead to deportation. Due to these implications, many immigrants will not seek Medicaid assistance or the services of health centers.

Mandatory HIV testing of immigrants and refugees creates further problems. The implications are clear that HIV-positive persons will be denied legal immigration status. Charges that the Immigration and Naturalization Service's (INS) mandatory HIV-testing program is discriminatory and inadequate are not surprising. Critics have claimed that its sole purpose is to deny legal status to HIV-positive persons and that it will lead those who are found to be HIV-positive to deportation to their native countries, most of which do not have adequate resources or treatment facilities available for treating HIV-infected people.

An immigrant from Thailand recently returned to his home country for a visit. While he was there, it was discovered that he was HIV-positive. INS will not allow him to return to the United States to be with his wife and child. He is presently living in a refugee camp.²⁵

With these factors in mind, we are led to believe that the actual number of AIDS cases among Asians and Pacific Islanders is much higher than it appears. And, although the absolute rate of AIDS cases in this community is relatively low, it is important to note, that in comparing the monthly HIV/AIDS surveillance reports from January 1989 to January 1990, there was a 32% increase in the number of AIDS cases among these groups within only one year's time.²⁶

Informational and Educational Outreach and the Role of the Media

It was not until 1987, four years after the first Asian/Pacific AIDS case was diagnosed in the U.S., that an agency was funded specifically for prevention and education within the Asian and Pacific Islander communities. Currently, there are several agencies providing prevention and education workshops and materials in different Asian and Pacific Islander languages. However, most of these agencies are located on the West Coast, specifically San Francisco, Oakland, Seattle, Los Angeles, and Honolulu. Services for Asians and Pacific Islanders in other parts of the U.S., particularly New York, Boston, Washington DC, and Chicago, are severely lacking. Culturally appropriate direct services for HIV-infected Asians and Pacific Islanders are virtually nonexistent. Because of the lack of available funds (efforts to obtain funds are a continual struggle), volunteer efforts and grassroots organizations continue to play an important role in outreach to the Asian and Pacific Islander communities.

National organizations, such as the Asian American Health Forum (AAHF), the Association of Asian/Pacific Community Health organizations (AAPCHO) and the National Asian/Pacific American Families Against Substance Abuse (NAPAFASA), are creating platforms to advocate

for increased funding and awareness in an effort to combat the epidemic within the Asian and Pacific Islander communities. Also, several coalitions have been formed by various agencies and individuals to address the lack of funding and available services.

Mainstream AIDS agencies also have had difficulty in confronting the challenge of reaching the Asian and Pacific Islander communities, and only recently have begun implementing programs to target these populations. Both the San Francisco AIDS Foundation and the AIDS Project of Los Angeles have been funded to develop an informational hotline in several Asian languages. In both cases, however, the funding for these projects are limited, and not expected to last for more than one year. While some mainstream AIDS organizations "do their best" to provide clinical and support services, language and cultural barriers impede these groups from providing proper and effective care. In addition, many Asians and Pacific Islanders do not have access to clinical trials and other programs (i.e. food banks and emergency funds) due to the aforementioned barriers.

Most public and private sector facilities — whether mainstream or Asian and Pacific Islander-serving agencies — that do provide primary, secondary, and tertiary care in a culturally-relevant manner are inadequate or nonexistent in these communities. The few centers that provide such services operate with limited resources and most often cannot meet the demand of patients seeking care. Furthermore, access to bilingual-bicultural health care workers is largely limited, and most often unavailable at most facilities that serve large numbers of Asians and Pacific Islanders. *The shortage of bilingual, culturally-sensitive services, unfortunately, is a determining factor in whether health care will be sought.*

Lack of proper financing; racism among mainstream agencies and funding organizations; issues in regard to sexuality and AIDS education, homophobia, and drug use; denial within the Asian and Pacific Islander communities; and cultural and language barriers all contribute to the continued lack of adequate and effective services for this rapidly growing population, and create barriers for those who are attempting to provide AIDS education and services to the Asian and Pacific Islander communities. Also, very little research has been done on Asian and Pacific Islander communities. A survey of AIDS knowledge and attitudes within the Chinese and Japanese communities in San Francisco was recently completed, and a similar survey within the Filipino community is currently underway. But, other proposed research projects have typically been rejected.

In a community where homophobia is extreme, and where 75% of AIDS cases are male homosexuals/bisexuals, proper methods of outreach and services have been unsuccessful, or even worse, they have been nonexistent. Mainstream gay safer sex models have been attempted by Asian and Pacific Islander health/AIDS educators, but they have failed in these communities. For example, in San Francisco, the "Stop AIDS" model, developed by gay men, was found to be ineffective among

gay Asian and Pacific Islander men, because it was not culturally relevant. Moreover, other models that have been developed by the gay community that work for the black and Latino communities have been ineffective among Asians and Pacific Islanders who are grappling with HIV/AIDS.

Dr. Terry Gock, chair of the Asian Pacific AIDS Task Force in Los Angeles, estimates that at least 50% of Asian and Pacific Islanders with AIDS are first generation.²⁷ First generation immigrants and refugees lack knowledge of Western medical practices (males, especially, show great pride when stating that they have never been to any "doctor," for example, and tend not to be prone to preventive health care measures). Other barriers, including their invisibility within the communities and language, trust, and confidentiality issues, lead to the total frustration of the health care providers and educators who are trying to reach them. Collaborative efforts among the gay/bisexual and heterosexual communities, however, are starting to pave the way for ongoing dialogues that address crucial issues such as these — and others, such as sexuality, drug and alcohol use, death, and outreach to women and youth.

For prevention and treatment methods to be effective within these highly diverse communities, they must be culturally sensitive and linguistically specific.

A 61-year-old Southeast Asian woman with AIDS is admitted to the hospital, because she is not taking the correct doses of her medication. Her son misinterpreted the doctor's instructions because he did not understand English very well.²⁸

For example, there are no pamphlets targeted toward English-speaking Asians and Pacific Islanders, and many of the existing mainstream pamphlets that have been designed for the general population are not culturally appropriate.

Also, there are many obstacles encountered when attempting to develop presentations in the different languages. The Tagalog language, for instance, does not have clinical terms for words such as penis, vagina, or intercourse. Therefore, the community health worker has to use familiar street terms, which many people find offensive, or English terms, which many people do not understand.

Many concepts and behaviors do not translate easily into Asian and Pacific Islander languages. For example, the Chinese characters used to pronounce AIDS, literally translates as, "love, disease, death" — and, what does that mean? Mixed and conflicting messages are given by these characters. In many Asian languages, the literal translation for "homosexual" is "deviant."

Another obstacle in regard to language can be noted in the Mien and Hmong communities, which do not have written languages. How then does one effectively and efficiently administer a pre- and posttest? There are also high illiteracy rates among Asian and Pacific Islanders; almost 80% of Laotian and Cambodian Americans, for

instance, cannot read their own languages.

Mainstream media plays a powerful role in educating the general public, including English-speaking Asians and Pacific Islanders, who rely heavily upon such outlets as their main source for information. Nonetheless, nationwide campaigns on matters such as substance abuse, sexually transmitted diseases, and AIDS do not address or portray Asians or Pacific Islanders, and, when they do, they often perpetuate the model minority myth and stereotypes that tend to compound problems even further.

In addition, Asian language media has historically reported false information on HIV/AIDS. In early 1983, when information was revealed that Asians and Pacific Islanders may be immune to HIV, it was featured by the Asian language media. Now, seven years later, many of those who heard or read this information still believe they are immune to HIV. As recent as October 1989, a Filipino newspaper headline read, "The Philippines' AIDS problem — Not Serious."²⁹ Conversely, the Filipino community has been the most affected of all Asian and Pacific Islanders. Such misreporting is particularly of concern to those conducting AIDS outreach programs in culturally diverse communities, as many Asian and Pacific Islander immigrants and refugees cannot benefit from mainstream media efforts because of their cultural differences and levels of acculturation; they therefore rely heavily on their native language media sources.

The media and organizations that conceptualize health education campaigns also must address issues of racism within their own infrastructures: merely including an Asian and Pacific Islander as a token image is not enough. Asian and Pacific Islander health professionals, researchers, and community activists need to be tapped into as resources for stories that affect the nation as a whole. Ignorance and a lack of cultural awareness are detrimental to the vitality and growth of the Asian and Pacific Islander community.

Conclusion

While the U.S. is traditionally known as a "melting pot," we must be aware of, and appreciate the uniqueness of the traditional culture of each American. As the demographics of the Asian and Pacific Islander community continue to change in the United States, the health needs and status of this population regarding HIV/AIDS needs to be adequately addressed. Health professionals and policymakers must familiarize themselves with the ethnocultural issues surrounding accessible and affordable health care/AIDS services for Asian and Pacific Islander communities.

Lack of knowledge increases both the spread of HIV and paranoia. The most effective tools available are proper education and accurate information. When addressing the Asian and Pacific Islander communities, and indeed all communities of color, one must be very knowledgeable and aware of the cultural and linguistic differences that will enable one to provide effective education and services.

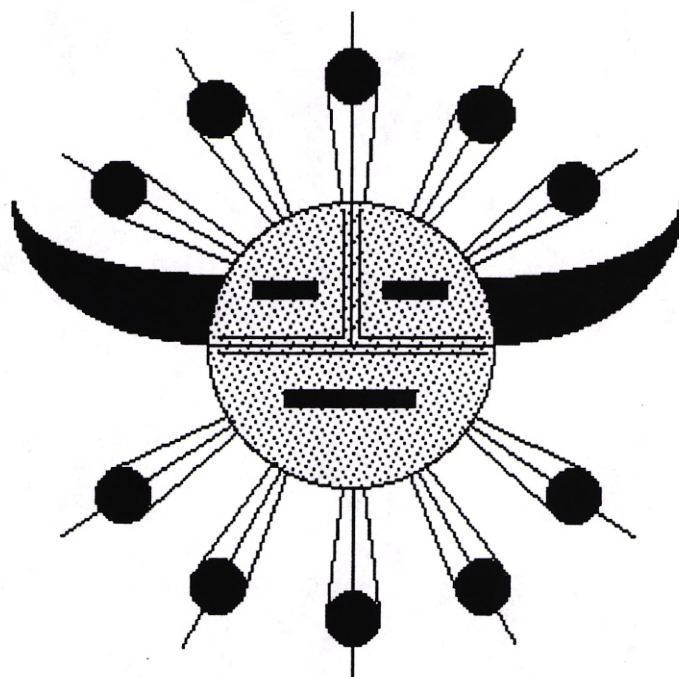
Two major barriers must be confronted in order to do this. One, we must overcome lack of funding, under-

standing, and sensitivity from both the public and private sectors. Two, the "model minority" myth, as perpetuated by both mainstream society and Asians and Pacific Islanders themselves, must be eliminated. Ignorance and a lack of cultural awareness is detrimental to the vitality and growth of the Asian and Pacific Islander community and to the nation as a whole. By continuing to work towards the elimination of the above barriers, we will gain a better understanding of this epidemic that continues to spread throughout this rapidly increasing segment of our society.

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Native American



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will be used in order to avoid the cumbersome and lengthy expression, "American Indian/Alaskan Native," which has several meanings: racial, ethnic, and legal.

The definition of who is, or who is not, an American Indian or Alaskan Native, depends on who is doing the defining. But, in the most general sense, these are individuals who are recognized by an aboriginal nation of North America as citizens of that nation. However, each nation or tribe exercises its sovereignty by defining who its citizens are, and there are no standard rules for what determines tribal citizenship. For example, some tribes require that individuals have a particular blood quantum (see box below); some that their mother is a member of the tribe; and some that they be descended from a base roll of tribal members at a particular point in time.

Congress occasionally has established its own eligibility requirements for specific federal programs for Indians, and the U.S. Census has relied on an individual's own perception of his or her ethnicity. "Federally recognized" American Indians or Alaskan Natives are tribally-recognized citizens of the original nations of North America that have maintained a government-to-government relationship with the United States. Since 1924, Indians have been dual citizens: citizens of the United States, and citizens of the aboriginal nation to which they belong.

We Are of Mixed Racial Descent

The majority of Native Americans are of mixed racial descent. In 1910, a special census of the American Indian population found that 35.2% of the Indian population at that time were of mixed racial descent.² By the 1930 census, 42.4% were "mixed-bloods." Moreover, the number of mixed-bloods varied by tribe. For example, among the Ojibwe (in 1930) only 18.7% were "full-bloods," while among the Pima 97.9% were full-bloods. In 1985, the U.S. Bureau of the Census reported that more than one-half of all American Indian men and

women were marrying non-Indians.³ Mixed racial descent leads to underreporting in case surveillance. For example, an Office of Technology Assessment report on Indian health (1986) stated that ethnic misidentification was the most important limitation on available mortality data.⁴

Such difficulties have led researchers to believe that there is underreporting of AIDS cases to, and by, the Centers for Disease Control (CDC) in respect to this community.⁵ Most case surveillance relies upon the diagnosing physician's report of an individual's ethnicity. The original information may or may not have come from the patient directly. In cases where a physician relies upon skin color or other racial features or on the last name, mistakes occur; it is not always easy to tell by sight or by name, who is or is not Indian. Native Americans, as a group, do not always fit the stereotypical racial characteristics expected by most non-Indians. It has been my experience that even Native Americans who are not of mixed-race often are misidentified as Filipino or Chinese. Also, many Indian people in the Southwest and California have Hispanic last names, and in the state of Washington many coastal Indians have intermarried with Filipinos. The solution to the problem is to encourage Indian people always to report that they are Indian, and to encourage service providers to *ask* before assuming a person's ethnicity.

We Are Invisible in Our Own Land

We are invisible in our own land. Many Americans are surprised that AIDS is a problem for our people — or even that we still exist. The realities of contemporary American Indian life are unknown to the vast majority of Americans, partly due to our small population. Since the initial European invasion of North America, epidemics of diseases over the centuries — including smallpox (perhaps the biggest killer), diphtheria, typhoid, cholera, syphilis, typhus, and alcoholism — against which Indians

"CERTIFICATES OF DEGREE OF INDIAN BLOOD"

In this late twentieth century, American Indians and Alaskan Natives are still being issued identity cards called "Certificates of Degree of Indian Blood" (CDIBs) by the U.S. government. These purport to "document" the amount of blood that an individual contains (here, a nonliquid measure) of an aboriginal tribe ($\frac{1}{2}$, $\frac{1}{3}$, $\frac{1}{32}$ and even $\frac{1}{1024}$ Cherokee or Creek, for example), as if it were possible for this to be an accurate measurement of ethnicity.

A common question now faced by an Indian person who is of mixed race is: "How much Indian blood are you?" It is curious why such a question is not automatically asked of the Irish, German, Italian, or Polish Americans, or indeed of any other ethnic group in this country.

Only black ethnicity was measured at one time by "blood" in Louisiana (it was measured in quadroons and octoroons, etc.), presumably to insure that no one with any black ancestry would taint the white bloodline of the inhabitants. Any at-

tempt to resurrect this nonsense with blacks today would be met, I am sure, with extreme reactions.

Why then do such certificates continue to exist for American Indians and Alaskan Natives? Where else does such a system exist? And what cultural assumptions and scientific facts underly their persistent use?

Our ethnic identity includes our communities, histories, memories, traditions, rituals, and kinship, which cannot be found in a blood quantum.

have had no immunity, have cost the lives of millions. A recent study of the history of epidemics among American Indians and Alaskan Natives estimates that approximately 500,000 North American aboriginals lost their lives each century from 1492 until 1900, the aboriginal population nadir.⁶

We as Native people have come close to extinction as a human community, and we are very conscious of that fact. Try to imagine a world without the benefit of the richness of our cultures, our experiences, and our presence. We have greatly contributed to the survival and growth of the American people, our country, and as far as that goes, the world. To illustrate what I mean: several years ago, I visited Romania, where I was presented with a meal of the Romanian national dish, *mamaliga*, a corn mush. It never occurred to my hosts that domesticated corn was a gift from aboriginal America to the Europeans. When most people think of potatoes, a staple in the European diet, they think of the Irish, even though potatoes were brought to the Irish from aboriginal America. My tribe, the Choctaw, even donated to the Irish Relief during the potato famine.

During the 20th Century, the Indian population grew substantially, from 100,000 to more than 1.5-1.7 million self-identified people of aboriginal descent, and to somewhat less than 900,000 legally-recognized tribal citizens. Nonetheless, Native Americans still make up less than 1% of the total U.S. population.

Not All Indians Reside On Reservations

When most people think of Native Americans, "reservation" is usually one of the first words that pops into their minds. In fact, only one out of four Native Americans resides on a reservation.⁷

Many Americans are unaware, for example, that what is now the state of Oklahoma was, prior to 1890, Indian Territory (not a true territory in the sense that Puerto Rico is a territory, but the location of small Indian republics). This territory was used, from the time of the purchase of Louisiana from France until the 1870s, as a relocation center for tribes driven from their homes in every region of the United States. The territory was originally granted by the U.S. to the so-called Five Civilized Tribes of the Southeast, with legal titles issued by the President of the U.S. After the Civil War, the Western lands of these tribes were taken and used for concentrating other tribes driven from their homes by the U.S. Army. Although the tribes of the Southeast had been forced to exchange their ancient homes for new land beyond the Mississippi, it came as a shock that, within one generation, the U.S. even took that away when in 1907 the state of Oklahoma was created. It may be of interest to note that, in 1906, the Five Civilized Tribes came within one vote in Congress of creating a separate Indian state called Sequoyah.

Oklahoma now has the second largest Indian population of any state. It, like California, the state with the largest population of Indians, is not a reservation state. In California, nine out of ten Native Americans live in urban areas;⁸ there are only two sizeable reservations

and a number of tiny rancherias. Also, the bulk of the state's Indian population has come from other states.

Reservations, which can be found from Maine to Alaska, are an important fact of Indian life and are unique to us — a few, in fact, are larger than some states (for example, the Navajo, which covers territory in four states) — but they tell only part of our story.

The myth that Indians live only on reservations contributes to the lack of visibility of the majority of Indians who live in cities or in nonreservation rural settings, and thus to problems with HIV seroprevalence data, AIDS case surveillance, and resource allocation.

HIV/AIDS in Native American Communities

As of January 1990, 159 diagnosed cases of AIDS among American Indians, Alaskan Natives, and Native Hawaiians had been reported and verified by the CDC.⁹ The Indian Health Service (IHS) and the CDC have just begun to undertake a seroprevalence survey of Native Americans nationwide. The purpose of this study is specifically to determine the extent of HIV infection in both rural and urban American Indian/Alaskan Natives communities. Results from this study are expected sometime in 1990.

AIDS cases have been reported among Native Americans in every region of the country, among both men and women, and from almost every age category; only ages 5 to 12 are not represented in the reported cases of AIDS, although there is a recent unofficial and unconfirmed report of a nine year old who was infected through sexual abuse. In comparison with the number of AIDS cases among whites, blacks, and Hispanics, these numbers may seem quite low. However, it is important to note that there are other sources of seroprevalence data, namely the Military Recruit Study and the Sentinel Hospital Study, that show American Indians/Alaskan Natives with higher rates of seropositivity than what one would expect from the number of reported cases.¹⁰ In California, the seropositivity rate for American Indians/Alaskan Natives in the Military Recruit Study is 4.4/1,000 second only to, and almost tied with, blacks.¹¹ Compared to whites, relatively fewer men were infected through homosexual sexual behaviors, and relatively more were infected through IV drug use (though a portion of the IV drug users were also men who have had sexual intercourse with men).¹²

Because of misperceptions among non-Native Americans, efforts to inform Native American communities about the risk of HIV/AIDS, and how to prevent the virus from spreading, were relatively late in getting off the ground. Indian people were forced to take matters into their own hands when it became apparent that the government, health professionals, and AIDS activists of all kinds did not consider Native Americans at risk — or even consider them at all. Unfortunately, it was initially difficult for otherwise responsible people to believe that Indian people could be endangered by AIDS, in spite of acknowledged high rates of syphilis, gonorrhea, chlamydia, and substance abuse among our people.

Because of stereotyping, Native American people have not been acknowledged as being sexual in the

same way as the rest of humanity. For example, the suggestion that there were Indian people with same-gender or bisexual orientation was considered shocking. However, in the past three years, at least two major books have been published on traditional and contemporary bisexuality and homosexuality among American Indians.^{13, 14} The books provide convincing evidence that many tribes have included a traditional social role for homosexual men; little has been written about women who are homosexual, which may be due to the fact that writers on the subject have been European men. Although many of our traditional attitudes have changed under the influence of Christian missionaries and general European culture, they have not entirely disappeared. As Lame Deer put it, "To us a man is what nature, or his dreams, makes him. We accept him for what he wants to be. That's up to him..."¹⁵

To a somewhat lesser extent, the same attitude and response has marked reactions to the use of IV drugs. Although most people associate alcohol abuse with Indian people — and there is a modicum of research on the subject — little has been known or written about Native Americans and the use of IV drugs, such as methamphetamines ("poor man's cocaine"), cocaine, and heroin, for example. Moreover, intravenous drug use is generally associated with cities (where Indians are not Indians according to some government officials) and is not considered an issue for the more isolated, rural Indian people. The reaction of some health professionals working with Indians has simply been to assume that IV drug use does not happen, rather than to thoroughly investigate the issue. The evidence that does exist points to a problem — at least in some communities.¹⁶

Indian Health Status and the Role of the Federal Government

A common misperception is that the federal Indian Health Service (IHS) takes care of the health needs of Indian people, and that Indian people receive generous benefits from the U.S. government. Attention to the need for HIV prevention education for Native Americans was delayed among states and other federal bureaucracies, partially because of the mistaken perception that the Indian Health Service would "take care of them."

The IHS is a poorly funded, small agency in a huge health bureaucracy that is unable to provide medical services for even one-half of the Indian population. For the past several years, the IHS has attempted to restrict its services to an even smaller proportion of the Indian population, but has not been successful. For example, three years ago the IHS published proposed regulations in the *Federal Register* to limit its services only to Indian individuals with one-quarter blood quantum or more of a particular tribe. Although the proposed regulations did not go into effect — due to the virtually unanimous Indian opposition and the intervention of Congress — the search for ways to serve only a few Indian people has continued. In spite of the fact that the majority of Indian people live in urban areas, urban Indian health programs have faced over the past several years an ongoing effort by the Executive Branch of the government to

RESOURCES DESIGNED FOR NATIVE AMERICAN COMMUNITIES

WE OWE IT TO OURSELVES AND TO OUR CHILDREN, an awardwinning health education publication designed especially for Native American communities, is a booklet of traditional poetry, Native American stories, and images. Focus group testing showed that Native Americans felt embarrassed by most materials on STDs. To diffuse the embarrassment associated with STDs, this book was designed to be subtle, beautiful, and informative, in order to effectively teach individuals in small group settings about sexually transmitted disease (STD) prevention and treatment, including condom use.

*Grandmother Spider
Wove the world out of Herself
Silvery strands of color
connecting all
weaving webs of generations
and regenerations*

(This excerpt from the book is accompanied by a photograph speaking of the strength of a Yuma mother, holding a child on her lap.)

The images and legends appeal to individuals to think not only of themselves, but of the family, and of the generations to follow. They reflect the Native American tradition of being connected to the group, the tribe, and the family, and also reflect the reality that STDs are not an individual problem, but one of relationships and of society. The publication demonstrates that it is possible to present a number of messages, combine traditional Native American approaches with government health guidelines, and still speak to the reader with sensitivity and respect. \$5.

WE OWE IT TO OURSELVES AND TO OUR CHILDREN: THE VIDEO uses cartoons from *Understanding STDs* and *Understanding AIDS and HIV* to illustrate the causes, symptoms, treatment, and prevention of AIDS and STDs. 8 mins. \$35.

UNDERSTANDING STDs is a *storytelling packet* that consists of 25 separate cartoons illustrating the treatment and prevention of STDs. Each 8½x11 cartoon comes with text. Includes a facilitator's guide, with instructions for making handouts, transparencies, and slides for group presentations. \$5.

take away their funding support.

Even the medical care available to the few eligible Indian people has been severely restricted. An example of this is the fact that in 1984 per capita annual expenditures for contract care (the care mainly provided by sec-

UNDERSTANDING AIDS AND HIV, a companion piece to *Understanding STDs*, is a *storytelling packet* that consists of 25 separate cartoons illustrating the treatment and prevention of HIV infection and AIDS. Each 8½x11 cartoon comes with text. Includes a facilitator's guide with instructions for making handouts, transparencies, and slides for group presentations. \$5.

CIRCLE OF WARRIORS, a *video* (produced by the Alaska Native Health Board, in conjunction with the Seattle Indian Health Board and NNAAPC, and dedicated to the memory of Ray Harjo) featuring nine Native American adults and one child who are living with HIV/AIDS. They discuss sexuality, health, discrimination, and family. 27 mins. \$75.

FACE TO FACE, a *video* (produced by the Alaska Native Health Board, in conjunction with the Seattle Indian Health Board and NNAAPC, and dedicated to the memory of Ray Harjo) is composed of five extended interviews with Native Americans living AIDS who discuss various aspects of their lives, including health, sexuality, testing, childrearing, and discrimination. Discussion guide included. 47 mins. \$100.

AIDS: THE BASICS. A MANUAL FOR NATIVE AMERICAN HEALTH AND HUMAN SERVICE WORKERS — developed by Ron Rowell, MPH (Choctaw/Kaskaskia), Terry Tafoya, PhD (Taos Pueblo/Warm Springs), and Corinne Axelrod, MPH, (California Rural Indian Health Board) — covers: AIDS and substance abuse, STDs, attitudes, beliefs and psychosocial issues, traditional Native American medicine and AIDS, training, and target groups. Includes a sample needs assessment, a lesson guide, sample pre- and posttests, and other methods of evaluation, references, statistics, and a glossary. \$5.

SEASONS, a *quarterly publication* of NNAAPC, contains information about AIDS and HIV infection, HIV prevention, models for education, and updates on treatments, grants, and training. Free.

INDIAN AIDS HOTLINE: 800/283-AIDS

For more information contact the National Native American AIDS Prevention Center, 6239 College Avenue, Suite 201, Oakland, CA 94618, 415/658-2051.

ondary and tertiary care centers outside of IHS, but paid for by IHS) ranged from \$7.33 in California to \$473.15 in Montana and Wyoming.¹⁷ If you live, as I do, in an area where it is difficult to buy even one lunch or dinner for \$7.33, or if you are familiar with the cost of a one-day

stay in an average hospital, you will understand the quantity and quality of the health care that these funds purchase. When IHS has no funds to purchase AZT or aerosol pentamidine, for example, Indians with HIV infection may go without life-enhancing treatments. Physicians and health activists are now discussing the concept of "rationed care" for the general population, but for American Indians such care has been a way of life for decades.

A few years ago, the IHS budget was slashed by several million and the funds were transferred to the National Institutes of Health under pressure for increased government funding for AIDS. That money was never replaced, nor were the funds used to establish HIV prevention programs in American Indian communities.

"...the health status of Indian people is still poorer than that of the general U.S. population, on almost every health indicator."

In a system in which public funds are allocated on the basis of clout, either in numbers or due to a high degree of political organization, American Indians have had neither. Moreover, there has been little public support for continuing to provide Native Americans with the services promised in the past, and virtually no understanding that the minimal services that are provided were bought at a very high price. If one combines the lack of understanding among most Americans of the contracts their ancestors originally made with the native peoples of this land, along with the small Native American population, any attempt to improve the health of our people or to guarantee our rights under solemn agreements becomes extremely difficult, in almost all circumstances.

It should therefore not be surprising that the health status of Indian people is still poorer than that of the general U.S. population on almost every health indicator.¹⁸ Thirty-seven percent of Native American people die before the age of 45. In 1985, of the top 10 causes of mortality, four were directly caused by substance abuse, and the majority, if not all the rest, can be viewed as indirectly related. Infant mortality rates among Native Americans have improved considerably since the mid-1950s, but these rates still exceed those of all other races in the U.S., largely due to death in post-neonates.¹⁹

Outreach in Native American Communities

Although we might wish that AIDS education outreach efforts had been begun earlier, having been forced to organize our own efforts has not been without its benefits. This new challenge has reminded us of the elements of our culture that have allowed us to survive, in spite of everything that has happened, and to apply what we have learned in working with the AIDS epidemic. For example, our cultures' common values — respect for our elders, teaching our children survival skills, focusing on the extended family, strong spiritual traditions, storytelling and humor — all have helped us to

Traditional Medicine People Gather To Talk About AIDS

A special "Gathering for Traditional Medicine People and Healers to Talk About AIDS," is now sponsored annually in California by the Native American AIDS Advisory Board. Close to 200 people attended the last gathering, representing more than 33 tribes from throughout the state, to obtain information about AIDS, to discuss HIV/AIDS among Indian people, and to learn how traditional Native American practices, including the use of medicines and herbs, can be effectively used to help prevent and treat HIV/AIDS and other health problems, such as alcohol and drug abuse, in Native American communities. The three-day event has included traditional Native American ceremonies, sweats, and dancing.

Further information on these gatherings can be obtained by contacting Larry Murillo, Project Director, Native American AIDS Education and Prevention Program, California Rural Indian Health Board, 2020 Hurley Way, Suite 155, Sacramento, CA 95825, 916/929-9761.

design educational strategies that work for our communities. Traditional Native American healers have been quick to respond to the epidemic and traditional healing practices, many of which are preventive in nature, are being used. Indian people with AIDS have chosen to involve both traditional and Western medicine in their treatment plans. Also, Indian artists and musicians have worked on the design of materials. The AIDS prevention effort has become a force in the broader movement of self-determination for Native American people.

Indian communities have come together, and they have begun to organize. There are now locally-based, regional and national Indian AIDS prevention education efforts, both funded and nonfunded.

The National Native American AIDS Prevention Center (NNAAPC) in Oakland, California was funded by the U.S. Centers for Disease Control in 1988 to assist locally-based and regional efforts with training and technical assistance. NNAAPC is an Indian governed and managed private nonprofit organization. The agency operates a national toll-free Indian AIDS Hotline and a clearinghouse for Native American-targeted, AIDS-related, health education materials, and provides information services to clients, including distribution of a quarterly newsletter, *Seasons*. The National Indian AIDS Media Consortium, also funded by the CDC, is a NNAAPC cooperative project with the Native American Press Association that provides ongoing information to Indian newspapers and radio and television stations about HIV/AIDS, in order to encourage regular reporting on the issue.

Another national organization, the American Indian Health Care Association of St. Paul, Minnesota is also funded by the Centers for Disease Control to produce Native American-targeted health education materials and to assist its urban Indian clinic members.

In some states, Washington, for example, the Seattle Indian Health Board has joined forces with other people of color to insure that resources are made available for Native American projects. In Minnesota, the Minnesota American Indian AIDS Task Force has done an outstanding job of organizing both urban and reservation communities, and is working cooperatively with a wide range of agen-

"Our struggle is — as it has been for so long — a struggle for survival as a people. We are not being alarmist when we raise the potential of another demographic collapse due to AIDS and the disappearance of entire indigenous cultures. An epidemic which primarily affects those individuals in their most fecund years can destroy a tribe's future. It has happened before in our history and it can happen again. However, we are tough and we are determined. We will survive the AIDS challenge. We have 30,000 years of experience in America to help us do so."

cies and organizations. The Alaska Native Health Board has worked long and hard to reach isolated communities by utilizing new communications technologies and by producing excellent educational materials. In Arizona, the Inter-Tribal Council of Arizona has organized reservation-based AIDS prevention activities. In Phoenix, the urban Indian clinic has begun an outreach program to gay and bisexual Indian men and is working closely with

the Arizona Department of Health. In California, San Francisco's American Indian AIDS Institute has developed AIDS educational materials for Indian men and for teens and has provided training to local Indian agencies, and the Native American Health Board of Oakland has begun a Youth Empowerment Project to train Indian teens as peer counselors. In Oklahoma, the Intertribal AIDS Task Force and Oklahoma City's urban Indian clinic have been working hard to get the word out and to support Indian people with AIDS. In South Dakota, the Native American Women's Health Education Resource Center has begun organizing a statewide Indian AIDS Task Force, with participation from most of the reservations in that state. In Maine, the Penobscots and Passamaquoddies have established community-wide AIDS task forces and have held town hall meetings.

This is by no means an exhaustive list of AIDS activities in Indian country, but as you can see, Indian people have responded vigorously to the challenge posed by AIDS. *We know an enemy when we see one.*

Conclusion

Most Indians realize that AIDS cannot be divorced from other major health problems. They are all connected, and we must enable others to see these connections. There are many ways to approach HIV/AIDS prevention, but STD control and substance abuse prevention and intervention are the most obvious. The purpose of HIV/AIDS prevention education is to change behaviors that place individuals at risk. If we succeed in changing the sexual and substance abusing behaviors at the root of HIV transmission, we will also succeed in preventing other major problems like Fetal Alcohol Syndrome, STDs, chronic liver disease, and the majority of accidents, homicides, and suicides that occur among Native Americans. We must use every avenue open to us.

Our struggle is — as it has been for so long — a struggle for survival as a people. We are not being alarmist when we raise the potential of another demographic collapse due to HIV/AIDS and the disappearance of entire indigenous cultures. An epidemic which primarily affects individuals in their most fecund years can destroy a tribe's future. It has happened before in our history and it can happen again. However, we are tough and we are determined. We will survive the AIDS challenge. We have 30,000 years of experience in America to help us do so.

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This issue of the *SIECUS Report* was produced in cooperation with the Centers for Disease Control, Cooperative agreement # U62 CCU 2011 28-01. SIECUS is grateful to the Review Committee for their comments and suggestions: Antonio Burr, PhD, senior psychologist at St. Mary Hospital Community Mental Health Center; Maureen Corry, deputy director of community services, March of Dimes Birth Defects Foundation; Father Patrick McGovern, associate pastor of Our Lady of Fatima Parish; Rodger McFarlane, executive director of Broadway Cares, Inc.; Ron Moglia, EdD, director of the Human Sexuality Program (SEHNAP), New York University; and Catherine Smith, MPH, director of Family Life Education Projects, Girls Clubs of America.

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11412 AIDS Prevention Among Hispanics

This article was written by Gerardo Marin, Ph.D., and appeared in the September-October issue of Public Health Reports, which is published by the U.S. Public Health Service. For further information, contact Public Health Reports, Parklawn Building Room 13C-26, 5600 Fishers Lane, Rockville, MD 20857, (301) 443-0762.

AIDS Prevention Among Hispanics: Needs, Risk Behaviors, and Cultural Values

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The term Hispanic is used to denote current residents of the United States who trace their background to Spain or a Latin American nation.

Portions of the paper were presented at a meeting of the American Psychological Association, Atlanta, GA, August 1988. Tearsheet requests to Gerardo Marin, PhD, Department of Psychology, University of San Francisco, Ignatian Heights, San Francisco, CA 94117-1080.

Synopsis.....

Data from different sources show that Hispanics are over-represented in reported cases of acquired immunodeficiency syndrome (AIDS) (twice their proportion of the population) and that their rate of infection by human immunodeficiency virus (HIV)

is three times higher than among non-Hispanic whites. The behavior risk factors most frequently associated with infection in AIDS cases are IV drug use in the Northeast and high-risk sexual behavior in the West. HIV infection prevention strategies for Hispanics need to address high risk behaviors, taking into consideration associated culture-specific characteristics. Strategies need to address as well conditions such as racism and ethnic prejudices that keep many Hispanic homosexuals and bisexuals away from white or non-Hispanic gay organizations and publications, the lack of culturally appropriate drug treatment centers, the level of misinformation among Hispanics, and the possible high incidence among men of sexual intercourse with prostitutes.

Prevention campaigns need to include such Hispanic cultural values as simpatia, familialismo, personalismo, and power distance, if prevention campaigns are going to be perceived as relevant by Hispanics. Appropriate wording and communication channels need to be identified in order to transmit messages that will be perceived as credible and that will reach the largest possible audience.

INFORMATION is inconclusive about the extent to which Hispanics are suffering from the effects of the human immunodeficiency virus (HIV) epidemic. However, the need to develop prevention strategies that are both culturally sensitive and appropriate is evident from currently available epidemiologic information and the public health community's disease prevention campaign experiences.

This report describes the Hispanic population's areas of greatest need in acquired immunodeficiency virus (AIDS) prevention and identifies Hispanic socio-cultural characteristics that prevention strategies must reflect if interventions are to be effective.

Epidemiologic Information

The Centers for Disease Control (CDC) Weekly Surveillance Report for January 9, 1989 (1), showed 83,231 cases of AIDS reported to CDC. Of these, 15 percent, or 12,487, were among Hispan-

ics, nearly twice their general population representation of 8.1 percent, according to the 1988 Bureau of the Census estimate (2). The disproportion of Hispanics would be more pronounced if homosexual and bisexual men with AIDS were excluded, bringing the AIDS-case incidence ratio of Hispanics to whites to 9.3 to 1 (3).

Although reports by Hispanic AIDS patients reflect all types of risk behavior, only 53 percent of Hispanic men with AIDS are homosexuals or bisexuals who are not intravenous (IV) drug users, whereas 83 percent of non-Hispanic whites are in this category. The second largest category of Hispanic men with AIDS is heterosexuals who are IV drug users (34 percent), compared with 4 percent of non-Hispanic whites with AIDS (4). For Hispanics, the majority of heterosexual men with AIDS (87 percent) are IV drug users, compared with 83 percent of blacks and 45 percent of non-Hispanic whites (5).

The percentages vary among cities. In San Francisco, the majority (93 percent) of AIDS cases

among Hispanics have been found among homosexual and bisexual men (6), while in northeastern cities, the highest rates are found among intravenous drug users (4). While Hispanics live in all 50 States, the majority of AIDS cases so far is found in a limited number of cities, including New York, Miami, Los Angeles, and San Francisco. Relative risks of AIDS for Hispanics have been calculated to be up to 10 times higher in the Northeast than in other parts of the country, because of the concentration of IV drug users (7).

Hispanics show patterns of HIV antibody prevalence that are different from those of non-Hispanic whites. An analysis (8) of armed services applicants between October 1985 and March 1986 showed that Hispanics had an HIV prevalence of 1.07 percent, compared with 0.88 for non-Hispanic whites. Analyses of Department of Defense data (3) show that a higher proportion of Hispanics test HIV positive than do whites. During January 1986 and 1987, about 0.3 percent of Hispanics tested positive, compared with 0.1 percent of non-Hispanic whites. Similarly, 1984 data from the San Francisco Men's Health Study showed that 50 percent of the homosexual and bisexual Hispanic men in the study showed HIV infection, compared to 48.9 percent of their white counterparts and 65.5 percent of blacks in the study (9).

Study data show that Hispanics are becoming HIV infected as a result of risk behavior and that the number infected is greater than for other racial groups in proportion to the total population. The statistics imply an urgent need for massive prevention campaigns in order to lower infection rates in this group, which is already markedly underserved by health services.

Prevention Needs and Cultural Issues

Experiences with public health issues other than AIDS have shown that, in order to be successful, prevention strategies must address a group's needs as well as reflect its culture-specific values, beliefs, norms, and attitudes.

Knowledge and attitudes about AIDS. A leading requirement is to determine Hispanics' level of information about HIV infection. Although the National Health Interview Survey has included questions on knowledge and attitudes about HIV infection and AIDS since 1987, only provisional data from 1988 on Hispanics have been reported (10). The results show that Hispanic adults were less knowledgeable than non-Hispanic adults about

AIDS and about the prevention of HIV infection. The data are significant since the survey was conducted in English, tapping the level of AIDS knowledge of those Hispanics who, by using English, were more likely to have been exposed to information campaigns directed at non-Hispanics. Hispanics generally were as likely as non-Hispanics to have been exposed to mass media messages about AIDS.

A recent survey of adolescents in some of San Francisco's largest high schools (11) showed that Hispanics consistently were less knowledgeable about AIDS than blacks and non-Hispanic whites. Blacks and Hispanics were approximately twice as likely as non-Hispanic whites to have misconceptions about the casual transmission of AIDS. A community-wide survey of Hispanics in San Francisco (12) has shown that a number of misconceptions about the transmission of HIV-infection (such as toilet seats, blood donating, and drinking glasses) are still prevalent among significant proportions of those interviewed. Only 5 percent of the 404 adult respondents were considered to be properly informed. More than half (53 percent) of the respondents said that they knew little or almost nothing about AIDS.

Barriers to prevention efforts. A second important issue in prevention activities is the need to reach homosexual and bisexual Hispanic men. Language difficulties, cultural differences, racism, and ethnic prejudice isolate many of them from sources of information commonly available to non-Hispanic whites, such as gay newspapers and pamphlets and some gay bars. An additional difficulty is the fact that many Hispanic men who have sexual relations with other men may not consider themselves to be homosexual (13, 14) and therefore may reject or discount messages targeted specifically to homosexuals. A possible indication of the problem can be seen in statistics on male AIDS patients in San Francisco (6), in which 6 percent of all Hispanics with AIDS were bisexual, compared with 0.2 percent for non-Hispanic whites. Comparable national AIDS rates reported by CDC are 20 percent bisexual for Hispanics and 13 percent for non-Hispanic whites (4).

Latin American cultures tend to have strong anti-homosexual attitudes (15), which may prevent many men from accepting, or being seen reading, information on AIDS prevention. Experiences in the Dominican Republic (personal communication, A. Moya, Sexually Transmitted Diseases Director, Secretariat for Public Health, November 1987)

showed that posters informing men about the use of condoms were not effective because they did not want to be seen reading them; newspapers with the same messages were read readily.

IV drug use. Reaching Hispanic IV drug users, a critical risk group, is a grave concern. In San Francisco, 14 percent of Hispanic patients in treatment for IV drug use were found to be HIV infected, compared with 6 percent of non-Hispanic whites (16). Hispanic IV drug users are difficult to reach by conventional methods because treatment and prevention services usually are neither culturally appropriate nor available.

An added complication regarding the use of needles is the common practice in some Latin American countries of vitamin and medication injections being given by neighbors or friends, who are not involved in standard health delivery systems or professions and who are likely to use the same needles themselves. The San Francisco survey of Hispanics (12) showed that about 5 percent of Hispanics occasionally received injections at home. This potential route of infection is difficult to block, given the high costs of medical care and traditions which immigrants bring with them regarding the administration of medications by injection.

Attitudes about condoms. Severe difficulties are encountered in promoting the use of condoms by Hispanics. First, there is an apparent lack of information among Hispanics about the protection offered by condoms against HIV infection. The San Francisco study (12) found that slightly more than half of the respondents mentioned the use of condoms as protection. Together with the lack of information, there is a pattern of very low use of condoms among Hispanics. The 1982 National Survey of Family Growth (17) showed that a much lower proportion of Hispanics reported ever using condoms (39.5 percent) than non-Hispanics (52.8 percent), although there are few differences in the proportion of respondents using contraception (88 percent of Hispanics and 95.4 percent of non-Hispanics). Some problems in promoting the use of condoms by Hispanics are their association of condoms with prostitution and uncleanness (18-20), and perceived diminished sensation, discomfort, or inconvenience (20).

Use of prostitutes. Prostitution is a prominent subject of concern in AIDS prevention efforts among Hispanics. While there is no information on the frequency of use of prostitutes by Hispanic

males, various factors indicate patterns of frequent use. Large numbers of recently immigrated unattached males live in the large metropolitan reception points for Latin American immigrants, such as Los Angeles, San Francisco, Chicago, the New York-New Jersey area, and Miami. The cultural value of machismo promotes sexual intercourse with prostitutes to demonstrate virility and as a way of achieving sexual satisfaction (13). The danger of HIV infection is increased by the fact that black and Hispanic prostitutes have been found to have higher rates of HIV antibody prevalence (15.4 percent) than non-Hispanic white prostitutes (6.7 percent). The disproportion is found for prostitutes who use IV drugs as well as those who do not (21). There is evidence that while prostitutes may want to use condoms, client demands may interfere with their use (22, 23).

However, monogamy can be promoted among Hispanic men. A recent study (20) found that monogamy was seen as providing a sense of security and commitment in a trusting relationship, in addition to providing protection from disease. Promiscuity was most often seen in a negative light, as shallow, immoral, and causing problems for both the primary partner and the lovers, and with the paternity of children. However, a few respondents felt that multiple sexual partners provided variety, excitement, and an opportunity to learn.

Developing Prevention Strategies

Those who seek to develop successful prevention interventions for Hispanics need to consider using culture-specific values and norms, disseminating information in terms that are appropriate for Hispanics, and using channels of information that not only are perceived to be credible by Hispanics, but which are accessed by them. One such channel is co-interveners, usually friends or relatives, who may be significant figures for change in the community.

These actions can be expected to enhance the effectiveness of interventions in terms of acceptability and power to produce long term attitudinal, informational, and behavior changes. The expectations are based on the inclusion of culture-specific norms and values in interventions, and on interventions being designed while taking into account the cultural characteristics of the group.

Cultural values. Although there are important socio-demographic differences among the various

Hispanic subgroups according to country of origin, educational attainment, and acculturation level, all Hispanics seem to share core cultural values that differentiate them from other cultural groups. Core values need to be properly understood and applied in order for interventions to be effective.

A key cultural value is familialism, or the significance of the family to the individual (24), a value which includes a sense of obligation to provide emotional and material support to the members of the extended family, as well as a perception that relatives are both reliable providers of help and attitudinal and behavioral referents (25).

A second value of significance is collectivism, which reflects the importance assigned to friends and members of the extended family who may be providing companionship and helping to solve personal problems (26).

Simpatia which has no equivalent in English, is one of the most important cultural scripts of Hispanics and refers to the need for positive, smooth, interpersonal relations (27). *Simpatia* mandates politeness and respect and discourages criticism, confrontation, and assertiveness.

Personalismo refers to the preference for relationships with members of the ingroup (those with whom one identifies or considers part of the same ethnic group). Respeto addresses the need to maintain and defend one's personal integrity and that of others, and to allow for face-saving strategies whenever conflict or disagreements evolve. Power distance (28) reinforces the validity of power differentials in society and requires that certain persons, such as the powerful, the elderly, and the learned, be treated with special deference and respect.

Reflecting Hispanic cultural values in developing prevention strategies is one way of helping to ensure that interventions will be culturally appropriate, acceptable, and effective with Hispanics.

Culturally appropriate information. To be successful with Hispanics, an information campaign needs to consider the culturally appropriate way of presenting information about behaviors that are considered to be private (sexual), or which are disapproved of (IV drug use), avoiding the simple translation of messages already being used with non-Hispanic groups. The messages need to be available in Spanish for the 25 percent of Hispanics who do not speak English, as well as for the 60 percent who prefer to speak Spanish. The messages need to be available in English as well, for the 15 percent of Hispanics who prefer to communicate in English, or for whom it is their primary language.

Messages need to use words that are appropriately comprehended by Hispanics. The need to use easily understood words is seen in our recent study in San Francisco (29), where we found that most Hispanic males interviewed did not know the meaning or the referent of the Spanish equivalents for anal or oral intercourse. Similarly, the term active sexual life was misperceived as including only extra-marital and risky sexual practices. The findings imply that the content of messages directed to Hispanics will need pretesting in order to eliminate scientific jargon and to identify those words that are properly understood by the majority of the population.

Credible channels of information. The choice of appropriate diffusion channels and of media is significant, and designers of interventions should not assume that expensive electronic media are more effective than print media, or the less expensive pamphlets, fliers, posters, or billboards. Regional media usage surveys (30, 31) have found that radio may be a more important electronic medium than television for this purpose and that Spanish-language newspapers are not as frequently read as might be expected.

An analysis of the difficulties in reaching Hispanics who are involved in high risk behavior points to the need for reaching them by community-wide information dissemination campaigns and through the efforts of concerned relatives and friends (29). Such persons may be expected to be willing to intervene as a result of such deeply held cultural values as familialism and collectivism. Experience with Hispanic smokers who quit cigarettes with another person's help showed that 65 percent quit with the help of a close relative (32).

Conclusion

Culturally appropriate interventions can be attained through messages that incorporate culture-specific conceptualizations of the problem, that take into consideration cultural values, and that utilize appropriate channels for diffusion of the information. Efforts to provide culturally appropriate interventions are called for not only because Hispanics are overrepresented in the number of AIDS cases reported, but because there are indications that little behavioral change is taking place among Hispanics to prevent HIV infection (33). Culturally appropriate interventions can reduce the proportion of Hispanics becoming infected and, in the long run, decrease the number with AIDS.

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Hispanic Culture: Implications for AIDS Prevention

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J. Boswell, R. Hexter and J. Reinisch, (Ed.), Sexuality and disease: Metaphors, perceptions and behavior in the AIDS era. New York: Oxford University Press

In order to create community programs for the prevention of AIDS, one must have a thorough understanding of the group or groups that will receive such programs. In the case of Hispanics, this means that demographic characteristics (Amaro, 1987; U.S. Bureau of the Census, 1983), linguistic issues, variations among Hispanic subgroups and differences in the epidemiology of the epidemic (Bakeman, McCray, Lumb, et al., 1987; Marin, 1988) must be considered. In addition, before programs can be put into place, appropriate channels for reaching this population must be chosen (Marin, in press; Marin & Marin, 1989b). But by far the overriding consideration in developing such programs must be their cultural appropriateness. Only programs that thoroughly understand and respect Hispanic culture will be effective in slowing this terrible epidemic.

This paper will outline cultural attitudes and values that have important implications for the prevention of AIDS in the Hispanic community as well as present some initial data on reactions of Hispanics to AIDS prevention. The data are drawn from open-ended interviews conducted with over 200 Hispanic and non-Hispanic white adults in San Francisco regarding their perceptions of AIDS prevention. The data are used here to provide examples of the social and cultural processes being described.

The cultural issues described here are necessarily generalizations that have more usefulness when developing approaches for Hispanics as a group than for individuals. It should be kept in mind that acculturation processes, personality, and subgroup differences will have powerful effects on the values held by individual members of any culture.

Hispanic culture represents a particular set of values, norms, attitudes and expectations about the world that shapes those reared in that culture (Hofstede, 1980). The fundamental values and beliefs of the culture are similar for individuals from different Latin American countries (Marin, G., Marin, B., et al., 1987), even though many of the outward signs of culture (food, national holidays, dress) may be quite different.

Cultural Values

Familism. One of the most important cultural characteristics of Hispanics is familismo or the emphasis on the family as the primary social unit and source of support (Marin & Triandis, 1985; Sabogal, Marin, et al, 1987). The strong familistic orientation of Hispanic culture creates a number of obligations as well as a source of perceived support in times of trouble. Hispanics feel a strong need to consult with other family members before making a

decision, an obligation to help others in the family economically and emotionally and a strong sense of love and nurturing toward their children. In addition, familismo may mean that Hispanics will avoid sharing their problems outside the family circle. While these characteristics are not absent in non-Hispanic white culture, they are not as strong, and must compete with a strong sense of individualism and competition that non-Hispanic white culture fosters.

For familistic Hispanics, children are highly valued, (Sabagh, 1980) which may create certain difficulties when AIDS prevention is considered. The high value placed on children and fertility may impede the use of condoms precisely because they avoid pregnancy. In our data, Hispanics were much more likely than Anglos to cite pregnancy prevention as a disadvantage of condoms. The importance of children to Hispanics may also increase the willingness of HIV positive women to carry a pregnancy to term (Gross, 1987). Data from intravenous drug using women, over half of whom were Hispanic, indicate that many choose to conceive a child even after learning they are seropositive (Selwyn, Schoenbaum, Davenny, Robertson, et al., 1989).

Another implication of familismo in Hispanic culture is related to drug treatment programs. Such programs have

generally been set up for the more isolated non-Hispanic white, designed to substitute for the absent family.

Hispanic addicts are more likely to have access to their own families for support and are less likely to seek solutions to their problems in group settings, making most drug treatment programs seem inappropriate to them (Jimenez, 1980). There are currently few culturally-appropriate programs for Hispanic IV drug users (an exception is Szapocznik, Perez-Vidal, et al., 1988).

While familismo may create special problems for AIDS prevention, the power of familismo might also be used in the fight against AIDS. The impact of AIDS on the family and especially on the children could be a key factor in motivating the behavior change of high risk individuals. Due to familism, Hispanics may also be more highly motivated to talk to other family members about prevention. In our data from open-ended interviews, non-Hispanic whites frequently indicated that talking to someone else about changing their behavior to avoid AIDS would infringe on the person's personal freedom or constitute an invasion of privacy, but this concept was totally absent from the Hispanics' interviews. Hispanics were also much more positive about intervening with family members around AIDS and sexuality, mentioning it as an obligation to protect them from AIDS.

Simpatia. The concept of *simpatia* has no direct translation in English, but refers to the importance in the culture of smooth social relations. This is a central cultural value and social script (Triandis, Marin, et al., 1984) which mandates politeness and respect and shuns assertiveness, direct negative responses and criticism. *Simpatia* is essentially the opposite of confrontation, so any AIDS prevention activities that involve confrontation, such as insisting on condom use with a sexual partner, will seem inappropriate. The idea of a woman negotiating new sexual behaviors is very unusual for a Hispanic audience. A more appropriate approach might be to aim messages about condom use directly at Hispanic men. Additionally, effective methods of avoiding HIV infection that can be controlled by the woman directly (e.g., foam, spermicide) are urgently needed. Currently, some HIV prevention workers are recommending that women use spermicides rather than nothing (Nichols, personal communication), although studies of their effectiveness in destroying HIV are lacking.

The *Simpatia* script also requires that the Hispanic listener appear to agree with a message, even though he or she has no intention of following the advice or did not understand it. This makes it crucial that intervenors ask questions to assure that AIDS information and behavior change messages have been correctly understood.

Personalism. Personalismo refers to a preference by Hispanics for relationships with others in their social group. In practice, personalismo means that Hispanics may be more likely to trust and cooperate with health care workers whom they know personally and with whom they have had pleasant conversations, often referred to as "la platica" by Mexican Americans.

Respect. Respeto is the need for respect, especially for authority figures, in social relationships (Lisansky, 1981). Respeto requires that one's sense of personal integrity be maintained in interactions with others. By implication, a person receiving drug treatment must feel that he or she is treated with respect and valued, or treatment will be rejected. Another dimension of respeto is that often clients will not question an authority, even if they do not understand something that is said.

Time Orientation. Hispanics have a different perception of time than non-Hispanic whites, with a more flexible understanding of punctuality (Marin, 1987). Hispanics have a greater latitude before they would declare someone they are waiting for as "late," or feel that they themselves are "late." In addition, "saving time" is seen as less important than smooth and warm social relationships. A hurried pace or focus on saving time on the part of a

caregiver may be seen as rudeness, since in Hispanic culture time is not as important as interpersonal relationships.

Planning. Many AIDS prevention behaviors (e.g., purchasing and carrying condoms) require planning. There is very little direct evidence about these specific planning activities on the part of Hispanics, and arguments could be made for Hispanics to be both more and less likely to plan than other groups. Anecdotal evidence suggests that Hispanics often avoid planning for future events, saying for example, "When I'm ready to quit smoking, I'll just quit. I don't need to set a quit date." Fatalistic cultures might be expected to do less planning, since outcomes are not seen as in the hands of individuals. Fatalism is often a characteristic of agricultural societies which are subject to random changes in the weather and is embedded in commonly used Hispanic sayings ("If God wants, I'll see you tomorrow").

On the other hand, there are a number of equally popular Hispanic sayings that suggest an internally controlled aspect to the culture ("It's better to prevent than to be sorry" and "While one is praying, one hand should be working"). People immigrating from another country, who make up a substantial proportion of the Hispanic population, might be expected to be self-selected for planfulness or at

least the belief that they can have a significant impact on their own lives.

Hispanic Sexuality

Sexual Attitudes. Sexuality appears to be even more intensely private and personal in Hispanic culture than in non-Hispanic white culture. Anecdotal information suggests that sexual issues are not discussed often even between sexual partners. In traditional Hispanic culture, the "good" woman is not supposed to know about sex, so it is inappropriate for her to bring up subjects like AIDS and condoms (Burgos & Diaz Perez, 1986; Pabich, 1986). This type of sexual attitudes in Hispanic women has its effects on their satisfaction with their sex lives. Amaro (1988) found that married Hispanic women in Los Angeles had sexual relations infrequently and often perceived them as not particularly enjoyable.

Hispanic men, on the other hand, are often expected to be highly sexual beings. When asked about abstinence in our open-ended interviews, some Hispanic men felt that not having sex would be nearly impossible as well as unhealthy for them. But Hispanic men may not necessarily be well-informed about sexuality. When asked what might be used instead of penetration, a number of non-Hispanic whites mentioned mutual masturbation, but no Hispanics did so.

The differences between the expectations and attitudes of Hispanic men and women result in a fairly strong double standard that allows men to have sex outside of marriage, commonly with prostitutes. In our open-ended data, when asked if they were personally at risk for AIDS or knew someone who was, no non-Hispanic whites mentioned prostitution, but several Hispanics did. Given the higher rates of HIV infection in Hispanic prostitutes found recently (Centers for Disease Control, 1987), use of prostitutes is likely to result in additional spread of the virus. On the other hand, monogamy is highly valued in Hispanic culture. non-Hispanic whites were able to identify a variety of disadvantages of monogamy when asked, while most Hispanic respondents saw it only as something positive that enhances the relationship.

This combination of lack of discussion of sexual issues, negative attitudes toward female sexuality and use of prostitutes suggests that approaches to AIDS prevention that urge women to carry and use condoms will be ridiculed. Other approaches may be possible, including those that incorporate appropriate emphasis on machismo.

Machismo. Machismo is a complex phenomenon that may be both helpful and hurtful to an AIDS prevention campaign. Machismo incorporates the idea that the male has a serious responsibility to provide for and protect his family, which

could be extended by an AIDS prevention campaign to include protecting the family from the threat of AIDS. A dimension of machismo that could create difficulties in AIDS prevention is the need for an appearance that the man is in charge. A Hispanic woman who challenges her partner because he won't use condoms for example may be setting herself up for rejection or possibly abuse (Gross, 1987).

Condoms. Promotion of condoms is likely to be difficult among Hispanic men who associate condoms with prostitutes. A study in Bogota found that men reported using condoms more often for activities outside of marriage than for marital sex (Dailey, et al., 1973). Although there is a common belief that Hispanics will not use contraception because of the Catholic Church's prohibition, Hispanics are as likely as non-Hispanics to be current users of birth control (National Center for Health Statistics, 1986). However, Hispanics are less likely to currently use condoms for contraception (14% vs. 25% for non-Hispanics among currently married women using contraception). In our open-ended interviews, the only disadvantage of condoms mentioned by Hispanics was that they prevent pregnancy. A campaign to promote condoms among heterosexual Hispanics must be targeted at men and appeal to their machismo and protective concern for the family in positive ways. It may be easier to promote condom use outside of the marital

relationship, and it is likely that the advantages of using condoms that should be emphasized would probably differ from those used when condoms are promoted between steady partners. More research in this area is urgently needed. A campaign to promote condom use in a marital context may be impeded by many Hispanics' desires for large families (Sabagh,. Campaigns promoting condoms that focus on Hispanic women may be even less successful. Hispanic women were very uncomfortable in a focus group when a condom was presented to them (Compagnet, 1987).

Homophobia. Hispanic culture includes a fairly powerful homophobic component (Carrier, 1973; in press). One indication of this is that there does not exist any nonpejorative Spanish equivalent for the word "gay." In unpublished data from a representative sample of Hispanics in the Chicago area, Hispanics were found to be more homophobic than non-Hispanic whites, but less homophobic than non-Hispanic blacks (Ostrow, personal communication). Given this attitude, it is very common for Hispanic men who have sex with other men not to see themselves as homosexual, meaning that messages directed specifically at "homosexuals" or "gays" may be ignored by a large proportion of those at risk (Carrier, 1985; Ronquillo, 1987).

Homosexuality/Bisexuality. The rate of AIDS cases reported for Hispanic homosexual or bisexual men is twice

the rate of the non-Hispanic white population (Bakeman et al., 1987). Campaigns to reach homosexual and bisexual Hispanic men may be the most difficult due to the very underground and taboo nature of their activities, but Peterson and Marin (1988) have outlined some of the issues in such campaigns. For the Hispanic man having sex with men, it may be necessary to use gay-identified outreach workers who have been educated about AIDS to make contacts with them in places where anonymous sex takes place and talk to them about AIDS. Educational materials like posters and condoms might also be provided in such places as public restrooms.

Anal Sex. Little information is currently available on the frequency of anal sexual intercourse in most populations, but one study (Fairbank, Bregman et al., 1987) found that substantial numbers of Hispanics in San Francisco reported anal intercourse in the past month. Of those having sex with only one partner, 7% reported anal intercourse without a condom and 5% reported it with a condom. Of those having sex with more than one partner (17% of sample), approximately 20% had anal intercourse without a condom and 11% with a condom. Anecdotal information suggests that the rate of anal sex may be high in this community, attributed both to perceived increased sexual

pleasure for the male and the contraceptive result of this activity.

Hispanic Needle and Drug Use

Needle-use Behaviors. Some Hispanics in the U.S., especially those who recently arrived, use needles and syringes for activities other than drug use, such as ear piercing and giving injections of vitamins and medications (Compagnet, 1987). This activity is partly due to the fact that in most Latin American countries prescription medicines (including injectables) are available over the counter. A recent study in San Francisco found about 13% of the Hispanic respondents occasionally injected medicines or vitamins in the home (Fairbank, Bregman, et al, 1987). There is at least one case of family vitamin injections spreading HIV infection (Koenig, Gautier, & Levy, 1986). In addition, a survey of San Francisco Hispanics found that most respondents did not identify injection of vitamins or medicines in the home as a possible route of HIV transmission (Marin & Marin, 1989a). In our open-ended data, Hispanics who were unconcerned about medicine injections as transmitting AIDS felt they could take proper precautions, or that no one in the household was infected, so precautions were unnecessary.

Drug Use. Hispanics who use intravenous drugs appear to be infected with HIV at higher rates than non-Hispanic whites (Chaisson, Moss et al., 1987). This may be due to the economic difficulties of obtaining clean syringes or different drug using patterns. Drug use tends to be more frequent in Hispanic and black communities (Mandel & Bordatto, 1980) and may have different functions than those it has in non-Hispanic white communities. It appears to often be an entrepreneurial opportunity in a community with few opportunities to make large sums of money.

Subcultural norms within such a community are likely to be very important predictors of how the individual drug user behaves (Snarr & Ball, 1974; Stephens, 1985). One goal of a community prevention approach might be to change norms within the drug using subculture to make the use of bleach to clean needles and condom use more mandatory. Initial reports suggest that bleach use may be easier to encourage among drug users than condom use (Sorensen, 1988).

Changing norms in the drug subculture might be attempted through involving the entire community, but this approach has limitations. In open-ended interviews, Hispanic community members felt it was important for people to get off drugs and certainly avoid sharing needles to protect against AIDS. Hispanics were especially likely to feel that they should talk to others about the dangers of

drug use. But Hispanics were less convinced that bleach should be used to clean needles. Many respondents felt that bleach might not be enough to kill the AIDS virus or that they did not know enough about bleach to recommend it to a drug-using friend or family member. Changes related to bleach use may need to come from within the drug-using culture, rather than from outside, but Hispanics may be more willing to intervene with others about not using drugs at all.

Drug use prevention in the Hispanic community is an urgent need. It is likely that programs that involve the family of the youth at risk will be most successful in this group. Some work on culturally-appropriate drug prevention programs has already been conducted (Santisteban & Szapocznik, 1982), but much more testing and dissemination of these programs is needed.

Other Issues

AIDS Attitudes and Information. Only limited data exist on Hispanic knowledge regarding AIDS despite national surveys of AIDS knowledge (Dawson, Cynamon, & Fitti, 1987), because these surveys have not yet been analyzed by ethnicity. An assessment of information about AIDS transmission and prevention among adolescents revealed that Hispanic teens knew less than other groups (DiClemente,

Boyer, & Morales, 1988). A state-wide telephone survey of California adults also revealed that Hispanics had less information about AIDS than other groups (California AIDS Office, 1988). Marin and Marin (1989a) found that Hispanics in San Francisco were aware that HIV could be transmitted sexually and through needle sharing, but often believed that the virus could be transmitted casually as well. Many respondents in that survey were unaware that a person could look healthy and still harbor the virus.

In addition to having less knowledge, it appears that Hispanics may have more misconceptions about AIDS. Some preliminary data suggest that many Hispanics view AIDS as a problem almost exclusively of the white homosexual community. Also, in our open-ended interviews, three Hispanics mentioned that the HIV test might actually give them AIDS, although no non-Hispanic whites had this misconception.

Acculturation. The process of changes in behaviors and values due to exposure to the mainstream cultural patterns of the U.S. is called acculturation. The many values, attitudes and behaviors described thus far in this paper are all subject to this process, and individuals may be at many different points along an acculturation continuum. Those individuals who are less acculturated will tend to speak

Spanish and have more Hispanic friends than the more acculturated.

AIDS prevention campaigns should consider the acculturation level of their target audience. Marin and Marin (1989a) found that less acculturated individuals in San Francisco had significantly less correct information about HIV transmission than the more highly acculturated. It is likely that Hispanic AIDS prevention campaigns in English and Spanish might need to have different content and themes to most effectively reach their target audiences.

Conclusion

It is critical that AIDS prevention campaigns promote behaviors that are seen as credible, effective and attainable by the target population. Researchers and those developing such campaigns must actively seek information about which behaviors are appropriate to promote in a given group, rather than attempting to transfer a campaign that was successful in one population (gay men) to another (Hispanic drug users). Familistic orientation, the importance of interpersonal relationships, attitudes toward sexuality and drug use attitudes and behaviors must all be taken into account in developing successful AIDS prevention campaigns.

Acknowledgments

This project was supported in part by a grant from the National Institute on Drug Abuse, Number DA04928. The author gratefully acknowledges the thoughtful comments of Gerardo Marin, Ph.D.

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